A case study of an international fellowship to improve clinical education in a cross-cultural setting

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Introduction

In Japan, a longstanding focus on inpatient and subspecialty medicine has resulted in a lack of well-trained primary care physicians, especially in rural settings.[1] Japan is now attempting to place more emphasis on primary care. In the USA, many medical schools have developed clerkships that no longer focus solely on departmental inpatient services, but instead include ambulatory learning in office settings,[2] and community-based educational experiences.[3] I had the privilege of participating in the development and implementation of a fellowship program designed to provide Japanese physician educators exposure to USA academic primary care.

I played an active role in designing my fellowship curriculum. Dr. Taylor and I negotiated and agreed upon three goals for the one-year program: i) develop a strong knowledge base in the literature relevant to learner-centered clinical education in primary care and office based practice, ii) develop skills in independent functioning and creative problem-solving related to the relevant issues in medical education through active participation in experiential learning, and iii) develop an attitude toward the educational process to become a life-long student of learner-centered education focused on service to improve population health through primary care.

Every two weeks Dr. Taylor and I discussed the objectives and activities of the fellowship. I was expected to provide a detailed report about my progress. Based on this report, we modified my planned activities or objectives as needed.

My principal fellowship activities included the following: i) a literature review to identify key references on education of medical students in office setting; ii) observation of Harvard medical students' learning, including Patient Doctor (PD) I course for interviewing, PD II for physical examination, PD III for quality improvement, analysis of systems, and reflection, the Objective Structured Clinical Examination of the entire second-year class, ambulatory teaching in the ambulatory month of the core medicine clerkship and the longitudinal primary care clerkship; iii) interactive reviews of video recordings of ambulatory teaching, iv) precepting a medical student in office practice, and v) participation in the Harvard Macy Institute's Program for Educators in the Healthcare Professions in 2009. After completing the fellowship program, I thought carefully about what I had learned. There were four principal lessons learned.

Students need adequate preparation prior to starting a primary care clerkship. I learned the importance of a year-long course on interviewing and another year-long course on physical examination skills in preparing students for a primary care clerkship. I realized that students would not be able to function at a high level in their primary care clerkship without this preparation. I learned that teaching these preparatory courses is very labor-intensive with one faculty member often responsible for the supervision of only 2-4 students.

Teaching in the primary care ambulatory setting is characterized by trust, respect, preceptors' enthusiasm, and efficiency. I observed the development of a trusting relationship between teacher and learner in ambulatory settings. I recall several comments students made about their experiences. He said, I am satisfied with my ambulatory experience, because I can perform an interview and physical examination by myself. Moreover, Dr. … strongly supports me. I'm glad that such a great preceptor teaches me one-on-one. Another student said that Dr. … is an excellent teacher. I'm lucky to spend every week with Dr. ... at the clinic. Students appeared to both trust and respect their preceptors a great deal. The degree of trust increased over the course of the clerkship experience.

I learned that effective preceptors have a great deal of enthusiasm for teaching students. One preceptor taught me three important features of ambulatory teaching: being supportive, setting expectations high, and providing responsibility. Another preceptor explained that preceptors should convey the following message to students on their presentations. You do not need to make it perfect. Students will make mistakes from which they learn. Preceptors have a responsibility to make the experience safe for patients and students.

I learned about a One-Minute Preceptor model,[4] which is very useful in busy ambulatory settings. The model is composed of 5 microskills: i) get a commitment, ii) probe for underlying reasoning, iii) teach a general principle, iv) reinforce what was done well, and v) correct errors. One of the preceptors explained that the first two microskills are helpful to assess the student's abilities and level of knowledge, the most important part of one-on-one teaching.

A fellowship program is an effective way to learn about curriculum development, evaluation, and leadership. My skills in teaching and learning, curriculum development, evaluation, leadership, and the use of information technology for education improved considerably. I benefited from the multiple learning formats to which I was exposed including large-group presentations, interactive exercises, problem-based learning, observations, reflective use of journals, and discussion in large and small groups.[5]

A mentor is essential for a successful cross-cultural fellowship. My mentor helped me sustain my motivation to achieve my fellowship goals through regular discussions and encouragement. My mentor also introduced me to key individuals who could help me meet specific objectives. After my fellowship I returned to a rural university hospital in Japan. I am developing educational programs for our medical students as a member of our Medical Education Planning Committee of the Faculty of Medicine of our university, and taking a role as a preceptor at the ambulatory center of our university hospital, building upon what I learned in the USA.

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