# The Evolution of Integration:

# Innovations in Clinical Skills and Ethics in First Year Medicine.

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**ABSTRACT**

Critical self-reflection, medical ethics and clinical skills are each important components of medical education but are seldom linked in curriculum development. We developed a curriculum that builds on the existing integration of ethics education into the clinical skills course, to more explicitly link these three skills. The curriculum builds on the existing integration of clinical skills and ethics in first year medicine. It refines the integration through scheduling changes; adds case studies that emphasise the social, economic and political context of our province’s patient population; and introduces reflection on the “culture of medicine” as a way to have students articulate and understand their own values and moral decision making frameworks. This structured Clinical Skills course is a model for successfully integrating critical self-reflection, reflection on the political, economic and cultural contexts shaping health and health care, and moral decision making into clinical skills training.

It is well established that effective physician communication and interpersonal skills are an integral component of medical care and have a demonstrable influence on patient outcomes (Coutts & Rogers, 2000; Duffy et al., 2004; Epstein et al., 2005). The key role that communication plays in patient care was first noted three decades ago, when Pellegrino (1974) emphasized the need to educate truly humanistic physicians. By the early 1990s, effective communication and interpersonal skills and their elements[[1]](#endnote-1) had emerged as the cornerstone of clinical skills training for medical students (Epstein et al., 2005).

In Canada, this new approach was crystallized in the Consensus statement from the *Workshop on the Teaching and Assessment of Communication Skills in Canadian Medical Schools*, which stated that formal training in effective communication skills is needed at all levels of medical education,and suggested requirements for implementation (Cowan et al., 1992). In the U.S., the American Association of Medical Colleges (AAMC, 1998) had also encouraged faculties to teach communication skills. Innovations in medical curricula were implemented primarily through communication skills courses. The goal has been to have specific skills demonstrated, practiced and evaluated (Braddock, Eckstrom, & Haidet, 2004; Duffy et al., 2004).

At the same time that these innovations in communication skills training were occurring, a parallel movement had developed in the curricula of ethics education, emphasising physician self-reflection. This framework of reflective analysis seeks to ensure that the physician’s own sense of developing knowledge, skills and character is being taught and nurtured. Innovative approaches for teaching this reflective approach to medicine have included experiential learning, narrative approaches, and activities to practice self-reflection as a means of enabling learners to examine, articulate and challenge their own assumptions, values, beliefs, and attitudes (Braddock et al., 2004; Cohen, 2006; Wear, 1998). The American Association of Medical College’s *Medical School Objectives Project* [MSOP] (1998), set out goals for physician professional development, with detailed student teaching and learning objectives to meet those goals. As Wear and Kuczewski (2004) noted, “the language of the professionalism movement is now a given among those in academic medicine” (p. 1).

Together, these innovations -- patient-centered care and reflective approaches to moral decision-making -- have been referred to as part of a “new revolution” in medical education (Braddock et al., 2004). However, a challenge that medical educators have observed over the past decade of this “revolution” is that the new approaches continue to fall short of addressing the erosion of humanistic skills such as self-reflection and moral reasoning as students progress through the “hidden curriculum” of medical education (Wear, 1998).

At Memorial University we observed this challenge of ensuring that the humanistic skills of moral reasoning and self-reflection are retained and deemed relevant to clinical work throughout the four years of medical education. We responded by developing an innovative curriculum for undergraduate medical education that moves beyond the two-pronged (communication skills and ethics training) approach to clinical skills.

An innovative approach to integrating Clinical Skills and Ethics was introduced to Memorial University’s first year medical education programme in the early 1990s. This “narrative” approach is described in Pullman, Bethune and Duke (2005). Six years later we provide an update on how this successful program has further integrated moral reasoning with the clinical skills training of first year medical students. Specifically, our new curriculum refines the integration through scheduling changes; adds case studies that emphasise the social, economic and political context of our province’s patient population; and introduces reflection on the “culture of medicine” as a way to have students articulate and understand their own values and moral decision making frameworks.

