

## LETTERS TO THE EDITOR

## Collaborative learning in PBL

Student–patient contact:  
Are medical students too  
cautious?

Dear Sir

At Melaka Manipal Medical College (MMMC), India, PBL was introduced in the curriculum in 2006 in accordance with the Maastricht 'seven jump' process (Wood 2003). Recently, the PBL committee at MMC took initiative to explore students' experience of engaging in collaborative learning prior to presentation session. Out of 10 PBL groups ( $n=110$ ), five groups were considered experimental groups (EG) and the remaining, control groups (CG). We encouraged EG to involve in collaborative learning prior to presentation session. Each PBL group (EG) was asked to meet two times prior to presentation session. After a brainstorming session, in the first meeting, each PBL group met and discussed the learning objectives which were identified in brainstorming session. Each member of the group volunteered to discuss about one objective when they meet for the second time prior to the presentation session. One or two members of the group took up the responsibility to retrieve additional information about the topic from other resource materials. After the first meeting, each PBL group was involved in self-directed learning, during which they had the freedom to interact with their team members. One week prior to the presentation session, students met for the second time and each one discussed about one learning objective and tried to solve the problem in a collaborative manner. At the end, each PBL group was asked to reflect on the collaborative learning process by responding to a questionnaire. Later, both CG and EG students were assessed by different facilitators using the PBL evaluation form and the scores were compared using paired *t* test.

There was no significant difference in the scores between the groups; CG (Mean 13.98) and EG (Mean 13.60). However, EG students reflected that they enjoyed the collaborative learning process, and it made them more confident to present in the presentation session. They also felt that they could appreciate the multifarious modes of understanding a topic among the team members and the freedom of face to face interaction in the small group. Even though quantitative confirmation of the success of collaborative learning was not evident in our setting, students were urged to consciously get involved in collaborative learning prior to pbl presentation sessions.

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Dear Sir

Patient contact provides a rich resource for medical student learning (in particular, for the development of clinical reasoning, communication skills, empathy and professionalism). Existing literature suggests that patients are generally positive about interacting with students (York et al. 1995), whilst students report barriers to interaction, which may unnecessarily reduce clinical contact (Mathieson et al. 2009).

To investigate this discrepancy, we directly compared the attitudes of students and patients towards their interaction. Corresponding Likert scale questionnaires were distributed simultaneously to final year clinical students at the University of Oxford and to inpatients at their primary teaching hospital.

53 patients and 51 students responded and were demographically equivalent to their sampled populations. As many as 72% of students reported at least one barrier to interacting with patients, e.g. lack of motivation, difficulty identifying suitable patients or an appropriate time of the day.

Relative to patients, students significantly overestimated certain barriers; for example 51% of patients were happy to be disturbed when visitors were present but only 24% of students felt this was appropriate ( $p=0.007$ ). Likewise, 44% of patients were happy to be woken up by students but only 24% of students would do this ( $p=0.01$ ).

Students also significantly overestimated potential negative effects on patients; for example 39% of students worried that patients would hear unwanted things when doctors teach students in front of them, compared to 7% of patients ( $p<0.0005$ ). 26% of students thought that their presence interfered with the doctor–patient relationship, in contrast to 7% of patients ( $p=0.02$ ).

Students may be unnecessarily cautious in their approach to patients, leading to the loss of learning opportunities. Generalisability of our results is limited by a low response rate to the questionnaires – 26% for patients and 32% for students. However, we think that these preliminary findings warrant further investigation. If replicated, educational intervention could be targeted to help students overcome unwarranted barriers and therefore increase clinical contact.

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## Care needed when interpreting the importance of competency-based assessments

Dear Sir

Traditionally, the framework of medical training was time-based driven by unrestricted hours, patient service, and learning through experience. The need for a greater accountability of doctors together and the European Working Time Regulation reducing trainees' time in hospital, has led to the United Kingdom (UK) introduction of competency-based assessments (CBAs). However, their widespread implementation has caused much debate and controversy. Some believe they can improve medical trainees' performance and enhance patient safety, particularly in invasive procedural skills, while others feel they are an educational fad.

