The Journal of Obstetrics and Gynaecology

Taylor & Francis
Taylor & Francis Group

Journal of Obstetrics and Gynaecology

ISSN: (Print) (Online) Journal homepage: informahealthcare.com/journals/ijog20

Teaching Ward Rounds: what are the alternatives?

A. B. MacLean & K. A. Ramos

To cite this article: A. B. MacLean & K. A. Ramos (2010) Teaching Ward Rounds: what are the alternatives?, Journal of Obstetrics and Gynaecology, 30:6, 535-536, DOI: 10.3109/01443615.2010.503437

To link to this article: https://doi.org/10.3109/01443615.2010.503437

Journal of Obstetrics and Gynaecology, August 2010; 30(6): 535–536

informa
healthcare

EDITORIAL

Teaching Ward Rounds: what are the alternatives?

A. B. MACLEAN[1] & K. A. RAMOS[2]

[1]*University College London Medical School, London and* [2]*De La Salle University, Manila, Philippines*

Once upon a time I used to conduct a ''teaching ward round'' on Tuesday afternoons, prior to my Wednesday morning operating. There would usually be half a dozen pre-operative patients and perhaps some post-operative patients who were waiting to be sent home, or some patients admitted acutely from my last ''on call''. I call it ''teaching'' as contrasted with working ward rounds that are nowadays conducted in front of the white board with the patients' names, and decisions that are made without actually seeing the patients.

In those days the patients would arrive during the morning so that the medical students could spend an hour or more with the patients before they went for ECGs, chest Xrays etc and they would be back in the ward for our starting time of 2pm. The Ward Sister did not join us for the whole two hours duration but usually passed by to ensure that all was under control; junior nurses attended and were often asked to contribute to the discussion. Patients were informed beforehand and asked their consent to participate; the only patient I recall dissenting was the mother of one of the students. Some of the patients were anxious about what would happen, but almost uniformly agreed afterwards that they had learnt about their diagnosis and why they were undergoing such management.

Each patient was presented by a student. The exercise was to compress the relevant details gathered over their hour with the patient (taking a history) and present it in the language we were teaching them to use (giving a history) in five minutes. They were encouraged to give important details first; some students could not resist the temptation of starting with ''presenting symptoms'' and rambling through every detail gleaned of the history, laying a few false trails and then with a flourish suggesting a differential diagnosis that included most of their knowledge of gynaecology. This was ''patient-based learning'' (PBL), and uncertain details were ascertained by the student asking the patient. The students were able to observe doctor – patient interactions as the senior medical staff on the ward round listened to the presentation, listened to the patient's additional comments (listening for important answers is a skill difficult to teach in other environments), gave explanations that the patient could comprehend and participated in the ''consenting'' process. The next morning the patient was greeted in the anaesthetic room by the same student, who latter accompanied us to tell the patient of our findings and the procedures performed. Student learning was provoked by curiosity and some background reading overnight; they were amazed just what they had learnt and that they did not forget learning in such an environment.

What has changed? Nowadays patients are seen as outpatients for pre-operative assessment, they arrive in the ward on the morning of surgery (even if they are transplant patients on a heap of immunosuppressant therapy, or have travelled some distance through the night). The students no longer have a chance to take and give a history but observe the consultant anaesthetist and gynaecologist correlate the names on the theatre list with the patient in front of them. If the student is lucky and skilled he/she may get in early and ask the patient for consent to examine her under anaesthetic, or to scrub and stand at the table; otherwise the theatre session has little learning opportunities for them. They are unlikely to see the patient afterwards, partly because our university designates Wednesday afternoons as the protected time for sport and recreation, and the patient is home before nightfall. Even those patients undergoing major surgery are discharged quickly. In our next issue Everett and Crawford (Laparoscopic assisted vaginal hysterectomy and bilateral salpingo-oophorectomy as a day surgery procedure) describe how quickly 28 patients undergoing such a procedure can be whisked through the in-patient stay. Undoubtedly good for the hospital's budget (unless re-admission required, when the resulting ''fines'' might encourage longer post-operative hospital stay) and probably for the patient, but little contribution to medical student education or postgraduate training (unless they do the surgery, but this is less likely with minimal access techniques). What can we in the surgical trades do to enhance students' learning in these modern times?

This issue contains an Educational Review ''Ward based clinical teaching in gynaecology: principles and practice'' by Mukhopadhyay and Smith which describes a postgraduate learning exercise based on a ''pregnancy of unknown location''. We will not attempt to summarise the educational theory that the article describes but it appears complex beside the impromptu and informal lessons generated during the teaching ward round. Some younger and more recently appointed consultants will be familiar with these educational concepts, but the majority of

Correspondence: Professor A. B. MacLean, Department of Gynaecology. E-mail: a.maclean@medsch.ucl.ac.uk

ISSN 0144-3615 print/ISSN 1364-6893 online © 2010 Informa UK, Ltd.
DOI: 10.3109/01443615.2010.503437

clinicians teaching students will not – all the more reason for them to read this issue. Students still need to develop skills in giving a history or presenting a patient, and to be able to talk their way through what investigations might help and interpret the values, using terminology understood by the patient.