Our approach integrates critical self-reflection, reflection on the political, economic and cultural contexts shaping health and health care, and moral decision making into clinical skills training. It does so within an overarching framework that makes central the culture of medicine and emphasises students’ own self-governance over the impact of the “hidden curriculum” on their ability to maintain a humanistic approach to health care.

This paper describes the developmental process involved in this curriculum, focusing on the evolution of our integrated streams of clinical skills and ethics and the eventual culmination of our clinical skills course into a truly novel approach to that enables students to develop humanistic and critical thinking skills relevant and necessary to the practice of medicine. It details the specific components of our curriculum, identifies the specific strengths at our institution that have facilitated the development of this unique approach, and discusses the results of written solicited and unsolicited student evaluations of the curriculum.

**The Evolution of Integration**

The foundation for the novel curriculum was laid in the early 1990s, when the undergraduate Clinical Skills course was expanded to include specific education in bioethics. The approach used was a “narrative approach”, as described by Pullman, Bethune and Duke (2005). That approach uses narratives of illness to explain the “patient’s point of view”, but more importantly understands the course itself to be an exercise in narrative construction, what Pullman, Bethune and Duke (2005) call "narrative structuring". This narrative structuring approach opens up possibilities for students to reflect on their developing knowledge, skills and character as they ‘write their own chapter’ about their emergence as professionals.

From 2003 to 2009 we built on the integrated curriculum and narrative approach that had been in place since the early 1990s, in a way that made the potential of student self-narratives more possible. The changes were originally inspired as a means of responding to the changing demographics of our patient population, as well as to the growing concern with the perceived “ethical erosion” of our own medical students as they moved through the four-year curriculum. The changes were made possible in part because of the expansion of Clinical Skills faculty to include an ethicist whose primary discipline is medical anthropology. Our goals were: (1) to update the clinical cases and expand the use of standardized patients (SPs), in order to enhance their salience for the socio-cultural and political contexts of clinical work in our province; and (2) to explicitly teach reflection on the culture of medicine (a critique of the ‘system’) as a means of enabling moral reasoning skills to continue to evolve beyond the classroom setting.

**Course Description**

Since the early 1990s, our clinical stream (see Table 1) has used a combination of full-group and small-group discussion, with an emphasis on case-based small group learning using standardized patients. The cases progress in complexity throughout the course. Our teaching strategies for communication skills include mentoring, videotape review, and immediate feedback. Training in clinical skills includes communication skills, history taking and introduction to the physical exam. The doctor-patient encounter is used as the template for the learning process. Stewart *et al.*’s (2003) text on *Patient-Centered Medicine, Transforming the Clinical Method* is our primary source for the style of interviewing taught.

The parallel ethics stream (see Table 2) focused on the foundations of ethics and health law, using narrative as a metaphor to understand moral decision-making (e.g. reflections on one’s personal story; entering into the patient’s story). Ethical analyses of the clinical (standardized patient) cases were used to teach the foundations of ethics, providing a clear connection between ethics and clinical skills.

In 2003 we introduced a number of changes. First, we developed new clinical cases. These cases address a broad range of clinical concerns that are deeply shaped by the socio-economic, political, and cultural contexts of the Newfoundland patient population. Specifically, we added clinical cases that involve working with patients with mental health issues, refugee patients from a different cultural context, patients with special sensory disabilities (visual or hearing impairment), and patients living in poverty. Each case is designed to reflect the economic, political and cultural features of our Newfoundland & Labrador patient population. Each case highlights both communication and specific medical issues rarely broached in the more standard medical curriculum. As with the existing clinical skills cases, each case has a built in ethics component.

Second, the ethics stream was expanded in scope to more explicitly correspond in content and timing to the clinical cases. We made a change to the scheduling of the undergraduate medical curricula to ensure that the ethics classes occurred on the day following the clinical discussions.[[2]](#endnote-2) We divided the ethics content into themes that more closely corresponded in content and timing to the trajectory of clinical skills learning, adding a section on diversity (of ability, economic and social resources, and culture).

