Medical Teacher

ISSN: 0142-159X (Print) 1466-187X (Online) Journal homepage: informahealthcare.com/journals/imte20

Bring your own device into problem based learning tutorials

John Falconer, Sarah Gray & Kathy Gaul

To cite this article: John Falconer, Sarah Gray & Kathy Gaul (2014) Bring your own device into problem based learning tutorials, Medical Teacher, 36:12, 1086-1087, DOI: 10.3109/0142159X.2014.920493

To link to this article: https://doi.org/10.3109/0142159X.2014.920493

Published online: 29 Jul 2014.

Letters to the Editor

Is teaching communication skills integrated into Spanish medical schools curricula?

Dear Sir

It is taken for granted that the doctor–patient relationship is of great importance. It is thus necessary to teach communication skills in medical schools. However, little is known about how the training of this discipline is implemented into the curriculum structure of medical schools, especially in Spanish-speaking countries.

Traditionally in Spain this field was basically limited to postgraduate medical education, in contrast to other European countries. In 2005, the National Agency for Quality Assessment and Accreditation of Spain, which sets out the medical education curricula, affirmed *"effective communication"* as *"one of the seven basic competences in medical education"* (National Agency for Quality Assessment and Accreditation 2005). Furthermore, since the early nineties it has been universally encouraged that *"communication skills can be taught"* (Simpson et al. 1991).

Now is a good time, almost ten years later, to evaluate the results of this decision in our Spanish medical schools. An exhaustive analysis of the curricula and the study programs across the web pages of all Spanish universities shows that at present, these recommendations are not completely integrated yet (data can be requested from the corresponding author). Although private schools have more modern study programs, these are not fully adjusted to Bologna recommendations for training in communication skills. Moreover, our research shows that public medical schools have significantly more credits-hours allocated to this course.

Currently, the teaching of communication skills has not been completely implemented into many Spanish medical schools' curricula. Considering the national and international recommendations, an increase in the importance of communication skills in Spanish medical schools should have been expected. Nevertheless, there have been great changes in Spain. Much has been achieved since 1990; the average of credit-hours in this field has increased from 0.0 to 2.77, excluding the credit-hours from the transversal competence about communication.

Respecting the peculiarities of each university, we conclude that all Spanish medical schools should include these contents into their curricula as soon as possible and adhere to the recommendations. It should be pointed out that students must be trained in communication skills in order to facilitate an appropriate relationship with their future patients.

Guillermo Ferreira-Padilla, Teresa Ferrández-Antón, José Baleriola-Júlvez and Rut Almeida, ComunVista Research Group, Catholic University of Valencia, C/Quevedo, Valencia 46001, Spain. E-mail: g.ferreirapadilla@gmail.com

Declaration of interest: The authors report no conflicts of interest.

References

National Agency for Quality Assessment and Accreditation. 2005. Libro Blanco. Título de Grado en Medicina. España. pp 87,89,144. [Accessed March 2014] Available from: http://www.aneca.es/var/media/150312/libroblanco_medicina_def.pdf.

Simpson M, Buckman R, Steward M, Maguire CP, Lipkin M, Novack D, Till J. 1991. Doctor–patient communication: The Toronto consensus statement. BMJ 303:1385–1387.

Bring your own device into problem based learning tutorials

Dear Sir

At our Medical School, PBL traditionally runs 3 days per week. Students frequently describe getting "stuck" on small details for which they have no prior knowledge or that do not understand. There can be variability in level of accuracy of information shared by peers. The first and second year students regularly observe more senior students, residents, preceptors and faculty utilizing mobile devices for checking quick facts. As a result, students and tutors have suggested that a quick reference check could be useful to authenticate a proffered peer explanation or get past a sticking point. This has lead to the current

ISSN 0142-159X print/ISSN 1466-187X online/14/121086–1089 © 2014 Informa UK Ltd.
DOI: 10.3109/0142159X.2014.920495

investigation: Does allowing the use of electronic devices enhance or detract from the learning in PBL tutorials?

