Excellence in Medical Education

Educational Research and Scholarship

Issue 6: February 2015
Aims and Scope

The Academy of Medical Educators (AoME) was established in 2006. The main aspiration of the AoME is to improve clinical care through teaching excellence. *Excellence in Medical Education* has been designed with this aspiration in mind. The first five issues will focus on the AoME Professional Standards with invited expert reviews. Future issues will be based on specific educational themes with invitations to submit articles with a peer review process.

*Excellence in Medical Education* has been designed for the active and busy medical, dental and veterinary teacher. The aim is to highlight important educational topics, discuss challenging and controversial issues and stimulate debate. The series embraces 21st Century medical education with expert reviews, interviews and specialist articles. The series will provide an inspirational and thought provoking journey into the exciting field of medical education. We welcome articles and reviews for future issues so if you would like to contribute or comment please contact the Editor, Dr Vimmi Passi, at: vpassi@aol.com

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*Excellence in Medical Education* is available online to Associate Members, Members and Fellows of the AoME.

Despatch

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Welcome from the Editor

Dr Vimmi Passi,
Editor of Excellence in Medical Education

Following the success of the first five issues, I am very pleased to welcome you to the sixth issue of Excellence in Medical Education, an exciting new educational product for the members of the Academy of Medical Educators (AoME). This series embraces 21st century medical education with expert reviews, interviews and specialist articles. It provides an inspirational and thought provoking insight into the exciting field of medical education.

This Sixth Issue is the last of the series that focus on the Academy Professional Standards. This Issue focuses on the Professional Standards Domain Five – Educational Research and Scholarship. This issue takes the reader on an exciting journey from theory to practice in medical education. This Issue begins with an overview of Socio Cultural Theory in Clinical Education by Professor Andy Grant, highlighting the importance of this theory in clinical practice. This then leads onto the second article by Professor Nick Cooper on Professionalism as a Medical Educator – this excellent article discusses career development, scholarship, identity formation and recognition as a medical educator.

This leads onto an inspiring article by Professor John Sandars discussing the Challenge of Evidence Based Practice in Medical Education from a Knowledge Management Perspective. The fourth article provides a thought provoking article by Dr Malcolm Galloway on Challenging Diagnostic Overconfidence. The final article is a very inspiring interview with Professor Andy Grant, Dean of Medical Education at Swansea Medical School.

Excellence in Medical Education has been an exciting new venture and I would like to thank all of our expert authors for their thought provoking and fascinating articles. It has been a great pleasure working with you all. We welcome articles and reviews for future issues, so if you would like to contribute, please contact the Academy of Medical Educators at www.medicaleducators.org.

1. The AoME Professional Standards

The Academy of Medical Educators (AoME) is a charitable organisation developed to advance medical education for the benefit of the public through:

A. The development of a curriculum and qualification system;
B. Undertaking research for the continuing development of medical education; and
C. The promotion and dissemination of best practice in medical education.

In order to achieve these objectives, the AoME’s Professional Standards have been produced. These Standards have been designed to provide the basis upon which a curriculum for medical educators can be developed. They act as a framework against which professional progression as an educator can be planned and measured. The Standards are a tool designed to assist medical educators to work towards excellence.

To be engaged in effective and appropriate professional development is an integral part of Membership and Fellowship of the AoME. The Standards aim to help clarify the professional characteristics that should be maintained and built on for the variety of roles undertaken by medical educators. The Professional Standards are divided into themes and each theme provides details of the knowledge, understanding and practice that underpin the roles of those involved in medical education.

The Standards may be used by organisations to identify the skills and competencies required of those who undertake or fulfil an educational role. Organisations may also use the Standards to develop and offer a framework for training and continuing professional development in support of medical education. The Standards could be considered when setting objectives in performance and appraisal and used for assessing the performance of individuals within organisations.