Third, the students are encouraged to imagine the narratives that they and their patients create and in which they and their patients are embedded as shaped by broader cultural, political and economic contexts. That is, the concept of understanding medicine as a cultural system is introduced, and students are encouraged to make note of (and take notes on) the new “culture” into which they are being immersed.

Administrative changes to course management were also introduced. The integrative aspect of the curriculum was refined and emphasised to faculty, community facilitators, staff and students. Annual curriculum renewals are done jointly by a faculty lead from both the clinical and ethics streams. A single comprehensive course manual is used by all faculty, including small group facilitators and coordinators of the standardized patient program.

Faculty and community facilitators are instructed to cross-reference materials between the two streams. For example, a full group discussion in ethics will refer to patient cases being discussed in the small group clinical setting. In the clinical stream, facilitators encourage self-reflection and the exploration of ethical issues that emerge from the clinical cases. This cross-referencing models for the students the continual relevance of self-reflection and critique of the ‘system’ in their clinical work. Faculty development, delivered by the subject chairs, is provided at the beginning of each academic year, with a discussion and “check-in” halfway through the course and a debriefing at the end. This helps to confirm that the ethics and clinical streams are effectively integrated. Each of these strategies – the single set of objectives; the framing of clinical skills as narrative; the cross-referencing of content; the use of co-chairs from each stream to manage the curriculum; and the faculty development – enables the integration of self-reflection, reflection on the political, economic and cultural contexts shaping health and health care, and moral decision making into clinical skills training.

### Illustrative Cases

How this integration works in practice can be illustrated by referring to our teaching sessions on “poverty and health” and “refugee health”.

Figure 1

Integration of clinical skills[[3]](#endnote-3) and ethics[[4]](#endnote-4)

Ethics

Clinical Skills

foundation of ethics

principles of ethics

consent

confidentiality

truth-telling

duty to care

standard of care

ethical decision making in practice

communication skills

patient centred care

doctor patient relationship

determinants of health

continuity of care

head and neck exam

cardiovascular and respiratory exam

draping and gowning

writing medical histories

continuity of care

**Case-based themes**

working with community agencies

domestic violence

prescription drug abuse

prenatal diagnosis

mental health care

vision / hearing loss

substance abuse

HIV

cross cultural care

poverty and health

care of adolescents and children

adolescent sexuality

**Self-reflection of /reflection on system themes**

narrative approach

medicine as a cultural system

resource allocation

medicalization

patient advocacy

diversity and inclusiveness

poverty and professionalism

Poverty and Health. The “Poverty and Health” section occurs near the end of the second term and was designed to allow students to address the real life impact of poverty on families. This section begins with a full-group discussion within the ethics stream, where students are invited to brainstorm their own/others’ ideas about the “who” and “why” of people living in poverty[[5]](#endnote-5). A second aspect of the ethics discussion focuses on students’ ideas about stereotypes in relation to doctors and wealth/power. Self-reflective discussion and debate are used to encourage students to understand, articulate, and challenge their own assumptions about people living in poverty, and sets the stage for the clinical small-group work.

The session starts with a small subgroup of students (4-5 per group) interviewing four members of a “family” (SPs). This family’s health and emotional well-being has been deeply affected by the chronic underemployment of the mother and father[[6]](#endnote-6). The student group meets with individual family members who tell their own story. This enables students to see the impact of poverty on the daily lives of family members.

The following week, the students return to their larger group of seven or eight and begin by reflecting on the stories and concerns of each family member. The students have prepared with background readings, and this enables more thoughtful discussion of poverty and health. During that discussion, students are asked to prepare a monthly budget for the family based on current social assistance rates, and are coached on the items to include in a family’s budget. This gives students a tangible understanding of how and why families living in poverty often go without the necessities.

The juxtaposition by students of their own implicit values and moral judgements about poverty and health (through the ethics stream) and the stories of family members living in poverty (through the clinical stream) has been very valuable in personalizing the issue of poverty for the students. They no longer see poverty as hypothetical, but instead appreciate the complex ways in which poverty may impact on a family and in a community.

