- Students were encouraged to formulate their own assessment and plan.

- Students were encouraged to ask questions.

- Constructive feedback was provided.

- Physical findings were reviewed and demonstrated.

- Clinical decisions (e.g. selection/interpretation of tests, etc.) were explained.

- Clinical findings (e.g. X-rays, computerised tomography scans, etc.) were reviewed and demonstrated.

- Professional and ethical behaviours were modelled.

- Effective interpersonal and communication skills were modelled.

Due comment is made that even trained raters using the scale while observing the same clinician did not always agree on what they saw. The authors suggest that their instrument might be useful for identifying teachers who would most benefit from further development, either because they are new to the task or because they are operating well below the level of their peers. They also make the point that – as with OSCE score sheets – this instrument looks to be useful for recording that targeted behaviours have been performed. Being able to record *how well* they were performed is a further challenge.

Supporting students through end-of-life experiences

Kelly E, Nisker J. Medical students' first clinical experiences of death. *Med Educ* 2010;**44:**421–428.

There was an outcry in the Australian media in early 2009 following a television documentary that featured a medical student's clinical placement in a small town in rural Western Australia. The student had emerged from a fairly sheltered background to find herself fumbling to gain intravenous access while her elderly patient quietly died of ischaemic heart disease. She dissolved in tears, and promptly quit her placement. Whereas my personal armchair fury was directed at the clinical teacher who had slapped her hand and elbowed her aside, astonished letter writers could not believe that a student could get to the final year of her course without witnessing a death.

Kelly and Nisker have taken a thoughtful approach to better understanding the impact on students of the first time a patient dies while under their care, and how to shape the inevitable sadness, anger and feelings of vulnerability into a meaningful learning experience. The major themes that emerged in this qualitative, grounded theory study were refined into a chronological model that well describes a student's experience:

- preparation;

- the event itself;

- the crisis;

- the resolution;

- the lessons learned.

Although end-of-life issues are gaining increasing prominence in medical curricula, little prepares students for the emotional conflicts of being involved with a patient who dies. The authors refer to our quickness to train students in maintaining 'dispassionate equanimity' when patients die, believing that this will prepare them for a sustainable career, while perpetuating the myth that death represents our failure, and so should be ignored. The paper also gently teases apart students' differing views on the deaths of young people, older people and those who were not expected to die. Providing time for reflection and

active debriefing is presented as a way of allowing students to resolve (and learn from) the dissonance of being professionally detached and emotionally concerned at the same time.

Clinical teachers have much more to offer with an empathic query rather than with a brusque slap.

Assimilating inter-professional learning into the curricula

If they don't automatically dismiss it as just another educational buzz-phrase, many clinicians seem to view 'interprofessional learning' as an excellent idea that someone else really should implement. Which is a shame, because these same clinicians have usually drifted into interprofessional teams over the decades without ever noticing. Most will acknowledge that interprofessionalism is a key capability for the vocationally satisfied health worker who needs to deliver safe and efficient care, but few are prepared to actually facilitate its acquisition. Interprofessional learning (IPL) won't really be embedded within health professional courses until it becomes a formal part of their curricula.

Judy Stone runs an IPL project for the state health department in Canberra, Australia. Her paper argues that the best way to encourage IPL is to formally assess it at both the tertiary education level and within continuing professional development programmes. She couldn't do so without reminding us that 'assessment drives learning', and it is hard to disagree that one sure

way of raising the stakes for students is to explicitly assess your topic. Stone acknowledges that communication, teamwork and professionalism abilities are accepted as important generic skills (and are very much expected by all stakeholders in health care), yet we aren't very good at facilitating their development nor assessing their attainment.

Further problems occur when designing an assessment that values collaboration and team work, rather than encouraging competition as they usually do. Stone suggests that simulations – such as in simulated wards or emergency events – provide the best opportunity to formally assess students' interprofessional capabilities. She proposes a

range of written and directly observed tasks (as well as reflective exercises, and peer and 'patient' assessments) to capture the full range of student performance.

In her conclusion, Stone drives home the point that requiring IPL to be formally assessed will finally tip it into the centre of learning, teaching, policy and curriculum frameworks. The range and diversity of assessment modalities she suggests makes this feasible, although if IPL becomes yet another vital topic to be compulsorily assessed it will increase the burden on both universities and students. It also runs the risk of creating resentment against the topic, rather than having students