



## Authors' response to letter from Rizan CT et al. – PPE: A UK Perspective, “All for one, *NOT* one for all”

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## PPE: A UK perspective, 'All for one, NOT one for all'

Dear Sir

The recently published work by Chen et al. (2001) was read with keen interest by students of the Cardiff University Surgical Society at our fortnightly journal club. Whilst all members acknowledged the benefits of Peer Physical Examination (PPE), the proposition of formally integrating PPE into our medical curriculum sparked much debate.

Whilst Chen et al. (2001) identified culture and female gender as factors reducing propensity to participate in PPE; we anticipated that in an ethnically diverse, female-dominated (approximately 2/3) cohort, such as that seen at Cardiff University School of Medicine, PPE might attract poorer involvement than those reported here. Students must be endowed the same rights to which they are dutifully bound to grant patients, namely refusal of investigation, including examination. This necessitates an educational programme designed for all, which can accommodate the inevitable disinclination to participate expressed by some students. Hence we call for a solution which satisfies 'all for one, not one for all'.

In light of this we propose three recommendations for learning clinical examinations based on a non-uniform approach. Firstly, we endorse Cardiff's utilisation of actors through high-fidelity simulation as this can incorporate simulated pathology alongside unfamiliarity between examiner and examinee. Moreover, this replicates a realistic clinical encounter that requires development of patient-doctor rapport. Secondly, we felt that PPE is more appropriate in an informal setting between self-elected individuals. This informal approach allows repetitive practice of examination routine upon friends in order to achieve flair and confidence outside of the constraints imposed by the classroom. Indeed, many students conceded PPEs effectiveness in preparation for their Objective Structured Clinical Examinations. Finally, the use of bench top models should be highlighted in order to attain proficiency in performing intimate examinations.

In conclusion, we do not feel formal PPE adequately fulfils medical students learning requirements. Instead, we propose a multifaceted approach that provides consideration to the range of different clinical examinations taught at medical school. We would once again like to thank Chen et al. (2001) for their

interesting research on this topic and would recommend further research investigating validation of PPE as an effective adjunct for learning clinical skills.

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## Authors' response to letter from Rizan CT et al. – PPE: A UK Perspective, "All for one, NOT one for all"

Dear Sir

We are most pleased that our report generated interest and discussion among Rizan and colleagues in their journal club. We agree with Rizan et al. that the learning of clinical skills can, and should be facilitated through multiple modalities including peer physical examination (PPE).

It may not have been clear that our reported findings focused only on the PPE component of a formal clinical skills programme which also uses teaching videos, audio-visual aids, demonstrations, and high- and low-fidelity models as appropriate. This programme is the introduction to our overall clinical skills curriculum which also incorporates a variety of learning approaches involving simulated patients and contextual experiential learning. As noted in our article, the vast majority of students practised PPE during class time as well as on their own time, which would suggest they perceived value in this practice, whether done as part of the formal programme or informally.

Nonetheless, we do see an important role for the setting-specific, structured use of PPE in the learning of clinical skills in medical school for practical (e.g. resource and time constraints) and educational reasons (e.g. multi-source feedback), with consideration for student informed consent (Wearn and Bhoopatkar 2006), and sensitivity to cultural and gender issues (Rees et al. 2009).

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## PBL performance correlates with content acquisition assessment: A study in a hybrid PBL program at Alfaisal University

Dear Sir

One of the major challenges in Problem-based Learning (PBL) curriculum is to establish an effective PBL process and its reliable assessment. Von Bergmann showed that students who were recognized as having good process skills in PBL tutorials also performed significantly better on content acquisition tests (von Bergmann et al. 2007). However, Whitefield and Xie (2002) demonstrated that facilitators' evaluation of PBL process was not correlated with students' performance in the written examinations. This observation was attributed to the potential lack of objectivity in grading, e.g. subtle tendency for facilitators to over-rate the students. College of Medicine, Alfaisal University adopted a unique Problem-based hybrid curriculum which was designed to meet the special requirements related to maturity level of entering high school medical students. In this context, more experienced PBL facilitators were used in the early phase of the medical curriculum. We predicted that this approach would lead to a strong correlation between PBL process assessment and content acquisition tests.

We analysed the results of 54, 2nd year MBBS students of Alfaisal University who appeared in the semester-3 written examinations of 2010–2011 and ran a correlation between their scores in PBL process and their overall score in the written examinations. Our results showed that there was a strong correlation between scores of written examination of semester-3 and PBL process scores with  $r=0.72$  ( $p < 0.0001$ ). Further, there was also a statistically significant correlation between PBL scores and Multiple Choice Questions, Short Answer Questions and Objective Structured Practical Examination components of the Semester-3 written exam with  $r$  values equal to 0.59, 0.49 and 0.53, respectively.

We attribute this strong correlation to the following. First, we minimized the effect of factors which could make PBL facilitators grading unreliable by discussing the PBL process grading criterion at length with our faculty so that there was clarity and uniformity on grading system. Second, the new faculties were trained in PBL process by conduction of several

workshops by Partners Harvard Medical International (Alfaisal's collaborator) during this period. Finally, PBL facilitators managed group activity for a shorter period of time usually not more than 4 weeks; this allows them to assess the students objectively rather than on familiarity.

In conclusion, PBL process evaluation can be a useful method to assess overall performance of students provided there is proper training of facilitators and a clear comprehension of grading criterion.

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## DREEM – Time to evaluate?

Dear Sir

The Dundee Ready Educational Environment Measure (DREEM) is widely used to evaluate educational environment across healthcare settings (Roff et al. 1997). The time at which the questionnaire is administered during the academic year varies greatly in published studies and the original authors do not advise in this regard. We suggest that the timing of administration of the DREEM may affect results.

All year 3 students ( $n=108$ ) in our undergraduate medical program completed the DREEM at the end of each of the three clinical attachments ( $n=324$ ). At any one time, over a four-month period, an identical number of students are deployed in secondary, tertiary and general practice sites for 4 weeks. Clinical attachments are described as Attachments 1, 2 and 3, referring to their temporal order. Within each of these attachments, DREEM scores represent the educational environment at an identical mix of sites. Differences on DREEM score between Attachments 1, 2 and 3 would not be expected.

Mean total DREEM scores varied significantly between first, second and third attachments ( $p < 0.01$ ). The score rose from the first to the second attachment but fell back in the third attachment to a level below the original score. Significant differences in Perceptions of Learning, Atmosphere and Teachers were found reflecting the same pattern as the total score ( $p < 0.05$ ). This effect appeared to be related to duration of clinical exposure as mean scores did not vary when analysed by calendar month.