Refugee Health. Another example of successful integration is a case designed to introduce students to cross-cultural health care. Within the clinical stream, the objectives are: to develop an appreciation for the concept of cross-cultural care; to learn how to use a translator properly; and to be aware of the advantages & disadvantages of communicating with the assistance of a translator.

The clinical skills session begins with a one-hour plenary, delivered by staff from the provincial settlement agency, on challenges faced by refugees and immigrants to the province. This is followed by the regular weekly small-group case-based work where students interview a standardized patient (SP). For this session, the SPs are themselves newly arrived refugees who have been recruited from the community and trained. They portray a particular case of a refugee presenting, with a translator, to a family doctor with somatic complaints that are caused by emotional distress. The training is done over several weeks and in settings that are comfortable for the standardized patients.

SPs then come out of role and participate in a facilitated small group discussion with the students about challenges faced as a newcomer, based on their own experiences. They discuss community-based strategies for resettlement; they may address the difficulties faced in their home countries and refugee camps. After the session there is a debriefing for the standardized patients by the course chair (a family doctor with expertise in immigrant and refugee health) and the SP trainer. Students comment that they feel privileged to be able to learn and interact with the newcomers.

This session is timed to be nested within a series of five ethics classes (lectures and full-class discussion and debate) on diversity and ethical decision making. The first objective is to appreciate that bioethics comes from and responds to cultural norms. This includes (1) understanding that biomedicine is culturally shaped; and (2) reflecting on and critically examining the cultural basis of our own assumptions and practices. The second broad objective is to practice ethical decision making across cultures. This includes: (1) understanding the meaning of “culture” compared to “religion”, “ethnicity” and “race”; (2) identifying the importance and role of each of these in practice; (3) appreciating the continuum from cultural sensitivity to diversity awareness to inclusiveness in the health care system; and (4) appreciating that embracing diversity includes attention to any differences that may marginalize, including differences of ability, gendered identity, and sexual orientation.

# Evaluation of students

Within the clinical stream, weekly formative evaluations are provided in both informal (spoken) and formal (written) formats. Informally, immediate feedback on the demonstration of effective clinical skills is provided by peers, facilitators and “patients” (SPs) within the small group sessions. An important aspect of the informal feedback is the group critique of video-taped interviews. Students identify their own learning needs and written feedback is provided on self-assigned homework reports. Other written assignments include history and physical exam reports as well as case-based research reports. Summative (graded) evaluations are conducted by group facilitators at the end of each term. There is also a formal evaluation interview in the form of an OSCE at the end of the Clinical Skills course.

Within the ethics stream, a series of journal-style narrative reflections are the means of evaluation, with one journal submitted at the end of the each of the five course sections[[7]](#endnote-7). While the majority of submitted assignments are in essay format, approximately 10% of students choose to use creative expression, for example poetry, visual art, and video performance. Each journal corresponds to the topic discussed in that section. Evaluation is based on two factors: 1) demonstration of knowledge of the subject matter taught within that section; and 2) demonstration of ability to articulate and critically analyze one’s own values and beliefs; and articulate and challenge the political-economic context in which medical ideas are developed and normalized. Evaluation of the ethics component is based on a four point internal scale: Fail, Borderline, Pass, and Pass Outstanding. An overall grade is generated and this contributes 20% to the final Clinical Skills grade[[8]](#endnote-8). Therefore, while a student will not fail the Clinical Skills course based on the ethics component of the program, the weighting given to those components is significant and taken seriously by the students.

# Observations

The process of refining our integrated curriculum was made easier by the nature of and relationships between the four stakeholder groups involved in delivering the Clinical skills course: faculty, administration, SP staff, and community facilitators. First, having co-chairs representing both the ethics and the clinical streams to manage the curriculum content was essential to the translation of the evolving integrated approach to faculty development within each stream. Second the small group community facilitators (clinical social workers and psychologists) were highly motivated and dedicated to the idea of an integrated course. With the support of administration within the Faculty of Medicine, we were able to successfully argue for the continued funding of this valuable community facilitator aspect of the curriculum. Third, the ethics stream within the Faculty of Medicine was expanded to include two additional ethicists, which greatly increased the capacity to have a more thoroughly integrated Clinical Skills program. Fourth, staff in the Standardized Patient Program understood both the value and the complexity of an integrated approach. They have been creative and enthusiastic about training SPs to specifically facilitate a model of self-reflective patient-centered care. The Standardized Patient Program is well-supported and provides highly skilled actors and patients for students to interview and examine throughout undergraduate training.

