Editorial

Four decades ago, I arrived in Newcastle as the foundation Professor of Anatomy at the University of Newcastle. I had been recruited on account of my interest in medical education, and one of my first acts in Australia was to join ANZAME (the Australasian and New Zealand Association for Medical Education), which was then only a few years old. At that time, ANZAME was a mutual support group for a small band of people who were committed to improving the quality of the educational experiences of their students—referred to by foundation President, Bill McCarthy, as "Young Turks". At that time, "medical education was something the teachers gave to the students. The curricula in the medical schools were dominated by lecture presentations, essay examinations and clinical 'viva' assessments. Medical education as a discipline to be studied and developed was a concept virtually unknown in Australia" (ANZAME, 1997).

The invitation to write the editorial for this issue of FoHPE has caused me to reflect on what has changed, and what has not changed, in health professional education in those 4 decades, and the extent to which the range of papers in this issue is an illustration of those changes.

Even in the early days of ANZAME, there were non-medical members of the Association, and these people played a significant role in the organisation and its development. I do not have data on the changing composition of the Association; and even now, it is difficult to specify that composition exactly. Suffice it to say that the current membership appears to be distributed fairly evenly between medical and non-medical health professionals.

The implications of the change in composition of the Association had been under discussion for many years, but it took nearly 40 years for this to be reflected in the change in name from ANZAME to ANZAHPE in 2010.

However, even by the time of publication of the first volume of *Focus on Health Professional Education* in 1999, the multidisciplinary nature of the organisation was already evident—of the seven papers in the first issue, three were from professions other than medicine. It is interesting that of the eight papers in this current issue, four are from professions other than medicine. So in one sense, the balance could be thought to have changed little—although this statement runs the risks inherent in drawing conclusions from small samples. For Volume 17, the proportion of non-medical papers was similar, four or five out of eight.

In looking at the topics covered by the eight papers in the current issue, three were reports on surveys of, or workshops for, educators; one was an analysis of assessment scores; and four were explorations of the acceptability of specific educational practices to students, only one of which went on to examine the impact of this practice on student performance. Thus, most of the benefits intended to arise from these studies can be characterised as improved educator competence or the improved effectiveness of education or assessment practice; in only one was there an evaluation of the impact of a

ISSN 1442-1100

new educational practice on outcome, as measured by student assessment scores. I refer you back to Wilkinson's (2016) comments in the editorial for 17.1.

At one level, this is not unexpected in the journal of an organisation that is an association for health professional educators. But one wonders whether a greater emphasis on education, and encouraging the active participation of students in the process of education and measuring the outcomes of that process, might be a productive goal.

Historically, one of the ways of achieving that change in emphasis has been the introduction of new ways of learning. While in Newcastle, I was privileged to play a part in the introduction of "problem-based learning" (PBL) to medical education in Australia. Since then, the educational focus on the patient, their problem, their context and the consequent identification of what the learner must do and know has reshaped health professional education in many institutions, even though other names have been substituted for PBL.

One of the more dramatic changes in education has been the availability of information through information technology. When we started PBL in Newcastle, the focus of the student groups was internal, on discussing the patient, the problem and its context. Books or other sources of information were rarely referred to during the PBL session. Now, however, students in PBL groups spend much of their time accessing information on the web, and my experience has been that this external focus tends to detract from the group process of learning and communication, the major benefit which can and should arise from face-to-face interaction in small groups.

It is interesting to ponder that the seismic changes in society that have been brought about by advances in communication technology do not appear to have been reflected in published work on the process and outcomes of health professional education—at least as judged by my experience of the literature.

Although it is expected and intended that there should be a relationship between the process of education and its outcome, and that innovation in the former should lead to improvements in the latter, the balance between process and outcome, at least as represented in the small sample in this issue, still seems heavily weighted in favour of the process of education.

But the difficulty of demonstrating improvements in student performance should not be underestimated, given the myriad, and often unmeasurable, factors that contribute to that performance, as well as the challenges of ensuring the validity of assessments. Given the fact that most assessment instruments measure what students know—at the base of George Miller's (1990) pyramid—rather than what they can do, or what they actually do, we are left with the reality that, even at the final assessments before graduation, we are unable to measure how well students perform on many of the tasks that they are about to undertake after graduation. This is partly because, during their education, with some honourable exceptions, students are given less opportunity to contribute actively to the care of patients. Instead, their role tends to be that of spectators, peering in through the arrow slits of the ivory towers of clinical silos at patients who pass increasingly more rapidly before their eyes as lengths of stay become progressively shorter. No wonder

ISSN 1442-1100

there are complaints that, on graduation from university, students are not well-prepared for the rigours of practice, or that some professions have introduced "preparation for practice" courses before their graduates begin work in earnest.

The implication is that we should be looking hard at the institutional structures and processes that support (and limit) health professional education, and lobbying to bring about changes that will ensure that our graduates are "job-ready" and primed to become and to remain lifelong learners. I hope that future issues of *Focus on Health Professional Education* will reflect this struggle.

Prof Rufus Clarke
Associate Editor

References

The Australasian and New Zealand Association for Medical Education (ANZAME). (1997). *25th anniversary, 1972–1997: ANZAME the first 25 years: From cocktails to bush dances*. Sydney, Australia: Author. Retrieved from http://docs.wixstatic.com/ugd/363deb_de873aa9c401dba20b075e9ab080e829.pdf

Miller, G. E. (1990). The assessment of clinical skills/competence/performance. *Academic Medicine*, *65*(9), s63–s67.

Wilkinson, T. J. (2016). Editorial. *Focus on Health Professional Education*, *17*(1), 1–3.