The introduction of CBAs into UK training has given trainees the opportunity to have regular formative feedback with one-to-one time with consultants. The nature of the present CBA system gives summative scores for their performance, allowing for trainees to see progression. The concern is that these quantitative scores would be used as a potential means to rank without being standardized, and hence no basis for legitimate comparison. Consequently, we believe that all assessors must take CBAs more seriously, giving honest evaluations and must not shun away from labeling trainees incompetent in order to avoid confrontation. In addition, personal relationships must not be taken into account, as intra-professional feelings are independent of good patient care (McKinley et al. 2001.) As such, there needs to be a realization by consultants of their responsibility in assessing of trainees appropriately.

There is also concern about what CBAs can do to the mentality of trainees. There is worry that they change the focus to learning skills and attitudes, rather than teaching a solid understanding of the basic concepts and principles, meaning that "medical education" may give way to "medical training" (Leung 2002). Trainees are more concerned about proving competence for a one-off tick box assessment, instead of building up the numbers and skills necessary to deal with the complications of conditions and procedures. There is thus the worry that CBAs do not promote excellence and medical innovation, but instead focus on minimally acceptable standards.

Our overall view is that CBAs offer much in terms of formative feedback opportunities for trainees, but there needs to be an understanding that they are not a formal assessment

for career progression. Likewise, trainees need to recognize that a completed assessment is a satisfactory marker for what an assessor has observed, and is not a substitute for experience or continuing development.

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## Spirituality and medicine: views and opinions of teachers in a Brazilian medical school

Dear Sir

Although many physicians consider adequate to address Spirituality with patients and believe religious aspects can influence medical practice, few address it in practice (Curlin et al. 2005). We conducted a study aiming to show the opinions of medical teachers from a Brazilian medical school regarding Spirituality and health.

In 2007, medical teachers from a Brazilian State University were selected to fill a 16-question standardized questionnaire regarding this issue. Three medical students (MS) carried out the interviews with the teachers, all medical school campus buildings were evaluated by the students in predefined days and teachers were selected consecutively by the MS as been found in their departments.

For final analysis, 53 medical teachers were included, mostly men (51.9%), with mean age of 50.64 ( $\pm 8.9$ ) years and 25.83 ( $\pm 8.9$ ) years of graduation. Forty-seven (90.4%) reported that they believe in God and 31.7% attend to the religious services at least once a week. More than 72% of medical teachers believed that faith or spirituality can positively influence the treatment of their patients, 75.5% believed that prayer could have effects in the patients treatment, 62.3% want to address spirituality with patients and 50% believed that it is important for a medical school to prepare students for this issue.

Nevertheless, only 43.4% reported they feel prepared to address this issue, 27.8% have ever mentioned this issue in their classes and 92.3% felt that the Brazilian medical schools are not giving all required information in this field.

The most prevalent barriers cited by medical teachers were: lack of time (11.3%), lack of knowledge (9.3%), lack of training (9.3%), fear (9.3%) and being not comfortable to address it (5.6%).

These results present a clear difference between medical teachers' opinion and their action or training. Teachers believe this issue is important, but do not address it in clinical practice. Why does this happen?

According to Lucchetti and Granero (2010), there are some resistance to the introduction of these courses due to the lack of Brazilian studies and various preconceptions about sectarianism and religious coercion. Another explanation is the barriers reported by those teachers: lack of time, lack of knowledge, lack of training and fear. In fact, little training is available for Brazilian medical students regarding spirituality, which has repercussions in their graduation and even when they became teachers.