The Professional Standards are divided into core values of medical educators and five domains.
2. Professional Standards – Educational Research & Scholarship

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<th>Standard Level 1</th>
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<td>4.1.1 Is aware of basic educational theories and principles</td>
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<td>4.3.1 Demonstrates advanced understanding of a wide range of educational theories and principles</td>
<td>4.3.2 Critically evaluates the educational literature and applies this to his or her educational practice</td>
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<td>4.1.2 Is aware of literature relevant to current developments in medical education</td>
<td>4.2.2 Critically evaluates the educational literature and applies this learning to his or her educational practice</td>
<td>4.3.3 Develops new educational insights, theories and practices, through scholarly endeavours</td>
<td>4.3.4 Designs, supervises, manages and evaluates research strategies or projects</td>
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<td>4.1.3 Is aware of the principles of critical appraisal</td>
<td>4.2.3 Participates in the design and development of educational programmes, projects or research</td>
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<td>4.1.4 Is aware of the major issues and challenges facing medical educational research</td>
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<td>4.3.8 Evaluates and appraises research projects and their outcomes</td>
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3. Socio-cultural Theory in Clinical Education

Professor Andrew Grant

Think of a medical student on a ward round with a senior clinician and a group of his or her peers being asked to present a patient that they had just seen. There are certain rules about how to present the patient, which part of the history to present first, and the kind of medical language in which to make their presentation. During the course of the presentation the student asserts that they think the most likely diagnosis is one of pulmonary embolism, which is not only wrong but also makes no sense of the history and the clinical findings that have been presented. The Consultant does not tell the student that they are wrong directly but encourages them to look for themselves how their proposed diagnosis is not compatible with the history and examination findings. If the student is not able, with questions and help, to identify where he/she has gone wrong from his/her own knowledge, the Consultant may ask the other students in the group to help.

Constructivist Learning Theory

As educators in general and medical educators in particular we owe a great deal to Lev Vygotsky who, in his work on the development and learning of small children, concluded that learning takes place by social interaction and only by social interaction can also take place between learner and teacher 1. In our example the clinical teacher has chosen to use questioning as a form of social interaction to help the student. They have avoided telling the student that their answer is wrong and instead have asked questions that are likely to help the student to recognise from their existing knowledge that the first answer they gave was to the most likely diagnosis was wrong.

Vygotsky described the zone of proximal development by which, he meant what was achievable by the student when they were supported in their learning by a teacher or peer but that they could not achieve unaided. Vygotsky left only sparse written records of his work and multiple interpretations have been made over the years 2. Going back once again to our example where the student presents the patient, he does so in a specific order and using a sufficiently technical medical language. When the Consultant starts to ask questions they may be based on an assumption that there are some facts of medical knowledge that every medical student at this level would and indeed does know (e.g. characteristic pain experienced by a patient with a pulmonary embolism). The theoretical work of Vykotsky is developed by other authors and of particular value as a model against which to plan and develop clinical education is the work done on apprenticeship by Jean Lave and Etienne Wenger on situated learning. Lave and Wenger observed apprentices in a number of professional settings 3.

Lave and Wenger say that learning takes place, and only takes place, by legitimate peripheral participation in communities of practice 4. If we think for a moment of a junior medical student going on to a hospital ward for his or her first clinical placement. The ward will already have an established community of practice caring for its patients and the student is currently in the zone of proximal development because the level of interaction and feedback on the students’ ability to respond to the learning material is much more limited than in an interactive session such as the one just described.

To return to the way the students and their teacher interact, this represents Vygosky’s assertion that not only did learning take place through social interaction but that it always took place against a cultural background, and that cultural background exerted a significant effect on learning which was taking place 4. Going back once again to our example where the student presents the patient, the teacher does so in a specific order and using a sufficiently technical medical language. When the Consultant starts to ask questions they may be based on an assumption that there are some facts of medical knowledge that every medical student at this level would and indeed does know (e.g. characteristic pain experienced by a patient with a pulmonary embolism).
Excellence in Medical Education

Legitimacy

If our student is welcomed and made to feel that they are part of the community of the practice of the ward, then their role as learner is part of the community of practice, then their presence there will feel legitimate. If on the other hand ward staff are busy with urgent patient care activities, who either ignore or worst still are somewhat short with the student for getting in the way, then their place on the ward has no legitimacy whatsoever, and learning is unlikely to take place.

