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Letters to the Editor

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LETTERS TO THE EDITOR

Comprehensive care at a student-run health clinic: A unique partnership

Dear Sir

Developing a student-run clinic (SRC) presents numerous challenges related to liability, funding, continuity of care, and others. The Delivering Equal Access to Care (DEAC) clinic is an SRC at the Wake Forest University School of Medicine that was established through a partnership with a local community health clinic, the Community Care Center (CCC). This partnership is unique amongst SRCs and offers a variety of solutions to many common obstacles.

Issues of funding and clinic resources are aided by the operating space, medical equipment and laboratory space provided by the CCC. Liability insurance for students and physicians is provided by the parent institution, while non-affiliated members are insured through the CCC by the Federal Tort and Claims Act.

These solutions allowed DEAC to focus efforts on providing comprehensive long-term care to patients with chronic medical issues, a daunting task for most SRCs which struggle with infrequent clinic hours and variable staffing (Simpson & Long 2007). The DEAC clinic recruited physicians at the CCC to review emergent lab results and contact a preselected DEAC representative. All remaining labs are reviewed weekly and emailed to the supervising physician and student volunteers who electronically review this information, discuss the case, and contact patients with the necessary results and instructions. This system ensures adequate patient follow up and provides students with a level of post-visit responsibility that is lacking in many medical curricula.

Balancing student education with quality delivery of medical care is a major ethical challenge for SRCs. Student schedules are variable and limit the regularity by which patients are seen by a single provider. The electronic system of reviewing and reporting laboratory data at the DEAC clinic not only enhances the educational opportunities to students, but also ensures continuity and high-quality care received by patients. The DEAC clinic has truly been able to offer these patients a comprehensive medical home.

Partnering a SRC with an established community health clinic promotes student education and facilitates quality delivery of care. With over 131 accredited medical schools, over 1200 community health clinics, and a rapidly expanding population of underserved patients, many opportunities exist for expanding SRC partnerships.

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The socioeconomic origin of the students has a major influence on the ability to integrate medical studies

Dear Sir

Over 7000 French medical students took the National Ranking Examination in June 2010, the results of which determine their specialty/city of university. Many factors influence the choice to study medicine, one's abilities to learn medicine, and the choice of career specialty. Among these factors, socioeconomic status (SES) may play an important role.

We did a study concerning the SES and specialty choice of medical students. In March 2010, 5091 students (64% women) participated in the National Ranking Practice Examination which mimics the exact conditions of the real examination. Students were invited to respond to an e-questionnaire and were instructed about survey's aims and anonymity. Information about parental SES was given by 4307(92.4%) students. Higher professional occupations were the most represented SES among the students ($n=2478$, 57.5%), followed by intermediate ($n=566$, 13.1%), and administrative ($n=513$, 11.9%) occupations. Distribution of gender across social classes was homogeneous ($p=0.1105$). We found a major statistically significant difference between locations (Paris versus other cities) concerning the global distribution of medical students' parental SES ($p < 0.0001$): higher professional (66.6% versus 54.4%), intermediate (8.6% versus 14.6%), and agriculture occupations (0.38% versus 2.5%). There were no SES differences in the first six specialty choices (General Practice, Gynecology, undecided, Anesthesia/Intensive Care, Pediatrics, Cardiology) ($p=0.0803$).

To our knowledge, our sample is one of the largest populations of European medical students ever reported. It was representative as it included around 72.3% of the students in their sixth-year and was drawn from all 39 medical universities.

The parental SES of French medical students was less equally distributed than in the rest of the French population. A Danish study found similar results which have remained relatively constant for the University of Copenhagen during the period 1992 to 2007 (Pedersen et al. 2010). Despite the fact that women are overrepresented in medicine in France, parental SES remained homogeneous in our sample, which is also different than the general population. French medical schools recruit more students from higher SES than other social

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fields. One study has stated that this result shows the heritability of genetic and environment conditions as well as the socioeconomic forces at play in medical education (Fan et al. 2007). However, SES did not influence the specialty choice as it resulted from the interplay among several factors.

Access to medical school gives rise to a social selection that has evolved little since the 1990s in France. An intensified effort is needed to recruit more differentiated segment of students with regard to the demographic evolution in France.

