interventions appropriate for patients who are at different stages of readiness to change their behaviour. The OSCE will remain a part of the third year curriculum as an evaluative tool.

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Bioethics curriculum for paediatrics residents: implementation and evaluation

Jennifer M Cohn

Context and setting At Children's Hospital Boston, residents in paediatrics routinely see patients who are ethically challenging, providing fertile ground for the development of moral quandaries. Approaching an ethical dilemma systematically is a skill that must be learned and cultivated over time. Residents must acquire this proficiency, as well as countless others, during their 3-year training programme. Without deliberate efforts towards this end, it is unreasonable to expect residents to acquire these skills on their own. Residents should learn the principles of bioethics needed to develop a sound approach to moral dilemmas in their educational curriculum.

Why the idea was necessary Research shows that residents crave more structured learning on informed consent, the doctor–patient relationship and end-of-life decision making. A needs assessment survey administered to 120 residents in paediatrics at Children's Hospital Boston revealed a desire to know more about medical futility, ethics in medical research, and ethical practice in the age of managed care. Studies indicate that residents gain confidence and feel more competent when addressing moral questions after their programmes establish a formal ethics curriculum.

What was done An innovative 12 session, 2-year curriculum in bioethics was developed and implemented in September 2003 such that 6 lunchtime conferences per year are dedicated to teaching in ethics. Each of the 12 conferences addresses ethical issues related to specific hospital services on which residents spend time. Examples include 'Ethics and the ICU Patient', 'Ethics and Primary Care' and 'Ethics in the Emergency Room.' Sessions are led by multidisciplinary teams of faculty in bioethics, attending doctors, nurses and lawyers, all of whom have backgrounds in bioethics.

Evaluation of results and impact The curriculum in bioethics is evaluated by 2 methods. Firstly, after each session, residents complete feedback forms. Residents have given high ratings to the curriculum's relevance to a paediatrician's career, its importance to the care of children, and its ability to effectively convey important knowledge. Secondly, a formal research study is underway, aiming to create a new research tool that could then be used to evaluate the efficacy of the new ethics curriculum. Mentored by Dr Steven Joffe from the Dana–Farber Cancer Institute, I designed 5 online ethics vignettes. In May 2004, pilot respondents were asked to identify relevant ethical issues raised by the vignettes and to develop and justify a plan to address the ethical dilemmas. A scoring sheet was also developed and 2 independent readers have scored the pilot responses. Data analysis is underway to determine if the instrument has sufficient interrater reliability to make it a useful tool. To date, no instrument has been developed that will validly and reliably assess learning and competency in ethics. This study hopes to contribute such a tool that may be utilised in future research in ethics education. If successful, this new instrument will then be used in a future cohort study to evaluate the new curriculum in ethics at Children's Hospital Boston in an effort to define and evaluate ethical competency among our paediatricians.

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Are there specific competencies required by prison GPs?

Alison Jones & Chris Holmwood

Context and setting There is an increasing prison population in Australia, with different health needs to those of the community in general. Prison medical services are largely provided by general practitioners (GPs) who often only work part-time in the prison system. Many of their continuing professional development (CPD) needs are met through the programmes organised by divisions of general practice.

Why the idea was necessary There has been an increasing focus on the skills set required by GPs; in Australia the postgraduate college responsible for

overseeing general practice training, the Royal Australian College of General Practice (RACGP), has outlined a curriculum and specific competencies. There is increased awareness of the distinct set of skills required by GPs working in prison settings. Continuing professional development programmes do not specifically target the needs of prison GPs, although many of the competency areas will be relevant to the prison setting. There was a perceived lack of a comprehensive approach to identifying and meeting the training needs of GPs in our state, and perhaps nationally.

What was done The first stage of this study involved 10 interviews, 8 with prison GPs and 2 with people whose roles were closely linked to prison health care. The interviews with GPs explored their perceptions of gaps in their knowledge and skills. The themes to emerge from these data were presented at a group meeting of 3 prison GPs and the director of the Prison Health Service. The themes were refined following the feedback at that meeting. The second stage involved the development of a questionnaire based on the competencies outlined by the RACGP, to be sent to GPs working in prisons in 4 states. The respondents were asked to rate the importance of these competencies to their work in the prison setting.

Evaluation of results and impact From the data generated in stage 1, emergency medicine, management of fractures and mental health were identified as the main areas where skills needed to be acquired or refreshed. It became clear that prison GPs had no formal networking process for sharing best practice, reflecting on critical incidents or suggesting prison-specific training. There were different views across urban and rural settings, reflecting the fact that rural GPs tended to have had radiology training – a need identified by urban GPs. Prison GPs were often treating people who would have been referred for specialist treatment (e.g. psychiatry) had they been outside the prison setting. The data from the questionnaires suggested that many competencies were rated as highly important by most respondents, with the highest ratings falling in the clinical areas of mental illness and substance abuse. Competencies rated as less important fell into the clinical area of dentistry and the 'organisation and legal' domain.

In Australia, GPs in prisons often also work outside the prison setting. They need to balance their CPD activities to meet both roles. These data can inform policy on education and training for prison GPs. The study has also highlighted the need for a formal network within and across states to share best practice and develop appropriate training programmes.

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Cabin Fever: an innovation in faculty development for rural preceptors

Heather Armson, Rod Crutcher & Doug Myhre

Context and setting A new rural family medicine residency programme was established in Alberta, Canada in 2000. This group of 20 rural-based residents, in addition to the urban-based residents, are being trained in 21 rural and regional sites in Alberta over a 2-year period. One early challenge was that of faculty development (FD) for the 140 family medicine and specialty preceptors, most of whom were new to their roles as clinical teachers.

Why the idea was necessary Traditional urban-based FD was neither congruent with the location and philosophy of the rural-based programme, nor appropriate, given the programme FD goals. The Cabin Fever retreat was established with the overarching goal of supporting the recruitment and retention efforts of the Alberta Rural Physician Action Plan as support from the main academic centres has been shown to stabilise manpower in underserviced areas. Each FD retreat has had 2 focused objectives: context-specific preparation of preceptors for their new roles in both teaching and evaluation of clinical skills, and networking among rural preceptors and their families.

What was done The retreat was organised in a winter recreational setting. In a co-operative manner, the timing of other FD opportunities in the province were considered. This format was chosen as interruptions from the demands of practice were minimised, and opportunities for networking and social activities were readily available. The attendance of family members was explicitly encouraged – and funded – because of their crucial contribution to successful rural practice.

The FD retreat is held each year on the same weekend in February. It takes place over 3 days, with mornings focused on educational activities and afternoons left unstructured. Participants and their families reconvene for an evening meal in which exemplars are honoured and the contribution of families to programme success acknowledged.

The formal educational programme consists of 1 plenary speaker on the first day, followed by small