A role on the periphery

Clearly any new apprentice in a community of practice will start with a very peripheral role since they lack the knowledge and skills to practice at the centre of the community. However with development and with opportunities for learning, the learner can, in time, become less peripheral in their role and as well as being there to learn may have some place in the work of the community. After some training some medical students may be able to assist with certain tasks such as measuring blood pressures and taking blood. If we go back to our first example, when the consultant asked the student some questions on the understanding that they would know the answers, they were assuming a level of knowledge that “everybody in medicine knows”, and by doing that they were saying to the student – we are members of the medical community of practice and there are some things that everybody, including you, knows, and that all that I am doing is helping you to apply the knowledge you already posses. By doing that the students’ membership of the community of practice is being validated.

Participation

We have already talked about students as they move away from the periphery of the community practice towards the centre, acquiring skills, which may enable them to be more central participants in the community of practice.

Communities of practice

Communities of practice are a model of learning that is easy for anyone working in healthcare to be able to comprehend. Communities of practice bring groups of people together with varying levels of skills and experience to do the best possible job in the case of healthcare for the patient. Medical students, during their training, and indeed junior doctors, will become legitimate peripheral participants in many communities of practice and to talk again about the cultural aspects of learning by social interaction, it behoves those of us responsible for organising and supporting learning to make every effort that communities of practice that we are involved in foster legitimate peripheral participation in our learners. It is worth reminding ourselves at this point that according to constructivist theory it is only through social interaction that learning takes place and according to the situated learning theory it is only by legitimate peripheral participation in communities of practice that learning takes place. Therefore it behoves all of us who are responsible for student learning to think about how social interaction is taking place between our learners, between learners and teachers, and how we know that our learners are, with our support, in the zone of proximal development as much of the time as is possible.

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4. Professionalism as a Medical Educator: Developing a scholarly approach to your teaching

**Professor Nick Cooper**

Many doctors have been involved in medical education, from the time of Hippocrates to Osler and the present day, yet only in the last 15-20 years has there been an impetus to ‘professionalise’ this important aspect of a doctor’s role. While there are debates in the literature about professionalism in medicine this usually concentrates on areas of clinical practice, ethical dilemmas and breaches of patient safety and dignity. Is ‘professionalism’ in medical education different? While the purpose of education may be to support learners in the clinical environment, patient safety and improved healthcare outcomes remain paramount.

Although many autonomy and self-regulation are key features of professionalism other authors have expanded these concepts and Hilton describes 6 domains of medial professionalism, which include ethical practice, reflection and self-awareness, responsibility and accountability, respect for patients, teamwork and social responsibility. These same attributes are surely necessary for a professional approach to education and Hesketh et al suggested a framework with 12 learning outcomes. Building on this work the AoME has developed a Professional Standards Framework building on core values for medical educators.

Developing an identity as a medical educator is key to acquiring professional recognition. This is often accompanied by an increase in community clinical learning that has exposed more doctors to clinical teaching. Sutkin et al undertook a literature review to answer the question: “What makes a good clinical teacher in medicine?” arguing that outstanding clinical teachers should serve as excellent role models. A systematic review of faculty development programmes in medical education suggested that while there was an aim to improve teaching effectiveness there was little support in developing communities of practice in the workplace, which would enhance the identity for the medical educator and support their individual development within a supportive and nurturing educational environment. Irby argues that as the complexity of medical knowledge increases targeted faculty development is needed as the teacher transforms multiple forms of knowledge to support learners in an increasing demanding clinical practice. This is important as we develop continuing opportunities for educators to provide appropriate focused instruction for learners.

### Identity Construction

Professional identity in medicine is frequently considered as social identity, usually around the construct of developing as a physician. A recent qualitative study explored medical educators’ ‘social identity’ and found that many of their roles were operational and that developing such identity was difficult in a field where there are different roles and expectations eg manager, leader, teacher, researcher. Frequent value and recognition is perceived as less prominent compared to clinical practice and biomedical research. Developing a community of practice can be difficult in such circumstances so educators can often feel isolated and undervalued.

