# Students: the sensory system of medical education

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Rosemary has presented her research on role models at ANZAME for the last two years, and won the ANZAME student prize in 2005. She is also an NZMSA Representative and convened the Medical Leadership Development Seminar this year. Her main interests are public health and humanitarianism.

Lecturers, clinicians and teachers are forever explaining and espousing Evidence Based Medicine (EBM) to our weary student brains. This evidence based approach should determine the choice of drug, the length of stay, the type of procedure and hopefully the patient outcome. EBM also underpins significant areas of our assessment; literature reviews, clinical question projects and many of our summer studentships. We are able to discuss relative risk, sensitivity, specificity, and probability to support our budding clinical reasoning skills. However, our collective student knowledge about the theories and evidence which underpin our own medical education is woefully limited. We regularly discuss the best evidence for managing our patients, but rarely examine the best evidence for the education we receive.

This generalized student disinterest in education research belies a significant number of academics, educators, and researchers investigating ways to improve our training. Medical education is a research discipline in its own right. The field supports well circulated international journals and a number of regional medical education associations. In Australasia the predominant medical education group is ANZAME: The Association for Health Professional Education. ANZAME supports local researchers and educators by publishing a journal,[1] providing research prizes, and convening an annual conference. This conference allows curriculum designers, educationalists, clinicians and students to discuss challenges at our respective institutions and attempt some kind of best practice for the process of creating new doctors.

The ANZAME Convention 2006 was held on the Gold Coast in June and provided a welcome respite from the punishing cold in Christchurch. This was my second year as an ANZAME delegate after stumbling into education related research over the preceding summers. It is impossible to relate the presentations, conversations and ideas which filled the three days; examples will have to suffice. One study, by Otago researchers, is investigating how active learning behaviors (ie nodding and note taking) change learning outcomes in small group work. Sounds a bit abstract, but the point of the work is to decide whether we should be compelled to participate in tutes or whether we get just as much from sitting back and "letting it sink in". Another international project, with a center in Auckland, is investigating how students feel about performing physical examinations on each other. They hope to gain a better understanding of the issues and identify which students may be more uncomfortable with peer examination. This also has clear, practical and learning outcome implications. Other presenters discussed how students are selected in medical school, what they learn from internship, the role of dissection, how to best integrate international students, and how to respond to unsafe practices in OSCEs. Each of the presentations was followed by debate, discussion and suggestions. Only five students attended ANZAME but in most of these discussions they contributed a unique and vital perspective. I wished that there were more of us to represent a collective student voice. Lots of educationalists talked about what they think students enjoy doing and what kind of teaching they think we'd like more of. Surely it would be more useful if we were willing, and able, to articulate our own experiences to the people who work so hard for our benefit.

I believe that medical students have an obligation to be more active participants in shaping their own education and in education research. Firstly, we are the best people to assess the curriculum in its entirety. No member of faculty, or advisor, or teacher has the unique daily experiences that constitute our education. They will only understand what we find difficult, and what we enjoy, if we tell them. However, anecdote is not enough. If we expect to practice evidence based medicine then we have an obligation to contribute to evidence based education. Secondly, we are paying customers for this experience. We should be actively involved in getting the best education for the precious dollars that we pour into it. We can not possibly know if we are getting value for money if we are ignorant of medical education best practice. Finally, we have a professional obligation to our peers and we must play our part in improving our teaching for the next generation.

I think there are three main reasons for failing to meet these obligations. Firstly, we have limited long term investment in the process. Most curriculum innovations and reforms will be implemented once we have left the course and it can be frustrating to endlessly advocate for a nebulous cohort of students in the years below. Secondly, we are not well equipped to understand the theoretical and qualitative nature of medical education research. Entry requirements for medicine in New Zealand force many of us to study the sciences from an early age, to the exclusion of a broad humanities education. The complex multivariate nature of education forces almost all research to be qualitative and observational; modes which are considered "soft science" in our strongly biomedical education. Finally, we have few passionate medical educational role models. Fewer and fewer of our teachers are engaged in the traditional triad of clinical practice, education and research which defined academic medicine[2]. Education research is largely the domain of a few devoted medical education advisors or non medically qualified researchers. Few medical students come into contact with the curriculum planners and educationalists. Without exposure to role models passionate about improving our education it is difficult to become inspired ourselves.

Undoubtedly there are interested and passionate students overcoming these barriers working with faculty to improve their own education. New Zealand students have been significantly involved in ANZAME in recent years; serving on the committee, receiving prizes and presenting at conferences. A legion of long suffering student education representatives also attend meeting after meeting about budgets, timetabling, and staffing. However, the vast majority of us accept our teaching and our training unquestioningly - punctuated only by the occasional, token, feedback form. There are reasons for our ambivalence towards education research but none of them outweigh our obligations to be more informed, active participants. Becoming a doctor consumes and dictates some of the best years of our lives, yet we are content for the journey to be guided by a handful of passionate individuals that few of us ever meet. The process of becoming more involved doesn't have to be arduous and time consuming; reflect on what you do in a day, fill out feedback forms, go to feedback sessions, tell your conveners what you'd rather learn about, talk to your education reps, consider summer research into your education, inform yourself about education issues, challenge and contribute to the teaching we receive. We must take more responsibility for our education if we want to become the best possible graduates.

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## REFERENCES

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