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- *'docendo ac discendo'* - *'by teaching and learning'*



In this issue:

The art of basic wound suturing

Prescribing skills of trainee medical staff
Insight as a measure of educational efficacy
The mental state examination
myPaediatrics

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The International Journal of Clinical Skills looks forward to contributing positively towards the training of all members of the healthcare profession.

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Foreword



As we head into the New Year of 2010, the International Journal of Clinical Skills (IJOCS) can feel justifiable pride that it has fulfilled its ambition to provide the international healthcare community with an arena for clinical skills education and research. For almost all the healthcare professions, clinical skills form the basic foundations and therefore a combined approach is absolutely what is needed for the future provision of a high quality health service.

The role of the ePortfolio in both education and continuing professional development of healthcare professionals continues to evolve as training and revalidation become increasingly important. Clinical skills are an essential element of this process and in 2010 the IJOCS will be proud to publish abstracts and papers from the 8th international ePortfolio conference hosted by Eifel London Learning Forum 2010. Further information can be found at www.ijocs.org/eportfolio

This year will also see the launch of the new and exciting 'CliniTube' website – a free resource providing a single portal for accessing and sharing an array of information. It should be a valuable resource for students and should give teachers of numerous disciplines the opportunity to share educational materials. I'm certainly looking forward to seeing the 'Clinical Skills Lab' which should become an integral component of CliniTube and will comprise information on a variety of clinical skills.

The International Journal of Clinical Skills is a unique publication in its devotion to clinical skills. I encourage professionals all over the world to continue contributing to its on-going success. After all, our patients deserve nothing less than the best.



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Testicular examination: an evaluation of a one year trial of working with simulated patients to teach medical students within a UK clinical skills department

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Abstract

Recent high profile malpractice cases have challenged the ethical integrity of the medical profession like never before [2, 3] and have resulted in enormous pressure on the medical profession to ensure that unethical practices are challenged and prevented.

In response to this, the 'bar-has-been-raised' for medical educators as to the importance of teaching undergraduate medical students how to conduct an intimate examination in the correct and professional way. This may include breast, pelvic, testicular or rectal examination and involves patient examination and communication skills. Although the notion of using real people to teach medical students intimate examinations is not new, working with simulated patients to assist and teach medical students how to conduct testicular examination is considered within a UK clinical skills department [9, 10, 17].

Five male simulated patients were recruited and trained to work along side a clinical facilitator in the delivery of testicular examination for undergraduate medical students within a UK clinical skills department. The students were taught how to conduct a testicular examination with the use of a manikin and then through the use of a given scenario, they conducted a clinical examination of the simulated male patient with subsequent feedback.

Following delivery of sessions over a clinical year, 120 questionnaires were distributed to undergraduate medical students to evaluate the delivered sessions. The findings highlight that working with a simulated patient improved the student's ability to conduct a testicular examination and to communicate more effectively during the examination.

Background

The United Kingdom regulatory body for doctors, the General Medical Council (GMC), aims to ensure good medical practice. The GMC sets the knowledge, skills and behaviours that medical students should learn at medical school, as well as the teaching, learning and assessment standards. These regulations are set out in the *Tomorrow's Doctor* document [1] which states: "Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make the care of the patient your first concern."

This is particularly important when a doctor or medical student conducts an intimate patient examination. This may include breast, pelvic, testicular or rectal examination and involves patient examination and communication skills.

The teaching of intimate examinations poses ethical problems for students and educators, and in the last decade the ethical integrity of doctors has never been more questioned [2, 3]. High profile malpractice cases have put enormous pressure on the medical profession to ensure that unethical practices are prevented and challenged.

Further to the identification that medical students need to be able to conduct an intimate examination in a sensitive and competent manner, is the recognition that detection of testicular cancer has never been higher on the national agenda. Testicular cancer rates have more than doubled in the United Kingdom between 1975 and 2006. More than half of all cases are in men under the age of 35 years and over 90% occur in men under 55 years [4].

Teaching and delivery of the intimate examinations session within the clinical skills department at Southampton School of Medicine (UK) reflected these changes [5]. Preparations were made to deliver the teaching of testicular examinations. A selection of testicular manikins were selected for trial and reviewed by a panel of experts. Following extensive trials it was decided to purchase Nasco's Lifelform[®] Testicular Examination Simulator as this demonstrated anatomic realism with a soft thin outer skin with delicate underlying structures and four embedded simulated tumours.

