Thirteenth tip for teaching expertise in clinical reasoning

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have shown whether the students who have published were aiming for particular specialties. One would expect those aspiring for more competitive specialties to have been more academically active. I am convinced that a student who is interested in research will find countless opportunities to be involved in the many projects that are conducted in hospitals and universities; the driver is an individual student's motivation and initiative.

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Why teach medical students aspects of the respiratory examination that do not aid in diagnosis?

Dear Sir

For years medical students worldwide have been taught the long routine of the respiratory clinical examination and rehearse it religiously so that it can be repeated in their clinical OSCE's. However, it is unlikely that they require all aspects of the taught clinical examination to develop a differential diagnosis. There is much evidence to demonstrate that certain aspects are less reliable and have low specificity, most notably tactile vocal fremitis, whispering pectoriloquy and tracheal deviation (Benbassat and Baumal 2010). We do not teach our medical students to carry out investigations that have very low specificities, therefore why do we teach them to carry out examinations that do?

We hypothesised that doctors only carry out aspects of the respiratory examination that aid diagnosis in clinical practice. To find out whether this is true, a questionnaire was sent out to all doctors in a large teaching trust. 105 responses were received from a range of different grades and specialities, including 10 respiratory specialists. The results overwhelmingly showed that the majority of doctors do not carry out tactile vocal fremitis, whispering pectoriloquy and vocal resonance and only sometimes carry out tracheal deviation. Doctors also felt less confident picking up signs with aspects of the respiratory examination that are less reliable.

Medical students should be taught to perform the respiratory examination with the aim of exploring a diagnostic hypothesis. When teaching the respiratory examination, focus should be given to the more reliable aspects of the examination, which can aid the diagnosis of life threatening conditions. Less reliable aspects should be mentioned as "nice to know" but do not necessarily have to be performed routinely and should not be assessed in OSCE's.

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Thirteenth tip for teaching expertise in clinical reasoning

Dear Sir

We have, appreciatively, read Joseph Rencic's 'Twelve tips for teaching expertise in clinical reasoning' (Rencic 2011). We would like, however, to complete this survey with a thirteenth tip: 'take your gut feelings seriously'. Gut feelings are based on the interaction between patient information and a physician's knowledge and experience. (Stolper et al. 2011)

Most physicians will recognize that feeling of sudden heightened awareness or alarm, which sometimes emerges during consultation. That sense of alarm is an uneasy feeling, a sense of 'there's something wrong here' which activates the diagnostic process by stimulating a physician to formulate provisional hypotheses with potentially serious outcomes and to weigh them against each other. On the other hand, a sense of reassurance means that a physician may feel confident about the management plan and/or about the outcome, even though he/she is not certain about the diagnosis: 'it all adds up'. These gut feelings act as a compass, a kind of skilled intuition (Kahneman & Klein 2009), steering physicians through busy office hours and making complex situations manageable. Most GPs trust this compass. Dual-process theories contrast analytical reasoning like the use of Bayes theorem and decision trees, and non-analytical reasoning like pattern recognition and gut feelings as two continually interacting modes of knowing and thinking (Stolper et al. 2011). Gut feelings may alert physicians to slow down switching to analytical reasoning. Cognitive neuroscience research provides support for the view that emotions are a vital component of the decision making process, helping us to thread our ways through the huge amount of information and knowledge. As Rencic already wrote: a combined non-analytical and analytical approach to clinical reasoning improves diagnostic accuracy.

Increased awareness of gut feelings, feedback, reflection and specific experience may help students to learn when to trust gut feelings and when to slow down.

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Let the patient teach: Patient feedback will help prepare medical students for the changing healthcare world

Dear Sir

In medical education, patients are typically used passively to practice clinical skills and are excluded from evaluation processes. Although medical education has shown adaptability to meet the broadening role of physicians, for example through teaching of management, advocacy and collaboration skills, relatively little has been done to meet the changing role of the patient. As healthcare becomes more collaborative (Swan 2009), patients are increasingly involved in their own care. Furthermore, formal assessments of patient satisfaction data are becoming linked to physician compensation (Sussman et al. 2001), giving patients greater responsibility in evaluating the system and its professionals. To be successful in this new paradigm, medical education must produce physicians who can function effectively in a world where patient feedback is central to their success.

Why should students care about patient feedback?

First, patient feedback is a key method for understanding satisfaction. Dissatisfied patients may act against their best interest, for example by not complying with their care plan if they are unhappy with their course of care or their relationship with their provider. As such, managing patient satisfaction can be deemed both a moral and professional responsibility for a physician and should be a core skill for medical students.

Second, new patient-driven online evaluations of healthcare providers (Swan 2009), such as www.RateMD.com, have the potential to directly impact physician reputations. Many of these platforms have potentially enormous influence and reach. Physicians need to be trained to dialogue with their patients so these online platforms are not the only or default outlet for patients to discuss their healthcare experiences.

Finally, as patients collaborate with their providers, they expect a more empowered and more patient-centered relationship (Swan 2009). Engaging patients to understand their experience will be a critical component of achieving true patient-centered care.

What steps need to be taken?

Curricula should consider enhancing the role of patients in medical education by incorporating patient feedback into student evaluation schemes to complement pre-existing methods. This exercise could help students better appreciate how patients perceive them and train them to solicit patient feedback themselves.

Trends are increasingly motivating physicians to satisfy patients. By incorporating patient feedback into curriculums, medical schools will take steps to produce physicians who live patient-centeredness and are focused on improving their patients' experiences and satisfaction. Patients undoubtedly have a lot to teach, they simply need to be given the opportunity.

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Medical students' perceptions of learning reflective skills

Dear Sir

We are writing to you on behalf of the Cardiff University Journal Club, encompassing medical students from year's three to five.

The paper by Vivekananda-Schmidt et al. (2011) in the October Issue of *Medical Teacher* highlighted a key issue within our journal club – reflective practice. Cardiff offers early clinical integration and has a course structure similar to those universities used in this study. The GMC clearly emphasizes in 'Tomorrow's Doctors', Professional Development and Practice (PDP), of which reflection makes up the bulk, as crucial for the safeguarding and development of doctors.

We feel that the study reflects views similar to those of Cardiff medical students, particularly related to relevant