### Teaching Skills

There has been a proliferation of Higher Education Institutions (HEI) offering postgraduate courses in education, usually at masters level. The year on year increase in new programmes, both by face-to-face and distance learning, demonstrates an appetite from junior doctors for gaining qualifications to support potential future educational roles in the NHS. Additionally the availability of intercalated Bachelor and Masters degrees, Academic Foundation Programmes and Academic Clinical Fellowships in Medical Education have all raised the profile of medical education as a ‘discipline’ in its own right.

Is there evidence that such courses make a difference? Research by Gibbs and Cofley across 22 Universities in 8 countries suggested that there was a link between academic development programmes and change in teacher behaviour and student’s approach to learning. Evidence for the impact of short courses is less robust although a questionnaire self-assessment study of consultants on a 3 day teaching course suggested some benefits in the acquisition and use of teaching skills and the authors concluded that “the teaching course is an effective vehicle for increasing consultant teaching skills”. Other studies suggest that many teachers develop skills through the acquisition of tacit knowledge by doing, a form of experiential learning where reflection is an important aspect.

### Career Development

Opportunities for career development in medical education are increasing. Clinical and Educational Supervisory roles have been developed in postgraduate education while the expansion in medical school numbers in the last decade, accompanied by an increase in community clinical learning, has exposed more doctors to clinical teaching. Sutkin et al undertook a literature review to answer the question: “What makes a good clinical teacher in medicine?” arguing that outstanding clinical teachers should serve as excellent role models. A systematic review of faculty development programmes in medical education suggested that while there was an aim to improve teaching effectiveness there was little support in developing communities of practice in the workplace, which would enhance the identity for the medical educator and support their individual development within a supportive and nurturing educational environment. Irby argues that as the complexity of medical knowledge increases targeted faculty development is needed as the teacher transforms multiple forms of knowledge to support learners in an increasing demanding clinical practice. This is important as we develop continuing opportunities for educators to provide appropriate focused instruction for learners.

### Scholarship

Poor funding of medical education research compared to biomedical and health services research is challenging for medical educators but Boyer’s seminal work provided a framework for medical educators where teaching should be appraised as a form of scholarly work. In 2006 a Consensus Conference on Educational Scholarship convened by the Association of American Medical Colleges (AAMC) outlined that a ‘scholarly approach depended on drawing on the results of others while scholarship required demonstrating work through peer review and dissemination of results’. While many educators will not focus on roles in medical education research adopting a scholarly approach will surely help support the identity of a medical educator and enhance future recognition.

### Recognition

The AoME through its Professional Standards Framework provides recognition for the medical educator and obtaining feedback on educational activities is a key component of personal and professional development. Evidence of a reflective approach to teaching and learning will increasingly be required for annual NHS appraisals when teaching is a recognised component of job planning. The General Medical Council (GMC) Recognising and approving trainers: the implementation plan provides a framework based on the Academy standards for such a process and being a member of good standing with the AoME will provide necessary evidence to support such a process.
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5. The Challenge of Evidence Based Practice in Medical Education: a Knowledge Management Perspective

Professor John Sandars

Background

Petersen made a plea in 1999 for evidence based practice in medical education and highlighted that “tomorrow’s doctors need informed educators not amateur tutors”. This plea is still as relevant in 2014. However, the notion of evidence based practice in medical education is a challenge to all medical educators and in this article I will present a knowledge management perspective since it can offer some useful insights into this challenge. The term “knowledge management” may be unfamiliar with many medical educators but can be simply considered to be a systematic approach to the creation, storage, dissemination and application of knowledge within organisations.