Will other approaches offer alternative ways to learn? The contributions of Gynaecological Teaching Associates (women who instruct our students how to perform a speculum and bimanual examination and then allow the students to perform this on them) have made a huge contribution to giving students the confidence and skills to perform such examinations in subsequent clinics (Pickard et al., 2003). Opportunities in outpatient clinics depend on the physical design of the clinic (rooms for students to use), the intensity of the clinic load, the willingness of a patient to see a student when she has come to see the consultant, or the willingness of the consultant to slow down the clinic pace to include student presentations. Can we employ surrogate patients with heavy menstrual periods, palpable fibroids, demonstrable urinary incontinence or undergoing investigations for infertility or an abnormal cervical smear, to allow students to take and give a clinical history and perform an appropriate examination? We employ actresses to play these roles during OSCEs, and they are used in other exercises eg role playing in ''how to break bad news''.

What does electronic learning offer? Until recently, probably not a great deal, but medical schools are now funding electronic learning development grants to encourage clinicians to consider new approaches (our department has recently received such a grant). Our Medical School is embracing a new final year curriculum with increased use of the virtual learning environment. E-learning still has to appeal to medical students, has to induce curiosity, has to allow some interactivity between student and screen and to provide rewards (by using such techniques in end-of-module assessments). It will not suit every student or suit every subject, and was better accepted if it allowed the learner to enter into a dialogue eg with the tutor, and allowed formative feedback (Wong et al., 2010), both facets of learning available in the teaching ward round. Concepts of ''Blended Learning'', where E-learning is used in parallel with patient contact (Ruiz et al., 2006) may be useful in gynaecology where imaging and pathology can be available on-line (Howlett et al., 2009a). Howlett et al., (2009b) also described real-time on-line access to ''foetal (sic) heart tracings during complicated labours'' as a teaching motivation particularly appreciated by their students. New technologies with touch screens might allow greater interactivity, and computer animations (Ruiz et al., 2009), Avatar (Noll et al., 2009) or Havatar (human – avatar pairing; Gordon et al., 2009) modelling would allow animation not previously considered possible.

The medical student still has to be able to interact with patients, ask questions and seek answers, and to formulate diagnosis and management options. Otherwise, in our modern, efficient and economic NHS we are in danger of ignoring clinical and bedside teaching of medical students. It was such an integral part of NHS activity in the past, and medical schools' reputations, both here and internationally, were weighed alongside the quality of their undergraduate teaching. In the future medical students will pay big money for clinical teaching and will complain loudly if they feel they are not getting value for money. If teaching ward rounds are now a thing of the past we must consider newer teaching models or we will see the next generation of doctors not trained for the purpose.

References

Gordon R, Bjorklund N, Smith RJ, Blyden ER. 2009. Halting HIV/AIDS with avatars and havatars: a virtual world approach to modelling epidemics. BMC Public Health doi: 10.1186/1471-2458-9-S1-S13.

Howlett D, Vincent T, Watson G, Owens E, Webb R, Gainsborough N, Fairclough J, Taylor N, Miles K, Cohen J, Vincent R. 2009a. Blending online techniques with traditional face to face teaching methods to deliver final year undergraduate radiology learning content. European Journal of Radiology doi:10.1016/j.ejrad.2009.07.028.

Howlett DC, Connelly JP, Vincent T. 2009b. Real-time online teaching to enhance undergraduate teaching. Medical Teaching 43: 1115-6.

Mukhopadhyay S, Smith S. 2010. Ward based clinical teaching in gynaecology: principles and practice. Journal of Obstetrics and Gynaecology: this issue

Noll JG, Shenk CE, Barnes JE, Putnam FW. 2009. Childhood abuse, avatar choices, and other risk factors associated with internet-initiated victimization of adolescent girls. Pediatrics 123: e1078-83.

Pickard S, Baraitser P, Rymer J, Piper J. 2003. Can gynaecology teaching associates provide high quality effective training for medical students in the United Kingdom? Comparative study. BMJ 327: 1389-92.

Ruiz JG, Minter MJ, Leipzig RM. 2006. The impact of E-learning in medical education. Academic Medicine 81: 207-212.

Ruiz JG, Cook DA, Levinson AJ. 2009. Computer animations in medical education: a critical literature review. Medical Teaching 43: 838-846.

Wong G, Greenhalgh T, Pawson R. 2010. Internet-based medical education: a realist review of what works, for whom and in what circumstances. BMC Medical Education doi: 10.1186/1472-6920-10-12.