Under the mentorship of Professor Felise Milan I served as a travelling fellow at the Albert Einstein College of Medicine (AECOM) in New York. My purpose was two fold: clinical skill teaching and to better understand the concept of entrustment in the US.

AECOM is situated in the Bronx and historically is highly regarded in view of the fact that its creation was courtesy of the world renowned physicist Albert Einstein. The focus of the school is to ensure a diverse student population and humanistic value to medicine.

The centre houses the Ruth L Gottesman Clinical Skills Centre which holds daily clinical skills teaching in relation to communication and the physical exam for early year and clinical year students. The centre is also involved in testing their own students and students from other schools within the US. Having witnessed their operation I admit that it is no easy task with all day testing that is run with such precision. The clinical skills assessment in the US in relation to the USMLE format differs to the UK based approach in many ways. Firstly there are no clinical examiners. Each encounter is filmed and scored by the simulated patient with a review of the testing in real time. I was lucky to be a real time testing reviewer. This helps to ensure that there are no issues during the encounter; queries from the learner for example or difficulties in relation to the simulated patient (SP), typically as SP’s can tire towards the end of the day and may not perform appropriately in view of this. I recall back to my testing days having one to two senior clinicians watch our performance. It felt at times more intimidating and the literature in this regard is vast particularly in view of the ‘hawk and dove’ concerns. Again educators are divided as to what is the right approach. The volume of candidates in the US in view of its larger population may be the reason for not being able to recruit sufficient faculty to serve as examiners. The other stark difference is the fact that in the US the clinical scenarios are more integrated. So rather than perform a standalone history or examination separately, the two are merged to focus more on asking relevant questions and examining relevant systems. Again this has merit as typically in real life clinical practice (certainly on the medical admissions unit at least) a full history and systems examination are often truncated. Again educators are divided as to the best approach.

The second focus of my visit was to better understand the concept of entrustment / entrustable professional activities (EPAs), the new facet to competency based medical education. As the evidence builds for this format the US has already employed EPAs as part of their residency curricula and are looking into this at the undergraduate level. As simulation is a cemented pedagogy in medical school we undertook a pilot study (under publication review) looking at trust based decision making for students managing two acute medical scenarios. The results proved fascinating and one of the primary take home messages was that it would be difficult to assess entrustment at the undergraduate level when they are so far from being actual practicing doctors. Again debates for and against doing so exist.
It was a fascinating experience to be based in the US and be witness to their educational strategies. I developed further as an educator, being more open in my approach and expressive. I admired the can-do approach in the US, the positivity and that anything is possible. I shall certainly be visiting again that is for sure.

I would like to thank Professor Felise Milan for educating me and also feeding me! I admired her steadfast approach to clinical skills teaching and her strong leadership qualities. I would also like to thank Mimi McEvoy, Patrick Herron and Daniel Myers for sharing their education journeys and their interests. Thanks to Meron Hollingsworth for her simulation guidance and Donna Mahoney, Dina Astorino and to Marykay Roddy-Champlin for their advice on living life!

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