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Students' perceptions regarding poster presentation associated with Mentored Student Projects

Dear Sir

Poster presentations constitute a major platform in scientific meetings across the globe. It forms a way of disseminating essential information to the target audience (Hess et al. 2009). It also encourages teamwork and improve communication skills. Melaka Manipal Medical College (MMMC) , Manipal Campus, Manipal University, India, offers the Bachelor of Medicine and Bachelor of Surgery (MBBS) course which is of five years duration, in which 98% of the students are Malaysians. Keeping in mind the specific needs of international students, our medical school took initiative in developing a Mentored Student Project (MSP) where students are required to undertake a research project under the guidance of a mentor, in the second year of their course. Students are required to present their work in the form of a poster as well as write a project report. Well before the poster presentation date, an orientation was given to students by the MSP faculty coordinators regarding poster design, content, background color combinations, acceptable fonts and so on. Posters which were presented by faculty coordinators in conferences were displayed as samples. We explored students' perceptions regarding the poster presentation event held in October 2010. We used a 10-item questionnaire which consisted of items focusing on orientation to poster presentation as well as the poster presentation itself. Students were requested to indicate their responses on a five-point Likert scale. Analysis of results revealed a mean value greater than 3.5 for all items. 'Poster presentation helped in enhancing my communication skills with my peers and teachers' was found to be scoring the highest mean (mean: (4.2 ± 0.96). Other items which scored a mean greater than 4 included 'presentation itself helped in demonstrating my knowledge about my work amidst an academic group' (mean: 4.01 ± 0.87), 'getting useful feedback regarding my work' (mean: 4.0 ± 0.84) and 'gaining confidence in presenting my work amidst an academic group in future professional meetings' (mean 4.1 ± 0.78). It was encouraging to observe that students benefitted from orientation as well as poster presentation itself, as evident from their feedback.

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Empathy integration: A two way street between medical students and standardized patients

Dear Sir

Pedersen (2010) provided a thought-provoking examination of empathy development and the ongoing separation of biomedical and patient-centered models of care in medical education. Without the integration of these models, physicians are unable to obtain a complete picture of their patients. Pedersen explained, "If medical training, . . . does not open up for the physician's situatedness and interpretations . . . and the patients' experiences, preferences, and values-medical students are likely to neglect interpersonal, existential and moral aspects . . .".

Standardized patient (SP) programs help facilitate the development of communication skills during a students' undergraduate medical training through simulated interviews (Stillman et al. 1990). Among other things, these exercises are designed to focus on increasing the empathic ability of students toward SPs (patients). Medical education and SP programs have the mission of helping students incorporate empathic behavior during patient interactions while also simultaneously diagnosing and prescribing.

Recently, our program observed another illustration of empathy that occurs: from SP to medical student. Using focus groups and thematic analysis for a different study, we unexpectedly discovered that most SPs have compassion for medical students during the simulation process (i.e., the interviews) as well as during post-interview feedback with students. The SPs reported their desire to *support* and *encourage* students so they could help them solidify more effective communication skills.

One focus group SP participant stated "I think the case not only helped me but it helps me grasp that they're (students) struggling with trying to figure out what *they* are comfortable with. You have to find your own way, how you perceive the patient, and what's comfortable for you to relate with."

Based on these early observations, should not empathy be examined from both perspectives in medical education: student to SP as well as SP to student? If understanding the feelings of patients is found to improve certain aspects in the process of clinical treatment (Beck et al. 2002), can understanding the feelings of students improve certain pieces of a student's performance? Based on Pederson's assessment of the importance of weaving empathic education into medical education, we believe these questions warrant further exploration and attention.

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An international comparison of professional attitudes among medical students in Ireland

Dear Sir

Following the recent report in the Medical Teacher by Tokuda et al. (2009) in Japan and previously that of Barry et al. (2000) in the United States, we decided to compare their findings on medical professionalism among final year medical students in Cork.

The internationally validated Barry professionalism questionnaire, consisting of six case scenarios was administered to 100 final medical students at UCC, following ethical approval from the Cork University Hospitals Research Ethics Committee. This questionnaire detailed six6 professional dilemmas, with each scenario followed by four possible answers, which students were asked to rank according to the order of appropriateness. The dilemmas presented were: pharmaceutical payments for enrolling patients in a study, disclosure of a teenage patient's details to her mother, suspicion of alcoholism in a senior physician colleague, patient requesting treatment