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## Patterns of approaches to studying of pre-clinical, clinical and post graduate students from a setting in a developing country in Asia

Dear Sir

Marton and Saljo (Marton 1976) were the first to describe the three approaches to studying; deep approach (DA), strategic approach (SA) and surface apathetic or superficial approach (SAA). Subsequent studies indicated that students can change their learning approach and that differences exist in the study patterns between the East and the West. The aim of this study was to describe the patterns of approach to studying among Sri Lankan undergraduate and post graduate students.

Pre-clinical and clinical students of the Faculty of Medicine, University of Colombo and post graduate trainees in surgery at the National Hospital of Sri Lanka were invited to complete the

Approaches and Study Skills Inventory for Students (ASSIST) questionnaire (Dai Hounsell & Anderson 2001).

A total of 187 pre-clinical (M: F 96:91), 124 clinical (M: F 61:63) and 53 post-graduate students (M: F 50:3) participated in this study. Analysis showed that SA had the highest score in all three groups. Clinical students had the lowest DA score. There was a large correlation between DA and SA ( $r=0.51$ ,  $p < 0.001$ ) and a small correlation between DA and SAA ( $r=0.214$ ,  $p < 0.001$ ). There was no correlation between SA and SAA ( $r=0.056$ ,  $p=0.285$ ).

The strong correlation that we observed between DA and SA has been described previously among Asian and also Western students. What was surprising is the absence of a correlation between SA and SAA, which has been previously described in Asian students (Kember & Gow 1991). In addition, the limited resources in developing countries in Asia provide an advantage for strategic students by means of higher marks at examinations and increased opportunities favouring the SA. However, the decline in DA score is most probably due to excessive work load. Though the decline in DA in clinical students is surprising at the first glance, this is a well-described phenomenon in the west (Stiernborg & Bandaranayake 1996).

Our study has shown that the approaches to studying are different between pre-clinical, clinical and post-graduate students and is different to the pattern observed in the west.

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## A competence-based curriculum for vocational training in general practice in Germany: Nearby or far away?

Dear Sir

In contrast to the developments in many European countries, no competency-based curriculum frame such as CanMEDS or EURACT exists in Germany. Vocational training in Germany is based on "volume" and "time". As Germany is a competency-

based curriculum “naïve” country, we aimed to question German vocational trainees what competencies they believe they will need working as a future GP and how they believe they will learn these.

Sixteen semi-structured interviews were conducted within a qualitative approach with GP vocational trainees, recorded and transcribed. Transcripts were analysed using qualitative content analysis according to Mayring.

Vocational trainees believe that GPs should have a fundamental medical knowledge base to cope the daily challenges. In addition, social competences are believed to be very important to communicate empathically with patients. Beside those medical and social competences, they feel an increasing demand for capabilities in organization and management. However, competences which were not in mind of the participants and might be essential for primary care from an international point of view were: “scholar” and “health advocate” from CanMEDS and “Community orientation” and “holistic approach” from EURACT respectively. Teaching was mainly regarded as a matter of “learning by doing”. Many trainees criticize that there is no “teaching culture” in particular among hospital doctors.

To face the challenges of the future, first and foremost the shortage of young doctors in general practice, the conditions of vocational training in Germany have to be improved. In this context, implementation of a competence-based curriculum for vocational training should be an aim. However, in accordance with the experiences of other countries, it would

be reasonable to initiate part of the reforms as pilot studies (Lillevang et al. 2009). This offers the chance that single elements can be tested in practice as, for example train-the-trainer programs, a structural element which is totally unknown in Germany. With our program “Verbundweiterbildung<sup>plus</sup>” we have already started one of those pilot projects promoting regional networks of hospitals, practices, universities and further institutions. In this context we offer additional trainings, promote the networking of the vocational trainees through regular meetings and aim for implementing a train-the-trainer program.

Hence, it will be exciting to see how vocational training will develop in the next years in Germany. However, in case of no improvement, young doctors will “vote with their feet” and adopt other courses (e.g. go abroad, go outside patient care).

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