This article discusses further developments and advancements of the delivery of the intimate examination session within the clinical skills department at Southampton.

Simulation manikins

The use of manikins within the simulation domain is now widespread and enhances learning. A global perspective of the use of simulation and manikins is offered by Ahmed 2008 [6]: "Educational resources for skills centers include simulated patients, videotapes, manikins, and simulators, simple anatomical models (models of body parts), computer-assisted learning, interactive videos, dolls for resuscitation, pelvic models for speculum examination. Real or simulated patients are needed to demonstrate physical signs and genuine histories. Use of simulators, e.g. a plastic arm containing rubberized vein (for injection procedures) are widely used in clinical centers. Other examples of use of simulators include sets for examination of breast, lymph nodes, prostate, and different body systems, in particular 'Harvey' for cardiovascular system."

As Ahmed [6] points out simulated patients are needed to demonstrate physical signs and genuine histories, whereas manikins as simulators can be used for simple anatomical models. These simple anatomical models include breast and testicular manikins as used within the skills department at Southampton.

The Tomorrows Doctor document [1] states that doctors should be able to 'communicate clearly, sensitively and effectively with patients'. When teaching medical students intimate examinations at Southampton clinical skills department a simulated patient would be employed who would 'wear' the breast manikin, or 'hold' the testicular manikin. The student would be given a scenario and would conduct the examination and communicate with the simulated patient whilst holding or wearing the manikin. These sessions were evaluated well by students; however, student feedback also included comments such as:

"Wasn't as useful as other sessions due to the limitations of the plastic models."

"And, no matter how good it is, no manikin is ever as good as the real thing."

"Massive, plastic/rubber specimens don't compare, plus a real person brings communication into play."

The use of manikins, as has been shown, can be useful to improve intimate examination teaching. However, as Cowdrey [7] points out: "The manikins are dreadful; they are completely inadequate for learning the technique (female pelvic examination). The main thing is that you can't communicate with a manikin."

Cowdrey's comments [7] have been echoed by Siwe [8] who noted "none of these methods (manikins) have the ability to promote interaction with the 'patient' and facilitate communication and interpersonal skills."

The teaching of intimate examinations at Southampton School of Medicine did encourage patient dialogue and student interaction when conducting intimate examinations, however, the question was asked 'was there a way to improve communication during the intimate examination teaching session so that it was clearer, more sensitive and more effective?' [1]. The notion of using real people who would be prepared to use their own bodies to teach medical students how to conduct intimate examinations was explored.

Conducting intimate examinations on real people

The notion of using real people to teach medical students intimate examinations is not new [9, 10]. Kretzschmar [9] found that the methods used to teach students the female pelvic examination were lacking and that their learning was deficient. The teacher never knew whether the student had examined the internal organs correctly, as there was a lack of feedback and confirmation by the patient because she did not possess the skill to do so. Medical students, who are learning, can achieve this by performing their first pelvic examination with healthy women working as 'gynaecological training associate' (GTA) patient educators. The GTA is a non-medical female trained to teach pelvic examination while themselves being examined by students [11]. The GTAs work in pairs, with one acting as the patient and the other acting as the instructor. This teaching method is highly effective [9, 12, 13]. It is reported that the ability of the GTA to give immediate feedback to the student is highly beneficial and can reduce student anxiety during the session [9, 14, 15, 16].

Robins et al [17] found that medical students who conducted testicular and rectal examinations using standardised patients (real people) during a carefully orchestrated session [17]: "Experienced less anxiety when crossing person space boundaries, overcoming a variety of proscriptions on gender-appropriate interactions, and increasing their confidence to perform these sensitive examinations."

Recruitment

Southampton has a bank of approximately 100 simulated patients (SPs). Simulated patients are role players who effectively train health care professionals in communication and diagnostic skills [18]. Their contribution to the creation of a safe, yet realistic learner centred environment is invaluable [19].

In March 2008 questionnaires were sent out to male SPs on the Bank explaining that we were embarking on a new educational initiative and if they were interested to find out more they were invited to attend an information session. Three SPs attended

the information session, which was held by a clinical skills facilitator and a Consultant Urologist (Head of Year). The session included an overview of the proposed educational initiative with accompanying rationale and details of the actual teaching sessions. The session ended with a question and answer session.

All male SPs were happy to participate and were duly screened for normal testicular anatomy – as students need to learn what is normal before they can identify what is abnormal.