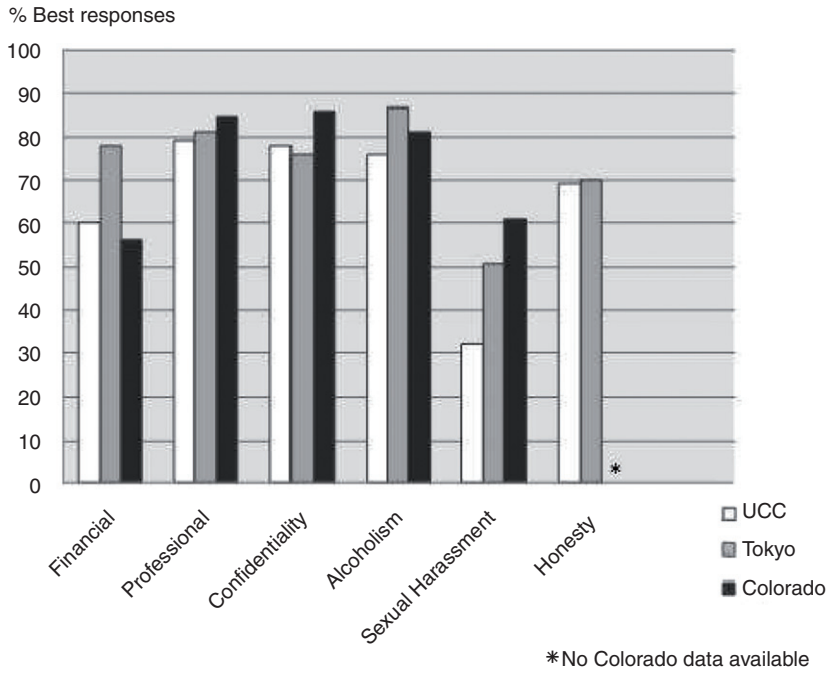

Figure 1. Percentage of ideal responses to dilemmas presented.

but insisting it not be documented, investing in a local private radiological service, and inappropriate gestures and behaviour by a male staff member towards a female colleague. All students completed the questionnaire. Each question had an ideal response, and a second, imperfect but equally acceptable response. The best-answered question by UCC students, which had the highest number of best responses, related to prescribing/honesty. The poorest answered questions involved sexual harassment and alcoholism, with only 25% & 14%, respectively, choosing the ideal response. Figure 1 shows the sum of both the ideal and second best answer. This allows a comparison to be made to the Japanese and American data which was published in this manner.

Emerging doctors in Ireland were similar to their international colleagues in their inability to consistently respond optimally to professional dilemmas. In particular, their best responses to the issues of sexual harassment were sub-optimal compared to international colleagues. This may reflect a relative immaturity of the Irish students who were predominantly high school-entry medical students, while the Japanese and US subjects were qualified doctors.

The medical profession in Ireland, as in other countries, has been rocked by a number of high-profile scandals (Clark 2006), bringing the professional and ethical training of medical students into a sharp focus. Despite the increasing profile of professionalism and ethics in medical education world-wide, this report and others (Lempp & Seale 2004) demonstrate that the unwritten rules and expectations can continue to elude many students. Considering that disciplinary action in later life has been linked to poor understanding of professionalism and ethical conduct as a student (Papadakis et al. 2005), it is imperative that the next generation of physicians can identify, understand, and address the varied professional challenges they may face.

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Teaching faculty to teach: A new approach to global awareness

Dear Sir

Medical educators must employ innovative faculty development pedagogy if they wish to train doctors who are able to succeed in a world that continues to increase in complexity. In recent years, Taiwan has seen a rapidly growing immigrant population. Training future physicians in cultural competence will be essential to their being able to deliver proper care to a multicultural array of patients. Furthermore, the obligation to better serve disadvantaged populations regardless of ethnic or racial background is fundamental to medical professionalism and health ethics.

The Center for Faculty Development (CFD) was charged with developing a course that would properly equip faculty members with the skills to teach students to appreciate the cultural intricacies of medicine. Before designing the course, two surveys of the faculty were conducted. "Personal Growth", "Teaching and Mentoring Skills", and "Professional Development" were ranked as the areas they specifically desired training from the CFD. The faculty was also interested in learning about the operations and setup of prestigious universities around the world as well as the history of medical education and its current state in both the East and the West. With this input in mind, a curriculum was designed that interwove threads related to personal growth and leadership with general topics concerning cultural competence and globalization.

The course meets monthly in conjunction with a required faculty meeting. It examines how social, cultural, and economic factors influence an individual's health values, beliefs, and behaviors.