Understanding the nature of “knowledge” is fundamental for appreciating both the challenge of evidence based practice in medical education and knowledge management. Apley was the first to present an important distinction between two main categories of knowledge: explicit and tacit. Explicit knowledge represents knowledge that has been codified, usually in the form of text. This category of knowledge is that which is presented as “evidence” for evidence based practice, such as guidelines or systematic reviews of research studies. Lack of understanding knowledge in contrast, tacit knowledge is developed throughout years of professional experience and tends to be revealed when observing their expertise or skilful professional practice. However, when experts talk to others about their practice it can also reveal their tacit knowledge but this is very rarely considered to be worthy of the title of “evidence”, and is often belittled as anecdote. These distinctions are important since both explicit and tacit knowledge are required to inform effective decision making. For example, “knowing what to do” (such as the findings from previous research) also requires “knowing how to do it”, with knowledge required about the difficulties of implementing previous interventions. A major challenge for knowledge management, and also for evidence based practice, is how to develop and provide a system that considers both explicit and tacit knowledge.

Knowledge management challenges

Creation of knowledge

Having knowledge that can be used for decision making requires easy access to the available knowledge, including both the explicit and tacit categories. Relevant published evidence may be difficult to retrieve since medical education research is widely dispersed across many journals in both medicine and social sciences, and also a lot of potentially useful medical education research is not published in journals. A quick perusal of the abstracts and posters at a medical education conference quickly reveals the extent of research in medical education, and these often include the important experiences of “how to do it”. However, these presentations are only rarely archived or indexed, thereby limiting retrieval and dissemination of the findings.

The last decade has seen the increasing use of a variety of social media, such as blogs and discussion forums, in all aspects of professional life and medical education is no exception. The use of social media creates opportunities for
sharing the essential tacit knowledge required for decision making but archiving and searching the range and variety of this rich knowledge base is almost impossible at the present time.

Application of knowledge

The professional expertise of medical educators is a skilful blend of both explicit and tacit knowledge that requires an approach that is more than mere blind application of published evidence to practice. Professional practice is highly context bound and effective decision making about the most appropriate intervention requires sharing of tacit knowledge that is gained from local and wider contexts.

Responding to the challenge

Opportunities need to be created for medical educators to actively participate in all aspects of the knowledge management of medical education and there are a few priority areas for action.

In the creation of knowledge, medical educators can try to influence funding bodies to fund research methodologies that have an increased focus on both process and outcome. Realist evaluation recognises that the outcome of an intervention in a complex social system, such as found in medical education, may not have a direct causal link between the intervention and the outcome1. A realist evaluation attempts to identify the various environmental factors in the context so that they can be used to inform the application of the findings to other contexts. For example, the use of a particular intervention may show improved performance but it is rare for the findings to highlight the unique context in which the intervention was implemented, such as high commitment of time by tutors to deliver the intervention or that mandatory attendance by the students was required. Similarly, action research2 and design-based educational research3 embrace the complexity of the social system and context within which a medical education intervention is implemented. These approaches use iterative cycles to increase understanding of the facilitating and constraining factors that determine the effectiveness of an intervention. However, there are few studies using these approaches in medical education, although these approaches are commonly used in other areas of education4.

In the storage and dissemination of knowledge, there is a need for all involved in medical education, including professional organisations, conference organisers and publishers, to value the importance of professional expertise and the “tacit knowledge” dimension for the decision-making aspect of evidence based practice. It is too easy for the “high, hard ground” of academic certainty to look down upon “the swampy lowlands” of professional practice5. There has been an increasing trend for many medical education journals and conferences to have linked social media to allow the audience to share opinion and experiences but an important step may be to ensure that what is often regarded as simple anecdote can be presented in a more scholarly way. Single case studies can be important sources of evidence to inform decision making and this can be achieved by linking observations from the single case experience to a wider body of literature (“how do the findings add to what is already known”), interpreting findings within a theoretical framework and providing sufficient details about the context so that “naturalistic generalisation” can be obtained6.

The application of knowledge can be improved by creating opportunities to share their tacit knowledge, with medical educators actively engaged in communities of practice and collaborative decision-making. These communities need to move beyond simple journal clubs, that often reinforce the “evidence is best” paradigm, to more inquiry based communities that engage in critical review of personal practices7. Action learning sets can provide opportunities for professional and personal growth but at the same time have a focus on developing and implementing medical education interventions8. These opportunities require adequate protected time for busy medical educationalists but the main barrier that may need to be overcome is a change in mind-set to value their importance.

