



Open book assessment in medical school

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examination and communicating with children. This session used manikins and videos with small group teaching. However, this simulation may not effectively introduce students to the real-life challenges of interacting with children and the non-cooperative child.

Therefore, we piloted an interactive 'live' induction session during August 2013. Fourteen 5th year medical students received small group teaching on examination and communication skills using well-children volunteers (aged 2–5 years). The sessions were facilitated by consultants and lasted for 2 hours.

Questionnaires were distributed to collect both quantitative and qualitative evaluation data using Likert rating scales and free text comments. All students agreed or strongly agreed that the practical session was helpful. All students agreed or strongly agreed that they felt more confident in starting their attachment after the induction session.

This creative approach to paediatric induction offers a realistic, yet practical way for students to gain confidence when starting their paediatric placements. It is being adopted across Imperial College Medical School, and further refinements are anticipated. The use of well-children in such training has potential benefits for students as well as familiarising children to the hospital environment.

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Getting the most out of dissection

Dear Sir

We were moved by Loh's account of her experiences in the dissection room (Loh 2014). Loh, although initially filled with trepidation, soon became immensely curious, and then grateful towards her cadaveric mentors. Such curiosity is what all medical educators want their students to feel during dissection classes; sadly, however, this is not the case. We believe that there are three key factors contributing to this.

Firstly, students are typically unprepared for what to expect when initially attending dissection classes. The resultant anxiety makes initial engagement with the cadavers difficult. We feel that an introductory lecture, in which the benefits of cadaveric teaching and its somewhat graphic nature are

clearly outlined and explained, will help to shorten the acclimatisation period.

Second is the issue of time. Given the density of medical curricula, students are often rushed in the dissection room (Azer & Eizenberg 2007). Whilst this is understandable, we feel that the hurried nature of anatomy teaching results in students being unable to develop a "connection" with the cadavers, and thus reap their full educational benefits (Loh 2014). Timetabled sessions in which students are allowed to examine the cadavers at their own pace would help to overcome this hurdle.

Lastly, many anatomy demonstrators adopt a didactic approach during teaching. Whilst time-efficient, intellectual curiosity and exploratory thought are stifled. The true beauty of anatomy cannot be dictated, it must be discovered. Thus we feel that demonstrators should aim to answer questions and correct mistakes as students work through the cadaveric anatomy, rather than offer mini-lectures.

The issue of anatomy teaching is understandably a sensitive area of discussion, with many conflicting ideas. We recognize that the aim of all educators is to provide an optimal teaching experience for students and, as such, our aim is merely to add to the debate, ultimately aspiring for all students to benefit from dissection as much as Loh.

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Open book assessment in medical school

Dear Sir

Recently, my stint in clinical research required me to achieve satisfactory competency in statistics. A semester was set out to undertake teaching on an array of statistical methods. The first half of each session demanded lecture-based teaching whilst the last was spent undertaking various tutorials involving the production of statistical tables and graphs, depending on the question in nature. The final part of the semester comprised a two-hour assessment, an assessment which was open book.

Open book assessments are certainly a rarity in medical school. I personally did not undertake any but with the advent of the prescribing safety assessment this year and access to the

BNF, the concept of assessment in the traditional sense has certainly been revolutionized.

From a personal perspective, I look forward to reading formal research around the topic – the open book statistical assessment was certainly not a walk in the park. The format of the assessment required significant theoretical application. The book simply allowed for refreshment of factual knowledge. The assessment relied on candidates being able to interpret data provided and comment accordingly. For example, research data with confidence intervals, *p* values, odds ratios, Wald and degrees of freedom values featured heavily. In addition, candidates were asked to comment on assumptions made, potential confounding variables and additional univariate and multivariate tests of choice, as well as construct potential tables for data we would like to collect for specific research questions.

In medical practice, postgraduate training often relies on referring to current literature when managing a patient appropriately, particularly evidence-based specialty guidelines. Of course, it is important for candidates to learn the theory; but I wonder whether the use of open book assessments could potentially be a good thing. If constructed properly, they could provide a more suitable platform of theory application as opposed to simple recall.

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What medical students need: Virtual patients or real patients?

Dear Sir

According to Cook & Triola (2009), virtual patients (VP) are a 'specific type of computer program that simulates real-life clinical scenarios; learners emulate the roles of health care providers to obtain a history, conduct a physical exam, and make diagnostic and therapeutic decisions'. In brief, VPs are simulators that allow medical students to improve its clinical reasoning, knowledge and decision-making skills.

Nevertheless, one as a student must not forget that patients are not only beholders of sickness, but human beings. It is clear that VPs will never replace 'real patients', but in exchange, the most important contribution of VPs is the safe environment where students can practice without any risk of harming (Poulton & Balasubramaniam 2011).

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As medical students from a Latin American country, we believe that a global collaborative approach is needed, where virtual patients and live patient encounters are part of the learning experience. One important factor to assess is the integration of VPs in medical curricula in order to 'get the best from both worlds': the quick learning experience from VPs and the real-life heart-touching inspiration a real patient gives you.

For Latin American countries, this is hard to accomplish due to the fact that there are no studies regarding the success or failure of curricular implementation of VPs. There are numerous projects that aim to develop VP networks for the sharing of patient cases in Europe (e.g. <http://www.virtualpatients.eu/referatory/>). However, a Latin American network, if none already exists, would be beneficial to the community here.

One solution could be to create a system where resources are shared between medical schools that do have VPs and schools that do not. By doing so, we will not only solve the problem of VP development in developing countries but everyone will benefit. Students in medical schools that do have VPs could do clerkships with real patients and the students who have never experienced VPs could do so as well.

We believe that a global education is the only way in which health, technology and society can benefit each other the most.

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Use of a melanoma simulation model in a dermatology Objective Structured Clinical Examination station

Dear Sir

Various techniques are available to simulate skin cancers including prosthetic adhesives (Goulart et al. 2012) and hand-painted moulages (Hernandez et al. 2013), which can be applied to the skin of standardized patients (SPs) during an

At the university or at the medical school, the assessment of PSMS should be done through a survey independent of care units. Indeed, the knowledge and skills of MS vary depending on their level of learning or their involvement in specific trainings. Furthermore, they are not fully integrated in one care unit even after a whole semester of internship. CASPer® assessors are typically medical students, medical residents or faculty with an interest in admissions review. At times, non-medical faculty are involved in the scoring process to add another element of objectivity and diversity of assessment. During scoring, the personal identifiers of the student are not available to the assessor. This is to eliminate bias.