



Letters to the Editor

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LETTERS TO THE EDITOR

Needs assessment for
continuing medical
education in Nepal

Dear Sir

At present there is no structured system in Nepal for ongoing, continuing medical education. This is of concern for all doctors, but particularly those in remote rural areas who work in isolation and have minimal access to textbooks, journals and the internet. Ongoing continuing professional development is a key area for the maintenance of good quality clinical care and has thus been identified as a priority for health care providers in many countries (Peck et al. 2000). Access to CME has also been found to be an important factor for improving retention rates in rural areas (Butterworth et al. 2008).

We recently undertook an extensive survey of doctors working in rural areas of Nepal in order to define their learning needs, both in terms of CME content and the preferred format, as well as to identify important barriers to learning.

Of the 213 doctors interviewed, almost 50% had less than two years clinical experience. 69.9% had a computer, with 55.3% having internet access. Doctors' main priorities for CME were the management of acute emergency problems in obstetrics, medicine, paediatrics and trauma/orthopaedics.

There was a clear preference for skills based courses, but there are significant practical difficulties in providing these on a regular basis. Interactive, accessible, up-to-date CME was wanted. Internet and CD ROM methods came low on the preference scale, possibly due to a lack of exposure to these techniques.

Many respondents expressed the desire for someone to guide them through a CME programme.

Following on from this study, our team is now developing an up-to-date, interactive CME programme on CD ROM, with particular emphasis on acute emergency management. Although this medium was not popular, we felt this may be due to lack of exposure, and it is ideally suited to our context. Internet is not practical due to the poor phone line system. To encourage doctors to undertake the CME we are offering a skills-based course in obstetrics on completion, as well as piloting a system of mentoring by senior General Practitioner via phone and email.

Our hope is that this programme will support junior doctors in their life long learning as well as improving the quality of care received by patients in remote rural areas. Innovative methods are needed to address the particular social and geographic challenges found in Nepal.

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A picture is worth a thousand
words: The use of visual
imagery in medical school
application prospectuses
in the UK

Dear Sir

Application prospectuses to medical schools are an overt marketing approach to entice potential applicants to a particular medical school. Visual images are extensively used in marketing literature to persuade and influence decision-making at a subconscious level. Our recent study highlights the possibility of this effect on medical school applicants and we recommend careful consideration of current approaches and the need for further research.

We performed a content analysis of the visual images in the application prospectuses of all (32) medical schools in the UK. We found that 15 (46%) of prospectuses contained photographs of students learning in laboratories, 13 (41%) in clinical skills centres and 11 (34%) in secondary care settings. Only 2 (6%) of the prospectuses contained photographs that clearly depicted students learning in primary care settings. Photographs of people wearing white coats were contained in 24 (75%) of prospectuses and 14 (44%) of prospectuses contained photographs of people wearing surgical scrubs. There was no major difference between medical schools except that one of the newest medical school had the highest number of photographs that depicted secondary care settings, laboratories and people wearing white coats.

The reason for the selection of photographs for application prospectuses by medical schools is unknown but it represents, as in other educational application prospectuses, the institution's underlying values about teaching and learning. The high portrayal of 'technical' aspects of medicine may convey a strong message to prospective medical students and this has important potential implications for both prospective students and medical schools. Prospective students who have an intention to practice primary care may be dissuaded from applying to medical school. Students who are attracted to a highly 'technical' curriculum may not develop careers in primary care and they may also become increasingly

frustrated when they realise that much of the later course, and also future medical practice, concentrates on long term care in primary care settings rather secondary care. This may result in students dropping out of the course.

We recommend that medical school admissions departments should carefully consider their approach to using visual images in admissions prospectuses and also that further research is performed to identify the intentions of medical schools in their choice of photographs in application prospectuses and the influence of these visual images on prospective applicants.

Ethics

Formal ethical approval was not required since the documents are in the public domain, and freely available for comment, and no human subjects were involved. Anonymity of the medical schools has been respected.

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Why do British undergraduates favour physicians' teaching compared to surgeons?

Dear Sir

We investigated the quality of undergraduate medical education by means of a structured questionnaire which explored attitudes and opinions towards teaching that students had received. The questionnaire was distributed by email to clinical medical students (third-year and above) from a leading medical school in the UK and provided undergraduates the opportunity to nominate doctors who made the most significant contribution to their medical education. The returned questionnaire responses were collated and the nominations were analysed with anonymity maintained at all times.

A total of 183 undergraduates responded, of whom, 96 nominations (52.5%) were for specialist doctors as opposed to

doctors in training who received 87 votes (47.5%). A total of 111 (60.7%) of the nominated doctors were specialist physicians, 51 (28.0%) were surgeons and 21 (11.3%) were doctors practising in primary care or family medicine. The doctor who received the highest number of votes was a specialist in Obstetrics and Gynaecology and the other five top teachers comprised of four physicians and a primary care doctor. Qualitative information regarding the attributes of these doctors which made them good educators included terms such as approachable, organized, punctual and flexible. Students were also impressed by their nominated doctor's ability to motivate, explain topics clearly in sufficient detail and also maintain interest during teaching sessions.

