



Expanding the objective structured clinical examination (OSCE) to teach documentation, coding and billing

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Research is an important part of clinicians' work. However, I have gained the impression that successful researchers are sometimes valued over enthusiastic clinical teachers. Research success is easy to quantify whereas teaching quality may be not, particularly not objectively (Katarey 2012). This *per se* holds true, but that is where students again come into play. Courses are evaluated regularly, and who is better to judge a teacher's performance than participating students? I, therefore, propose that universities should systematically identify qualified educators – based in part on student evaluations – and support this important clinical sub-population with the same resources as research staff.

And, what enables clinical teachers to be good at their craft? In this student's opinion, it is as Steve Jobs once put it, "The only way to do great work is to love what you do" (Stanford News Service 2005).

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Using the DRECT to assess the intern learning environment in Australia

Dear Sir

We assessed the learning environment of interns at our hospital to establish the practicality, acceptability and internal consistency of the Dutch Resident Educational Test (DRECT) in an Australian teaching hospital.

In the past, the Postgraduate Hospital Educational Environment measure (Roff et al. 2005) has been used in Australia, but its ability to measure different dimensions of the learning environment using three distinct subscales has been challenged.

We made two modifications to the DRECT for the local environment ("consultant" instead of "attending" as the doctor supervising the interns and "educational supervisor" instead of "speciality tutor" (Boor et al. 2011, 5 March 2013 personal communication). We also asked the interns if they could state three aspects of the learning environment they would change.

Following Ethics Committee approval 53 of the 60 (88%) interns completed the questionnaire and also indicated the

three aspects of the learning environment they would change if they could. The overall Cronbach alpha was 0.95 and the overall mean scale scores differed by rotation ($p < 0.05$).

There was no difference between the male and female interns mean scores for either the individual items or subscales. The interns' responses to what they would change in the environment did not identify any new issues previously unaddressed in the questionnaire. The changes they requested were consistent with the ratings in the questionnaire.

The Cronbach alpha, the high response rate and the fact that all questions were answered, suggests that the DRECT is suitable and practical to use in our environment. No new items in the learning environment were raised in the free question suggesting that the DRECT is comprehensive for our environment.

Our two lowest mean subscale scores were for supervision and feedback. These are fundamental to clinical training and need to be urgently addressed in all intern rotations. A follow-up study is needed to ensure the necessary changes are made.

The Medical Board of Australia accredits intern positions every five years but, with our intern positions increasing annually we need to quantitatively assess unit quality more frequently. The DRECT also provides greater detail than the accreditation process on the quality of each intern rotation thus making it easier to address weaknesses.

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Expanding the objective structured clinical examination (OSCE) to teach documentation, coding and billing

Dear Sir

The Objective Structured Clinical Examination (OSCE) can augment traditional written tests to assess medical trainees' clinical competencies. Coding and billing is poorly taught and inadequately evaluated, and trainees report feeling unprepared for this aspect of medicine (Fakhry et al. 2007). One

program incorporated documentation and billing exercises as part of an abbreviated 2-case OSCE and noted instances of under-coding, over-coding and even insurance fraud (Franzese 2008). We developed a formative geriatrics fellowship OSCE to teach principles of documentation, coding, and billing and to inform curricular improvement.

The OSCE blueprint included geriatric syndromes, end-of-life care, geriatric practice sites and varying patient complexity (robust, frail and dying). Fellows encountered six 30 minute scenarios, followed by 15 minutes to complete documentation, coding and billing. Performance checklists (history, exam and management skills) were completed by standardized patients and geriatrics faculty to provide individualized feedback.

Afterwards, fellows participated in a didactic session that modeled application of compliance principles to the six cases. Fellows received sample documentation for each case – including audit forms using Medicare guidelines highlighting key elements of the history, physical exam and medical decision making that determined billing. Fellows compared these samples with their documentation, coding and billing submissions.

Blueprinting the examination using key competencies, care locations and patient complexity guided creation of a highly-relevant examination. We identified deficits in attaining relevant history (alcohol abuse in elders) and exam findings (pressure ulcers) that affected documentation. Most fellows lacked understanding of basic compliance concepts that practicing geriatricians encounter – supplying rich opportunities for individual and program improvement. This experience highlighted the value of using the OSCE to teach documentation, billing and coding principles which support fellows' transition from learners to independent practitioners.

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Gender inequality in academic medicine in Japan

Dear Sir

According to the latest Japanese Ministry of Health survey, women comprise 18.9% of all physicians and 35.9% of physicians under 30 years old in Japan. Despite increasing number of women physicians, women in leadership positions remain a rarity in Japanese academic medicine. Some countries systematically gather and publish data on faculty ranks and promotions by gender in academic medicine.

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However, no comparable data exists in Japan. I reviewed the faculty rosters of all 80 Japanese medical schools and found that women constituted only 2.6% of all full-time professors and only two out of 80 deans (2.5%). Of 103 women full-time professors, 49 (48%) had positions in the departments of basic medical sciences. There were only few women professors in the surgical field (one each in neurosurgery, plastic surgery, breast surgery, otolaryngology and obstetrics and gynecology). For 51 public medical schools and 29 private medical schools, the percentages of women full-time professors were 2.2% and 3.1%, respectively. There were no women in full-time professors in approximately one third of medical schools. The scarcity of women in the leadership positions is also evidenced by another survey evaluating the number of women in Japanese academic societies: women comprised only 6.8% of all councilors of Japanese medical societies; 55 out of 100 societies did not have any women in director position (Tomizawa et al. 2012). In surgical societies, women constituted only 1% of councilors. A common argument to justify the paucity of women in leadership positions is that fewer women have been in the field long enough to have achieved leadership positions (the so-called "pipeline" argument) but the proportion of women in leadership positions is substantially lower than expected from the physician gender ratio in the current leadership generation.

Japan lags behind other countries in gender equality. In a report by World Economy Forum (Hausmann et al. 2012), Japan ranks 101th out of 135 countries in gender equality, mainly due to the underrepresentation of women in economic and political participations. My finding suggests that significant gender inequality is also present in academic medicine. Measures are needed to benchmark the representation of women and to promote gender equality in academic medicine in Japan.

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Communication skills training for health care professionals. What is it all about?

Dear Sir

Very few articles clearly report the basic strategies for empathic communication and Communication Skills Training (CST) in medical education. A successful communication is