One SP who participated during the first term left the programme at the beginning of the second term. Two more SPs were therefore recruited and subsequently trained.

Training

A three hour training session was held in the summer of 2008, just before the start of the medical undergraduate term commencement. The SPs were shown a PowerPoint® presentation of testicular anatomy and physiology with accompanying handouts. Data in this presentation was kept as simple as possible, since the SPs were of non-medical background.

SPs were then taken through the actual content of the session and the proposed scenario that was to be used when students were examining the SP.

Session delivery

Initially the testicular examination sessions included 8 students and were run alongside female breast examination. The first 30 minutes of the session involved the use of manikins where the facilitator demonstrated how to conduct a breast and testicular examination. The students were then split into two smaller groups of four who would go to another room with another facilitator and a male SP. One group of students would conduct testicular examination whilst the other group of four students conducted breast examination and then the groups would swap over. However, following feedback from SPs and students alike, the total number was reduced to six students per session.

During the academic year 2008-2009 there were approximately 240 undergraduate medical students at Southampton School of Medicine. Thirteen sessions were delivered per term: thirty-nine sessions throughout the academic year. The first four sessions had eight students and the remaining thirty-five sessions had six student spaces. A total of 207 students (86%) attended the sessions.

The sessions were run along side female breast examination; however, the data presented in this article only covers testicular examination.

Data collection

Data was collected between January and June 2009. A total of 120 questionnaires were distributed to medical students who had attended an intimate examination session (breast and testicular) asking them to complete a seven-item Likert scale [20]. Sixty-one questionnaires were returned (51%). Twenty-nine questionnaires were completed by male students (47%), thirty-one by female students (51%) and one student who preferred not to say (2%).

The first two questions were concerned with the student anxiety prior to the session and how prepared they felt. The next two questions were concerned with student ability and communication following the session. Question five dealt with how relevant and useful the session was. The final two questions were concerned with the allotted time the student was given to complete the examination and whether the feedback given was useful and constructive.

A further two questions asked the student to comment on the advantages and disadvantages of learning testicular examination on a real person. The intention behind the inclusion of the last two questions was to obtain a broad range of data, which could then be quantified using themes where appropriate.

The responses to these questions are illustrated in Figures 1-7 and are presented in the same order as they appear on the questionnaire.

Findings and Discussion

Figure 1: "I felt anxious about attending the session?"

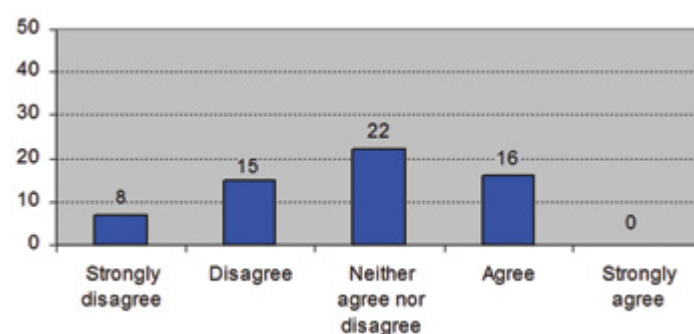


Figure 1 show that approximately 38% (n=23) did not feel anxious before attending this session; a similar number of students 36% (n=22) neither agreed nor disagreed regarding experiencing anxiety before the session. In contrast 26% (n=16) did feel anxious before coming to the session. It was not clear why students were anxious prior to attending this session, but it may have been that they were afraid of hurting the patient if this was their first testicular examination.

An equal number of male (n=8) and female students (n=8) felt anxious before the session, which shows no statistical difference. Male students (n=5) strongly disagreed that they felt anxiety before attending the session whereas females (n=3) disagreed about experiencing anxiety before the session.

Figure 2: "I felt adequately prepared for this session?"

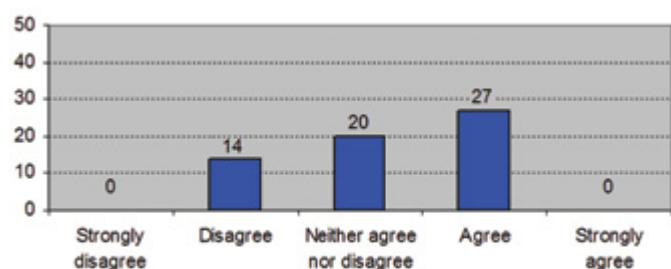


Figure 2 shows that approximately 23% of the students did not feel adequately prepared for this session (n=14). Interestingly, 64% of these were male students (n=9). No student offered any rationale for why they felt inadequately prepared for this session, although one student commented that 'students should be advised to revise testicular anatomy and physiology'. From the next academic year, this note will be added to the session introductory information, which the students receive at the beginning of their attachment.