Conclusion

Evidence-based practice is an essential aspect of the scholarship of medical education and the use of a knowledge management perspective can provide useful insights into some of the challenges that currently face all medical educators. A clear message appears to be that valuing professional expertise is essential for the implementation of medical education interventions, with obvious implications for enabling participation in this essential aspect of being a medical educator.

References

6. Challenging Diagnostic Overconfidence

Dr Malcolm Galloway

Introduction
No-one can reasonably be expected to be familiar with every disease that can afflict the human body. There are areas of knowledge that we use in our day-to-day diagnostic practice with which we are well acquainted, but for much of the rest, we should be able to manage by knowing when we are uncertain, and if so, what to do about it.

Unfortunately, our meta-knowledge, our knowledge about what we know, and in particular, the calibration of the degree of certainty of our knowledge, is limited. There is some evidence of a link between the certainty of a doctor in a diagnosis and the chance that it is correct, but the link is weak1. Worryingly, the least well performing people in a variety of domains are typically the most overconfident 1 2 3 4.

Overconfidence in diagnostic certainty has been suggested as one of the key factors behind the approximately 15% of medical diagnoses which are incorrect3. They may not necessarily be correlated5, and when dealing with medical overconfidence, it is important to be clear about which kind of overconfidence we are dealing with.

How Can Overconfidence Be Challenged

As a profession, medicine, with its experience-based hierarchy might expect that experience alone would combat overconfidence. There is some evidence that older adults have greater insight into the limits of the certainty of their knowledge5. Unfortunately, experience does not always lead to improved calibration. Sometimes it can even compound the problem6. So it would seem that just waiting for doctors to recalibrate with experience isn’t likely to work.

Could we solve the problem by paying doctors bonuses for accurate diagnoses7? Probably not - financial reward does not appear to lead to improvement in calibration8, and in some circumstances may reduce improvement9.

Can awareness of overconfidence be sufficient to combat the problem? When confronted with the evidence relating to overconfidence, we tend to accept that this is a problem, but a problem for other people. Most people think they are less biased than most people20. Biases may be easy to identify in others, but are inherently difficult to identify in ourselves by introspection alone21. Even Daniel Kahneman, a guru of decision making research, has commented that “…my intuitive thinking is just as prone to overconfidence, extreme predictions, and the planning fallacy as it was before I made a study of these issues.”22 If even he can’t change his own thinking, how can the rest of us? Well, there is evidence that we can change our thinking and behaviour, so perhaps Kahneman is being excessively certain in his belief that his own biases are unimproved.

Excessive certainty (or judgment overconfidence) describes a cognitive bias that could be impairing their practice or learning. Both types of overconfidence (excessive certainty and positive illusions) have been demonstrated in a wide range of populations, including doctors 7. They may not necessarily be correlated, and when dealing with medical overconfidence, it is important to be clear about which kind of overconfidence we are dealing with.

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be more engaging than teaching about these issues in an abstract way, detached from clinical practice.

The second step is likely to be difficult for many, given that we generally think we are less biased than other people\textsuperscript{19}. There is a metacognitive leap from appreciating that people generally need to challenge their biases, to accepting that we also may be less than perfectly calibrated ourselves. Reflective practice may be helpful with this, as may feedback and engagement with external quality assessment.

Unfortunately, given the tendency of the least able to most over-estimate their abilities, there is a risk that those with the most to gain from a reduction in their overconfidence may be less likely to perceive the need to use such strategies.

Once the doctor has decided that they want to challenge their overconfidence, they need to decide what action has the best combination of practicality and efficacy. Unfortunately there is currently a dearth of specific evidence on this in relation to medical practice.

**Reflections for Medical Educators**

Might we as medical educators be contributing to the problem of overconfidence in doctors? Confidence is easily acting as a role-model of metacognitive awareness or of over-confident practice.