We solicited 10 volunteer tutors (out of 36) within a 4-week GI system block in the second year of our medical school program, who would allow their students (8 per tutor) to bring an electronic device of their choice into their tutorial sessions. Up to this point, devices were disallowed and only a medical dictionary was used in the tutorial sessions. At the completion of the block, the participating students and tutors were invited to complete an electronic online survey including a Likert questionnaire as well as open-ended questions reflecting their experience during the interventions.

Of the respondents, fifty-four different types of devices were reported being used in the tutorial sessions. Tablets (35%) and smart phones (46%) were the most popular type of device used by students and tutors with laptops making up a small percentage of use (16%). Five percent of them felt that the devices did not improve PBL, 39% were neutral, and 55% either agreed or strongly agreed that the devices improved PBL. Ten percent of the students and tutors felt that the devices did adversely affect group dynamics, 17% were neutral, and 74% felt that the devices did not interfere with group dynamics. Five percent of those responding felt it did not improve accuracy. Sixteen percent were neutral, and 80% felt that it did improve accuracy. Overall, 89% were in favor of recommending while 11% were not.

In this pilot study, we found that PBL tutors and students overwhelmingly supported allowing the use of electronic devices into the PBL tutorials. This has led to a policy change, and devices are encouraged, but individual usage determined by group agreement only.

John Falconer, Department of Medicine, University of British Columbia, V1V1V7, Canada. E-mail: john.falconer@ubc.ca

Sarah Gray, Department of Cellular and Physiologic Sciences, University of Northern BC, Prince George, British Columbia, Canada

Kathy Gaul, Exercise Physiology, University of Victoria, Victoria, British Columbia, Canada

Declaration of interest: The authors report no conflicts of interest.

Is professionalism fractal-like?

Dear Sir

The Dundee Polyprofessionalism inventory (Roff et al. 2011) of lapses in undergraduate Academic Integrity requires respondents to recommend sanctions for more than 30 mini-Situational Judgement Scenarios on a range from 0 (Ignore) to 10 (expel/report to regulator). Now that data have been collected from administrations in 4 countries (Scotland $n = 375$; Saudi Arabia $n = 125$; Egypt $n = 219$; Pakistan $n = 480$) I observe that while the response profile overall can be significantly different between countries, suggesting different professionalism cultures, there is in each sample only one difference of more than 2 levels on the 10-point scale between genders. In the Scottish sample there were no statistically significant differences between each 20% of the respondents from early to late responders, though this has not yet been explored in the other datasets.

This observation is in contrast to the frequent gender differences reported in scores of studies around the world using the Dundee Ready Educational Environment Measure where respondents rate their personal perceptions of various elements of educational culture on a Likert scale of 0–5.

Are we seeing here the process of student socialisation into the comparative frames of reference of medical professionalism? Is the almost 'fractal-like' (http://classes.yale.edu/fractals/) profile of each cohort at least at the binary level of gender responses a function of both the cohort's homogeneity in terms both of its highly selective admission to medical school and progressive socialisation into strongly mandated professionalism norms?

It should be emphasised that this 'fractal-like' characteristic holds only at the binary level of, for example, gender differences in responses. There is more differentiation if we analyse by age or year-of-study.

Using the now relatively inexpensive online tools of 'Big Data' (Ellaway et al. 2014) we could extend this 'mapping' of individual and cohort professional identity formation in a variety of ways to track the learning curves. More research is clearly needed but, if confirmed, this fractal-like quality might also indicate that Professionalism studies may not need to rely on high response rates to be robust, but could be conducted with well-constructed stratified, representative samples of 20–30% of the target population.

Sue Roff, University of Dundee, Medical Education Institute, Dundee, United Kingdom. E-mail: s.l.roff@dundee.ac.uk

Declaration of interest: The author report no conflicts of interest.

References

Ellaway R, Pusic M, Galbraith RM, Cameron T. (2014). Developing the role of big data and analytics in health professional education. Med Teach 36:216–222.

Roff S, Chandratilake M, Mcaleer S, Gibson J. (2011). Preliminary benchmarking of appropriate sanctions for lapses in undergraduate professionalism in the health professions. Med Teach 33(3):234–238.

Student-run free clinics and complementary curricula

Dear Sir

Pre-clinical students often volunteer at student-run free clinics (SRFCs), where they learn history-taking skills, perform basic