Importantly, the course has benefited from clear support from the administration within the Faculty of Medicine. This support includes a funded standardized patient program and coordinator; a clinical skills administrative coordinator; support for community facilitators; and expansion of the number of ethics faculty. As well, administration supported our proposed changes to the scheduling and objectives of the undergraduate medicine curriculum in general, changes that were necessary to accommodate a revised integrated Clinical Skills course.

# Evaluation of the new curriculum by students

We used unstructured, open-ended written comments by students as a means of eliciting evaluative feedback on the curriculum. Written evaluations are done as part of the Clinical Skills evaluation at the end the year and prior to final exams. On the written evaluations space is provided for additional comments on the Clinical Skills course. Comments received between 2005 and 2009 were used for this analysis. Response rate to the opportunity to provide additional comments on the clinical skills course was close to 100%.

The response was consistently favourable:

*“The wide variety of cases we were exposed to was very helpful, especially for members of the class who live relatively sheltered lives and know little about poverty, mental illness etc. before beginning medical school .”*

“*The interviews with standardized patients are key. They are so well trained that you forget it’s not real. It really teaches you how to communicate. It’s excellent.”*

*“Exposing students to a variety of different clinical scenarios with simulated patients is an excellent experience. Many of the patients were very realistic which made for a more natural experience. They teach us how to connect with people in a safe environment.”*

Students reported that they appreciated that the course was fundamentally different in its humanistic nature from the rest of their medical school curriculum:

*“This course has been an excellent chance for me to re-energize and helped me remember why I chose to study medicine.”*

As well as the formal evaluation process, unsolicited written feedback was received in the form of notes to the ethics instructor. Students commented favourably on the opportunity for open discussion and debate on contentious issues in medicine. The self-reflective journals have been highly valued by students, with three commonly reported comments: (1) the assignments are a “safe” way to express their moral values, attitudes, beliefs in the face of the uncertainty of ethical dilemmas or patient care (for example, experiences interviewing SPs) without fear of ‘making a mistake’; (2) the assignments allow students to express their observations about critiques of the culture and politics of medicine, including commentary on unethical practices they have observed; and (3) the narratives are a change from the typical exam-style forms of evaluation and allow creativity and flexibility in format.

The success of the integrated approach to Clinical Skills is most evident in two particular extra-curricular activities initiated by students. In 2003, a discussion in an ethics class led students to launch the “Collected Works: MUN Medical Student Reflections”, based on excerpts of submitted Clinical Skills journals. That journal of reflective writings on the process of emerging as a professional continues to be published yearly. In 2005, the students initiated a community medical outreach project for newly arriving refugees. The MUN Med Gateway Project is a very successful program that was initiated as a direct result of the course session on cross cultural care and refugee needs in our community.

**Summary**

We still face challenges in the curriculum. One barrier to the successful long-term retention of the humanistic skills we teach is structural: This integration of ethics into clinical skills has not continued in years two, three and four of the medical school curriculum. A second barrier is that while our curriculum changes support the on-going reflection by *students* of how their values are being challenged or reshaped as they becoming increasingly immersed in the culture of medicine, we see a desperate need for broader *faculty* education. Anecdotal evidence indicates that the humanistic skills we teach are not always respected nor modeled in subsequent clinical teaching. In fact, advanced students have reported that the upper level clinical courses may contradict the values taught in the introductory Clinical Skills course, leading to moral dilemmas on the part of the students. More explicitly, there are faculty who tell upper-level students that the self-reflective aspect of this course is “soft stuff and not real medicine”. On the upside, as students become faculty, we are seeing changes in this attitude.