Unfortunately there is currently a dearth of specific evidence on this in relation to medical practice.

**Conclusion**

Overconfidence is a cause of misdiagnosis and is a risk to patient safety. We need to develop evidence-based tools to challenge this cognitive bias, but until these are available, some simple strategies are likely to be helpful. Regularly ask yourself why you might be wrong, seek and reflect on feedback, and consider using diagnostic checklists to try to challenge this cognitive bias, but until these are available, some simple strategies are likely to be helpful. Regularly ask yourself why you might be wrong, seek and reflect on feedback, and consider using diagnostic checklists (or cognitive strategies such as ‘consider the serious and treatable’) in areas of particular diagnostic risk.

**Acknowledgement**

I am extremely grateful to Kristoffer Ahlstrom-Vij (senior lecturer in philosophy at the University Of Kent) for helpful advice and discussion.

**References**

7. Interview with Professor Andrew Grant

Professor Andrew Grant is dean of medical education at Swansea University. His initial training is in medicine and he still practices as a GP. Andrew studied medical education at Maastricht and did a masters and doctoral research into reflective learning in undergraduate medical education. In 2012 Andrew led a GMC-funded project exploring support for medical students with mental health problems. With others Andrew has recently set up the Unit for study of doctors’ and medical students’ mental health and wellbeing which is based in Swansea.

Who were your most influential teachers?

My most influential teacher by far was my O Level and A Level Chemistry teacher in secondary school. The reason that I am still so inspired by him and his teaching was his dedication to being a teacher and to his profession. Mr. Bowen had no goal from his teaching other than the success and future happiness of his pupils. For that he was prepared to work very hard indeed and expected the same of us. He gave me a great deal of encouragement and in particular was very positive when I told him I wished to apply for medical school. Indeed he was as happy when I got a place at Charing Cross Medical School as he could possibly be. Indeed he was very positive when I told him I wished to apply for medical school. Indeed he was as happy when I got a place at Charing Cross Medical School as he could possibly be. Indeed he was as happy when I got a place at Charing Cross Medical School as he could possibly be. Indeed he was as happy when I got a place at Charing Cross Medical School as he could possibly be.

My role models have been my clinical colleagues who are able to continue to practice medicine in a thoughtful, compassionate and patient-centred way despite all the clinical pressures and working in the health service. I am in awe of the way that some people continue to put their patients first, to give their patients all the time they need, whilst finding themselves under massive competing pressures.

Please describe the most defining moments of your career.

Undoubtedly the defining moment of my career as a medical practitioner comes from my year as a registrar (or as a trainee as we were called then) under the support of my generous, supportive trainer Charmian Goldwyn and whilst studying the works of Michael Balint, I was able to experiment and develop as a practitioner in a way that I hadn’t previously imagined possible. This helped me as a practitioner to become more patient centred, more holistic and become a little more aware of the therapeutic interventions that I may be able to offer through listening and through consultation. I continued to study as a member of the Balint group at the Tavistock Institute at North London as a young practitioner.

The most defining roles of my career as medical educator without doubt came when I went to Maastricht to study for the Masters in Health Professions Education. The theoretical learning for the early parts of that course brought about in me an awakening of the real meaning of learning and alongside that the real task of an educator. I had been a trainer in general practice and also taught medical students at this stage for long enough to have observed many of the phenomena that was described in our theoretical learnings but with no idea that an author or authors had put their names to these phenomena and described them in an academic way. Top of the list for me is the concept of knowledge being something that is constructed by the learner rather than something that is transmitted from teacher to learner by various teaching techniques, i.e. lectures, seminars and e-learning. Alongside that I began my early understanding of Socio Cultural Learning Theory (although I didn’t call it that then) and in particular the teachings of Vygotsky on the Zone of the Proximal Development and educational scaffolding. These have provided a theoretical underpinning for my work as an educator since that time and continue to do so.

Please describe your current roles.

