

and engaging', and the more sobering 'I think it's pointless making all the groups prepare a presentation for transplantation if only half will present'.

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When medicine was a foreign language

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Context and setting Can innovation replace tradition in order to resolve a communication problem? This was the conundrum we faced at our university medical school in China. In a country with one-fifth of the world's population, medical education was failing. Patients and doctors spoke Chinese, but medicine was a foreign language. A country steeped in the tradition of mentor-based, listen-and-learn teaching methods was challenged by dissatisfied patients and unhappy encounters in the hospital. The listen-and-learn method trained doctors to be passive listeners, without the skills to communicate with patients.

Why the idea was necessary Although the rapid development and implementation of scientific research had greatly improved the overall diagnosis and treatment of many diseases, doctors faced increasing resistance from unhappy patients. Escalating tensions between doctors and patients created charges of conflicts of interest on both sides. Tensions were particularly high in the surgical disciplines, which carry greater risks of morbidity and mortality. A doctor would tell a patient about his or her disease and the associated risks and prognosis, but the patient would not comprehend or accept the information. Unrealistic expectations and unhappy outcomes led to complaints and the erosion of trust in the health care system. In China, medical education has emphasised using natural science to identify the disease and select the appropriate treatment strategy. The concept of humanism, of understanding, treating and educating the patient, had been lost over the decades as traditional Chinese medicine turned its attention to science.

What was done Chinese medical education underwent a revolutionary change in 2004. Problem-based learning (PBL), humanism and communications

skills training swept through the educational system and into our hospital.

In our training programme, we introduced the medical students to PBL and to the notion of how it prepares them to communicate with their patients efficiently and effectively. We set up scenarios of doctor-patient conflict and medical students took turns as patients and doctors in role-playing the interaction and resolving the problem. We raised questions about what is central to communications skills, the importance of understanding the core issue, and how this helps to establish a common ground between doctor and patient. The goals of these activities were to build up medical students' confidence, encourage willingness to communicate and better prepare doctors for clinical practice. Currently, student performance on internship is not judged by an examination paper, but by a combination of class reviews, interview results with patients and case analyses to generate an overall assessment of the individual intern student.

Evaluation of results and impact The problems of making a transition from the mentor-based system, incorporating PBL into a system dominated by the mentor-based model, and meeting the needs of a society in transition were all experienced within the microcosm of our department. However, when we surveyed the medical students, we found widespread satisfaction with the programme. The doctors remained concerned about misdiagnosis and missed diagnosis, but they said role-playing enhanced their interest in medicine and their confidence with patients. If such a sea change can take place in tradition-bound China, it may very well be successful anywhere.

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Reflection rubric development: evaluating medical students' reflective writing

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Context and setting Reflective capacity (RC) is deemed an essential component of professionally competent practice. Medical educators continue to strive to implement innovative pedagogy aimed at promoting RC development, often within a humanities and medicine context. The use of reflective

writing exercises within undergraduate and graduate medical education is expanding; however, tools to assist with evaluation and feedback are lacking.

A reflective writing curriculum innovation was introduced into the Doctoring course in the 2 years of pre-clinical education at the Warren Alpert Medical School of Brown University during the 2005–2006 academic year. The Doctoring course teaches clinical skills and professionalism through integrating instruction in medical interviewing, physical diagnosis, cultural competence and medical ethics. The course structure includes large-group didactic sessions, small-group processing and skill instruction, one-to-one, community-based doctor mentoring for skills practice, and reflective writing assignments. Within this course, 19 structured reflective writing exercises ('field notes' and reflections on case write-ups) are required of medical students and guided individualised written feedback from an interdisciplinary faculty team is provided. The interactive reflective writing paradigm of guided faculty feedback on students' reflective writing to promote reflection has recently been described.

Why the idea was necessary Curriculum initiatives that include reflective writing have created the need for a valid, reliable evaluative tool that can be effectively applied to assess the student's reflective level and its development. Various frameworks for assessing RC have been described, although definitions of reflection levels abound and existing measures can be challenging in their application. Publications on the utility of reflective writing in medical education have been largely anecdotal or based on student self-report.

What was done We devised a reflection rubric for determining student reflection levels within reflective writing exercises. Our reflection rubric emerged from both a comprehensive analysis of the literature evaluating the reflection construct and the synthesis of existing reflection measure instruments, and resulted in a more concise, user-friendly format. The rubric consists of five levels of reflection, for each of which clear and thorough criteria are provided (based on the integration of literature definitions). The criteria include such features as writing from the 'I' or 'we' perspective, moving from description to reflection and introspection, attending to emotions, and displaying transformative learning. Levels are as follows (bracketed descriptors adhere to Doctoring course evaluation guidelines):

- 1 *non-reflective*: habitual action (unsatisfactory);
- 2 *non-reflective*: thoughtful action (needs improvement);

- 3 *reflective* (competent);
- 4 *critically reflective* (exceeds competence), and
- 5 *transformative learning* (exceptional).

Evaluation of results and impact A 2009 reflection rubric pilot study provided encouraging results in ease of application and inter-rater reliability. The rubric was applied to a dataset of all Year 2 students' self-selected 'best' reflective writing notes ($n = 93$) and reflection levels were found to be distributed as follows (numbers of students in parentheses): level 1 (0); level 2 (17); level 3 (38); level 4 (28), and level 5 (10). Pilot inter-rater reliability on 10 random notes was at 0.7 for full agreement and 1.0 for one level of difference.

We propose that this reflection rubric represents an incremental step forward for the discipline. Longitudinal investigations of reflective writing exercises using this rubric will, we hope, assist educators as they reflect on the efficacy of such curriculum initiatives.

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A short palliative care experience: beginning to learn

Erica Brownfield & Sally Santen

Context and setting The Robert Wood Johnson Foundation issued grants to establish palliative care clinical learning opportunities for medical students. We developed a 1-week focused curriculum on palliative care that was embedded into the internal medicine clerkship. We examined the feasibility of a 1-week course incorporated into the medicine clerkship, and looked at knowledge and attitudinal changes in students who had completed the course.

Why the idea was necessary In 2000, the Liaison Committee on Medical Education (LCME) mandated that all medical schools 'must' teach about end-of-life care, yet few schools have developed a comprehensive educational programme during a 4-year curriculum. The relatively recent American Board of Medical Specialties designation of hospice and palliative care as a medical subspecialty in 11 medical practice areas adds further motivation for medical schools to develop palliative care training for medical students.

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