# Synthesis

This course integrates patient-centered clinical skills training with ethics education in self-reflection, moral decision-making, and reflection on the political, economic and cultural contexts shaping health and health care. Learning occurs experientially. The basic learning unit is the doctor-patient interview. The cases introduced in the clinical stream and referenced as narratives throughout the ethics stream match the socio-cultural and political realities of the clinical environment in which these emerging professionals will work. The format of small groups with trusted facilitators and peers fosters a safe and respectful learning environment. This format enables students to safely emphasise self-reflection on their own values and moral reasoning within the context of clinical skills training. By explicitly referencing the culture of medicine as part of the story shaping students’ own narratives, self-reflection on what one’s values are – and how they are (re)shaped -- becomes a “natural” part of patient-centered clinical skills reasoning.

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**Endnotes**

1. Later itemized as: respect, paying attention to the patient, being personally present, having a caring intent, and flexibility (Coutts & Rogers, 2000). [↑](#endnote-ref-1)
2. Attendance was made mandatory for the ethics sessions just as it had always been for the clinical stream. This expectation is framed as the beginning of their role as professionals with their obligation to classmates, teachers and eventually patients. We equate missing a session to missing a clinical obligation. [↑](#endnote-ref-2)
3. Students attend three-hour sessions, weekly for 24 weeks, in the first year of medical school Clinical Skills Course. They are divided in to groups of 7 or 8 and maintain the same group throughout the course. They have the same co-facilitators, a physician and community social worker, for the year. This significantly contributes to continuity of teaching and allows for more “safety” within each group. The format of the course uses the doctor-patient encounter as the template for the learning process. We use “Patient-Centered Medicine, Transforming the Clinical Method” as the basis for the style of interviewing taught.

   Cases have been designed to encourage learning about common issues in medicine. During the first term, students practice interviews with a standardized patient in the small group setting. The facilitators and SP provide feedback to the students. Students primarily learn by doing interviews and getting immediate feedback but they also have the opportunity to watch seasoned interviewers and critique their techniques. The group then discusses the case and identifies their own learning needs around the case and sets homework for the group. Group members gather the information in a variety of ways, including accessing community resources (e.g., Sexual Health Center), and educate their group about the learned material the following week. All cases have a medical ethics component.

   Interviews are videotaped for each student. This provides a way for the students to self-evaluate at their own convenience. All students are required to review their own tapes and show their facilitators selections during their end of term evaluation. As the year progresses, the students are brought to see patients in the teachers’ own practices, either in clinic, on home visits, hospital wards or in palliative or geriatric care. [↑](#endnote-ref-3)
4. Twenty-four hours of class time in ethics, history of medicine, and health law are held throughout the CS1 course, with a format of full-group discussion and debate. Content covers the full range of ethical, legal, and social (historical, cultural) topics set out by the CMA’s *Objectives of the Considerations of the Legal, Ethical and Organizational Aspects of the Practice of Medicine* (CLEO) and the American Association of Medical College’s *Medical School Objectives Project* (MSOP) (Cohen, 2006).

   In the ethics component, we frame our discussions using the “narrative structuring” approach, detailed elsewhere (Pullman et al., 2005). Students are taught how to reflect on patient narratives and to have a better understanding of their own narrative and how it influences their development as future physicians. Teaching strategies include role-play, debate on contentious (morally salient) issues, reference to popular television shows and films, and journaling. Invited guests present alternative (non-medical) ways of understanding illness and healing (e.g., film makers, writers, artists, anti-poverty activists). [↑](#endnote-ref-4)
5. The determinants of health are already taught through the broader undergraduate medicine Community Health course and are a helpful background for the students to discuss poverty and its impact on health and health care delivery. [↑](#endnote-ref-5)
6. The patient scenarios are standardized. [↑](#endnote-ref-6)
7. The first of these is a formative assignment in the area of history of medicine, part of the broader humanities teaching within clinical skills. [↑](#endnote-ref-7)
8. This 20% includes history of medicine teaching within the broader humanities component of Clinical Skills in Med 1; history constitutes approximately one-fifth of the humanities teaching, with the remainder being the ethics/law teaching. [↑](#endnote-ref-8)