Faculty development is only as good as the resultant student improvements. During the past three years, medical student participation in international electives has increased three fold. Students also possess a better understanding of socioeconomic influences on health and illness, a greater appreciation for international health, and improved foreign language proficiency (as measured by the official government English exam).

Faculty have also directly responded to what they have learned in the course, sometimes in unique ways. For example, two internationalized medical humanities courses launched by faculty members were given awards by the Faculty of Medicine and by the Ministry of Education for their ingenuity in integrating cultural appreciation with the traditional medical curriculum. The course materials were then selected to be published as the official medical humanities textbook for all of Taiwan. The faculty have also significantly enriched teaching, improved ethics dialogue in the classroom, inspired creativity, shown greater compassion, and provided new opportunities for research. These strides have led the

university to expand its global health initiatives thereby strengthening its service mission.

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Error reduction/recovery more empirical evidence needed

Dear Sir

Dror emphasized the importance of training for error reduction (Dror 2011) and he argued for training error recovery as well. For error recovery, it is necessary to detect and mitigate the error. In training error detection, Dror suggested to start with encouraging students to detect clear errors in others and to gradually learn to detect subtle errors of their own. In training error mitigation, the idea is to first provide trainees with a solution, then let them choose a solution between various alternatives and finally learn them to generate solutions themselves. This is an interesting comprehensive approach to error reduction. However, the proposed training program is quite time consuming and probably not applicable to all aspects of medicine.

The underlying assumption of Dror is that medical errors can be predicted, so that detection and solutions can be introduced in a learning program. This might be realistic for intensive care medicine, but it is not the case for psychiatry, given our limited knowledge about neurocognitive processes at brain level.

In surgery, Gawande and his team found that using a simple short checklist reduced errors dramatically (Jaynes et al. 2009). Maybe one of the most important things students should learn is to follow simple checklists no matter how superfluous it seems to be, just because the human mind works in particular ways. It is therefore an empirical question whether the program proposed by Dror reduces errors and consequences of errors in a cost-effective way compared to checklist approaches and whether it can be applied to all medical specialities.

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Patient care and training: Minimizing errors in medical care that result in patient harm

Dear Sir

Training can be time consuming and expensive, and one should strive for the most effective training that gives the greatest return with minimal investment. Considering these issues is important, and Hubbeling (2011) is correct in raising such concerns. Such a cost–benefit analysis must also consider the long-term payoff matrix and consequences resulting from investment (or lack thereof) in training.

When patient care is concerned, the rate of errors that cause patient harm persist, despite major investments (Landrigan et al. 2010). Even with extensive training efforts and comprehensive programs (that include visible posters, reinforcing a supportive culture, etc.), the effectiveness of checklists is limited (e.g. improved performance still encompassed 30% non-compliance with following all the steps in a check list (Pape et al. 2005)).

Error recovery training is aimed at error reduction and better patient care, and is based on the following.

(1) Training should be cognitively informed and brain friendly. If we want training to be effective, it must take into account how the learners acquire, store, and use information (Dror et al. 2011).
(2) An error recovery training approach is especially cognitively effective (Dror 2011).
(3) Check lists can be made more effective if they are supplemented with error recovery training.

An everyday simple illustration of this idea is that training people who use computers to frequently 'save' their work is not very effective; most people learn and remember (and do) 'save' their work only after they have been 'burnt' and lost work. Error recovery training, which provides such experiences, is an effective way to reduce error (in addition to the important value of teaching error recovery per se). It is not contradictory, but supports and enhances the use of check lists.

The cognitive claim is that error recovery forms better mental representations, makes the cognitive system more aware, provides salient and memorable road signs, and guides cognitive attention, to the issues that are needed for reduction in errors. As Hubbeling (2011) correctly points out, the effectiveness and usefulness of such new tools must be established by empirical evidence.

Error recovery training may not be applicable to address all aspects of medical care across all medical domains. Like check

lists, error recovery is one tool, among many, that need to be utilized in improving patient care. Many such tools are not mutually exclusive and can support one another (just as error recovery enhances the effectiveness of checklists). However, for these tools, as well as others, to work effectively and produce the desired outcomes, one must make sure they are cognitively efficient and brain friendly.

This approach not only makes existing tools more effective, but also gives rise to new ideas and novel approaches to training. Error recovery training is one such idea; it is aimed to help reduce error, improve error detection and train in error mitigation.

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