



The doctor who performs poorly in simulation: An approach

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one or more of: no data on past medical or family history of depression, use of a cross-sectional design and assessing students at only one time point, which was prior to or immediately after exams or at the beginning of the academic year. Current research on depression in British medical students is inadequate and neglected. The General Medical Council (GMC) must encourage medical schools to conduct prospective longitudinal cohort studies to identify prevalence, predictive individual and environmental factors and local barriers to seeking treatment.

International studies have reported higher rates of depression in medical students than age-matched peers. However these studies are not generalizable to the UK due to differences in course structure and environment. Despite this, research to identify prevalence of depression in British medical students has been scarce, with only two studies conducted in the past decade.

Quince et al. (2012) reported 5.7–10.6% of pre-clinical students and 2.7–8.2% of clinical students at Cambridge University were depressed. In contrast Honney et al. (2010) at University College London reported 32.4%, 10.8% and 5.6% of students in all year groups had mild, moderate or severe depression respectively. However both studies had numerous limitations.

Quince did not identify which students were already diagnosed with depression prior to medical school, making it difficult to ascertain whether depression occurred due to factors prior to or during medical school. Furthermore Cambridge utilises a pastoral system where there is a much higher level of contact with tutors compared to other schools and so vulnerable students may have been given much more support to prevent depression.

Finally, due to the fluctuating nature of mood disorders, measurements at one time point are not a reliable indicators of prevalence in individuals as a number of factors such as: exams and holidays can affect mood through the year. Only the Cambridge study followed students over several years, but it failed to make any significant conclusions due to a high rate of non-responders.

The lack of reliable prevalence and causative data on depression in this vulnerable group is a worrying sign. Medical students with depression are more likely to drop out of the course resulting in time and money inefficiently spent on incomplete education. Furthermore, as medical students form the foundation of the future National Health Service (NHS), the social impact can be significant. Regulatory organisations for UK medical schools such as the GMC need to encourage schools to frequently collect data and analyse it locally to identify prevalence rates, predictive individual and environmental factors and local barriers to seeking help and treatment. Data also needs to be pooled nationally so the GMC in concert with the NHS and the Royal College of Psychiatrists can implement national strategies aimed at the general factors affecting all medical students.

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The doctor who performs poorly in simulation: An approach

Dear Sir

As large scale clinical simulation programmes roll out, we are forced to confront the scenario where the performance of a trainee in simulation falls short of what is expected. Whilst policies and guidance are in place to address such an issue occurring in clinical practice, we are aware of no such guidance when applied to simulation. There is a responsibility on us as clinicians and educators to raise concerns about the performance of a colleague where patient safety is perceived to be threatened. Our protocol has been accepted for use in a region wide medical emergencies course (GMC 2013; National Association of Clinical Tutors 2013).

The maintenance of a safe psychological learning environment, whilst assessing competence and identifying potential threats to patient safety is a difficult balance. It must also be recognised that the learner may respond differently in simulated scenarios to clinical practice. There may not be the opportunity to observe a learner on multiple occasions.

Recognising these difficulties, we have agreed that where serious issues are identified (as defined by practice likely to lead to patient harm, or unprofessional behaviour likely to lead to patient distress), or the learner fails to recognise their own learning needs, the 'red' pathway is followed. Where available, all facilitators on the course will discuss and triangulate their views, with an action plan to be followed. The trainee will have face to face feedback with facilitators away from other trainees and the concerns will be recorded on a Mini-CEX and ACAT assessment tool. The course director will liaise with the trainee's educational supervisor and an action plan will be agreed with support provided as required.

For areas of poor performance which do not meet the criteria above, and where the trainee recognises learning needs, there is discretion available to the facilitators as to the course of action to be taken. Once again, the Mini-CEX and ACAT assessments are completed to document concerns, and an action plan is agreed. This is usually followed by repeat assessment once agreed actions are completed.

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A new challenge: The training of eHealth professionals, innovative actors of eHealth

Dear Sir

There is a burden of ageing population on health provision in industrialised countries. At the same time, internet, game consoles and all the derived digital tools, have revolutionised our lives. Technological developments used for these everyday tools have been quickly put to use in the field of health provision, explaining the exponential growth of what is called eHealth. In the field of gerontology, successes made possible by these technological advances have become legion, opening a particular field of eHealth allowing, for instance, rehabilitation in virtual spaces or with serious games or development of smart Zimmer frames. A complete field dedicated to monitoring is also emerging: connected pedometers or blood pressure monitors, smart clothes, mobile applications, telemedicine, etc.

The hospital, in the conventional sense of the term, seems to gradually disappear in favour of the development of a hospital 'at-home'. This notion is based on these self-monitoring technologies, but mainly on the development of these communicating tools such as telecare and online support. Indeed, these new technologies challenge the daily medical practice and create new relationships with patients. These changes lead to the emergence of new needs and it is important to clarify the range of competences of the personnel who will receive and analyse these data in order to take medical decisions: this creates innovative actors who will need to be trained.

In the same way, even if a patient's daily life is invaded by these new technologies, other health professionals should not feel helpless in the face of these innovative techniques for practising their profession (Wyatt & Sullivan 2005). Otherwise, we run the risk of disinvestment or withdrawal (Booth 2006). Therefore, it appears essential to provide help and support to staff to introduce these changes. The primordial issue therefore

appears to be the training of these new eHealth professionals in close collaboration with industrialists and providers of new eHealth services. It also requires the presence of teachers and trainers able to meet the challenges they face in ensuring a skilled and educated workforce of new professionals.

In conclusion, we need to be aware of the problem. It is time to move from a system based on individual skills in this innovative field to a formal recognised and effective system. This seems to be the only way to ensure that the adaptation of the area of health provision to these new technologies do not come at the expense of its actors.

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Creation of mHealth content aimed at medical students

Dear Sir

In the recent article 'Health professionals as mobile content creators: Teaching medical students to develop mHealth applications', the author (Masters, 2014) presents his findings from his work encouraging students to create mHealth content aimed at patients. I read this article with great interest as a medical student at The University of Manchester who has recently created an iBook aimed at educating other medical students.

I wanted to supplement and enhance the clinical skills teaching at the Manchester Medical School (MMS) by creating an iBook to give students a definitive guide to performing a Cardiovascular Examination. With a small amount of help from the faculty and no previous experience of content creation I was able to write an iBook using the iBooks Author application available for Apple computers.

I chose the iBooks Author application as all students at MMS are supplied with iPads upon entering their clinical years. Therefore by using the MMS iTunes U course and the Apple iBooks Store it was quick and easy to distribute the iBook to students who wanted the additional help with their learning.

iBooks Author is an intuitive and simple piece of software. It was easy to create an attractive and professional text in a relatively short amount of time. In a four week Personal Excellence Pathway (PEP) I was able to film the critical parts of