Thirteenth tip for teaching expertise in clinical reasoning

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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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Reference


Thirteenth tip for teaching expertise in clinical reasoning

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 fremitus, 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 fremitus, 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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Reference

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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References


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