It was not surprising that specialist doctors received the most nominations, perhaps because of their vast and superior clinical knowledge and greater experience in medical education compared with doctors in training. It was interesting that surgeons received far fewer nominations than physicians. Whilst some disparity maybe accounted for the fact that surgeons spend a lot of their time in the theatre, such low numbers are not encouraging. In an environment where the number of undergraduates is rapidly increasing, it is imperative that teaching is shared by all doctors to reduce the collective burden on the system. The danger here is that potential disparities may develop in the training and knowledge of medical students and result in the production of incompetent doctors. Specific measures including the employment of teaching fellows for certain subjects such as surgery, for example (as already introduced in some hospitals), may be the way forward to address these issues.

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Problem based practical courses (PBPC) induce self-directed structured learning of practical skills

Dear Sir,

The concepts of problem based learning, practical instruction schemes and student directed study design were combined in a problem based practical course (PBPC) of 'blood pressure measurement', carried out in 2006 and 2007 with 146 students. PBPC enhances the PBL-seven-step (e.g. Schmidt 1983) with practical steps, a rateable protocol, and unobtrusive teacher guidance to a PBPC-ten-step.

'At home' blocks give students the responsibility to develop a measurement design and to take care of all measurements.

A four blocks approach for the implementation of a PBPC proved useful. In Block 1, students prepare at home for theoretical and practical aspects (approx. 1 hr). Block 2 is a 1.5 hr seminar with all participants, which provides an interactive introduction. Blood pressure measurement sets are distributed and the necessary skills are instructed, based on a Peyton (1998) scheme, which was enhanced to six stages. This accounts for skills trainings in class and covers (1) teacher demonstration at normal speed, (2) step by step teacher demonstration with parallel full explanations, (3) student explanations followed by teacher actions, (4) all students perform and describe own actions, teachers observe, (5) groupwise student explanations followed by student actions, and (6) final student class demonstration and questioning. During block 3 (about 6 hr), done in groups at home, students collaboratively define measurement goals, settings, protocol, and evaluation scheme. After teacher approval, students execute the experimental steps. On completion, groups write and submit the protocol and prepare a presentation. Block 4 accommodates presentations in class (1.5 hr).

The PBPC learning and teaching processes were evaluated according to the seven category-framework of the Stanford Faculty Development Programme, and based on oral and questionnaire feedback (57.5% return rate). On 1-to-5 scales (1 best), Peyton approach was rated 1.83 ± 0.72 , grade of self-directed learning 1.90 ± 0.98 and control of the teaching session 2.67 ± 1.14 . Fifty eight percent experienced this course as highly motivating and creative while 40% stressed positive group dynamics. Groups reported that they spent a considerable time with block 3 for reasons of motivation and enjoyment.

To conclude, PBPCs combine guided and free practical education of practical skills with a high grade of motivation and positive learning outcomes.

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Medical education in first aid and basic life support in the Netherlands

Dear Sir

Adequate education in first aid and Basic Life Support (BLS) should be considered as an essential aspect of the medical

curriculum. An evaluation was made, by sending a questionnaire to all 8 medical schools, regarding whether the medical training was performed in accordance with the national Dutch guidelines for medical education stated in the "Blueprint: training of doctors in the Netherlands, objectives of undergraduate medical education". All medical schools in the Netherlands have accepted the objectives of the Blueprint, and a substantial part of the Blueprint has been legislated in the Individual Health Care Professions Act. The Blueprint has the following structure: (1) a brief description of the profile of the graduating doctor; (2) a review of common general objectives of medical education; (3) a list of problems which every doctor should be able to handle and (4) an overview of clinical pictures and diseases that should be known and skills that should be mastered. According to these objectives, any medical school graduate should be able to perform first aid and basic life support as instructed by the 'Orange Cross', the national health care provider for first aid and BLS in the Netherlands (Oranje Kruis 1997; Metz 2001). The response was 100%. Seven out of the eight medical schools train their students in first aid and BLS during the medical curriculum. The persons responsible for education were satisfied with medical training in first aid and BLS and did not mention any large needs to address. However, an average of only 38% of the clinical pictures and diseases and 69% of the skills were mastered at the level defined by the Blueprint. We have demonstrated that there is a wide variety in the content, amount and practical design of first aid and BLS training in medical curricula in the Netherlands. The medical education in the Netherlands does not meet the objectives stated in the "Blueprint". In our opinion, medical training should include training in emergency care, and this in turn should include first aid and basic life support. These training programmes and regular refresher courses should be mandatory during medical training to maintain the required competency level for first aid and basic life support. We recommend that all aspects of first aid and basic life support training for medical undergraduates be improved and implemented in the Netherlands.

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