I took on the role of Dean of Medical Education at Swansea University in the summer of 2014 so am still very new in this job. The course is still in its early stages and has as yet only had one cohort of graduates but evaluation of the graduates opinion of the education and the way the students are prepared for clinical practice suggests the course is very successful at turning out confident and able practicing doctors. My role is one of supporting the very dedicated team that puts on this course while challenging them to deliver a course that is academically stretching to the very bright graduate entrants. In the busy organisation, as well as executing the complexities of delivering a programme it also essential to ensure that learning is taking place at a level that will produce a level of graduate that is not only knowledgeable but also competent and able to apply what they know. It is my task therefore sometimes to ask if we might do things differently from how things have been done in previous years or to challenge people to revisit the theoretical underpinning of their educational activity. As well as my work with the Graduate Entry Medicine course I have also worked with a colleague to develop a Professional Doctorate course in Health Professions Education and this is running for the first time this year. My role within the Academy of Medical Educators has been to lead the Recognising Teaching Excellence workshops and in particular to develop a more effective mechanism for addressing the queries of those people who think that membership or fellowship of the academy might be of help to them and their career but who need more information.

Challenges for medical educators in the UK

There are of course many challenges to medical educators in the UK and also to those in Higher Education centres in the UK and in most parts of the world. However I believe that the greatest challenge is to ensure that our interventions as medical educators continue to stimulate the best possible learning to produce the best possible graduates. Not least among the threats to this are the students themselves. Medical students work very hard, they have a great workload and a great deal invested in their studies and their career and as such they are inclined to work in a very strategic manner. This is of course some of the students some of the time rather than all of the students all the time! It behoves us as medical educators therefore to constantly think about the educational effect on learning interventions and assessments. An assessment that stimulates the student to leave the wards and clinics and go and study in the library is probably likely to have a more negative effect on their learning compared to a workplace-based assessment where preparation can only take place within the clinical arena and with real patients. I would not wish to diminish the concerns of producing high class education in an environment where education often finds itself having to compete for a people’s time and resources with research and other university priorities, and of course the constant need to reduce costs and save money. Increases in student fees in the UK have understandably raised student expectations. The planned changes in legislation bringing full registration forward to the time of graduation posed a particular threat to Graduate Entry courses such as the one at Swansea as it appears likely that the current shortened 4 year courses may not produce enough hours of tuition to satisfy European law. This is currently being negotiated.

What are the most important values for medical educators?

The single most important value that a medical educator has to put across in every aspect of their practice as a medical educator and as a practitioner (where relevant) is that of patient centredness. The top priority for our future graduates is that they should put their patients first. Understandably they have their own needs and requirements but when they go out into the world and practice medicine their number one priority should be the patients well-being and to have acquired the knowledge and skills required to deliver that. I include good communication with patients and their families in patient-centredness.
Secondly, but not completely separately, is the need to demonstrate an empathy and understanding to our students, their needs and the pressures put on them. Initially I think that our students often appear demanding and it takes a while to recognise that there are many demands on the students themselves, many of those placed on the students by themselves but also from family, friends, school background etc. I know from my own research that medical students suffer from a higher prevalence of mental ill health than the general population and from age-matched controls. One of the causative features of this is the pressurised environment in which medical students work as well as the driven perfectionist personalities of those that come into medicine. My research therefore showed that as well as being willing to provide whatever support is necessary for students who experience issues with mental health it is also important to recognise that all medical students work in a milieu of pressure, stress and tension and that we should expect this and help them to develop coping mechanisms.

What are your aspirations for the Academy?

Undoubtedly my aspirations for the Academy have changed. I now recognise the massive role it has to play in supporting and professionalising people who teach students and qualified practitioners in the dental, medical and veterinary medicine professions. Currently some of this group particularly those working in the Health Service rather than Higher Education have few chances of developing a level of professional recognition for their teaching activity and I believe that the Academy does offer this. However, although the Recognising Teaching Excellence workshops have been more successful in the current year than previous years there are still too few of them still for the people that might benefit from joining the Academy but have no easy of finding out about this. We have made a short video which is now on the Academy website as well our power point presentation to reach out to those people who are not able to attend our workshops.

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