Figure 3: "This session has improved my ability to conduct a testicular examination?"

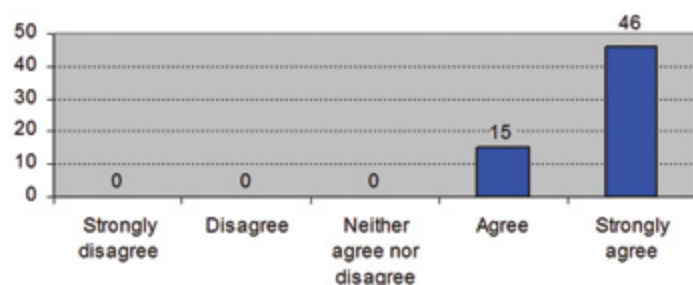


Figure 3 shows that 75% of students (n=46) strongly agreed that this session improved their ability to conduct a testicular examination. These results are not unusual and concur with previous findings [21]. From these results 41% (n=19) were male students and 57% (n=26) were female (one student declined to give their gender). This is not surprising as one female student commented, when asked what the advantages of the session were: 'knowing how hard to palpate etc'. The simulated patients are encouraged to communicate with the student during the testicular examination, about how hard to palpate the testicles, as this may be the first time a student has performed this kind of examination on a real person.

Figure 4: "This session has improved my ability to communicate more effectively whilst carrying out a testicular examination?"

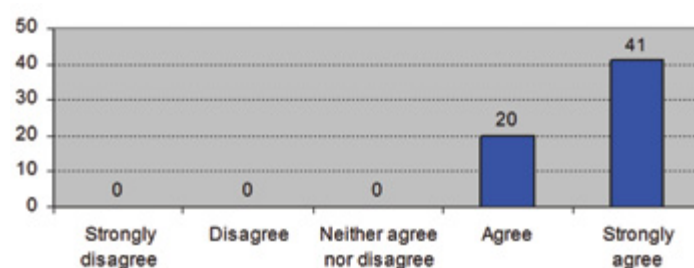
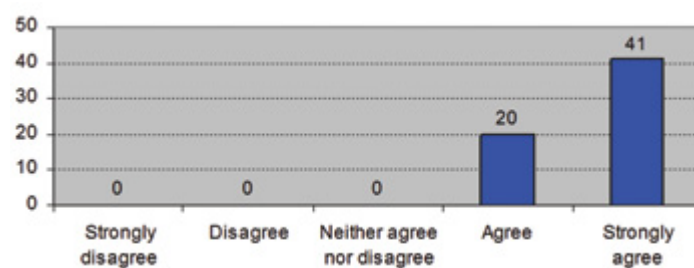


Figure 4 shows that 67% of students (n=41) strongly agreed that this session improved their ability to communicate more effectively whilst carrying out a testicular examination and 33% of students (n=20) agreed.

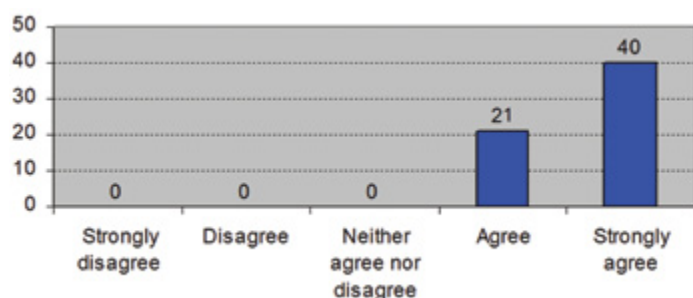
These results are not surprising and concur with previous results [22, 23]. Dubé previously conducted eight health professional-led semi structured focus groups and found that men prefer health professionals who develop a relationship with their patient when conducting testicular examination [22]. Developing a relationship involves communicating with the patient. These findings link with findings of women undergoing an intimate examination [24, 25]. Areskog-Wijma discovered that women are embarrassed when revealing a private part to a 'stranger' [25]. It is important therefore for both genders to develop a relationship, through good communication, with their health professional to minimise embarrassment.

Figure 5: "The testicular scenario used within this teaching session is relevant and useful?"



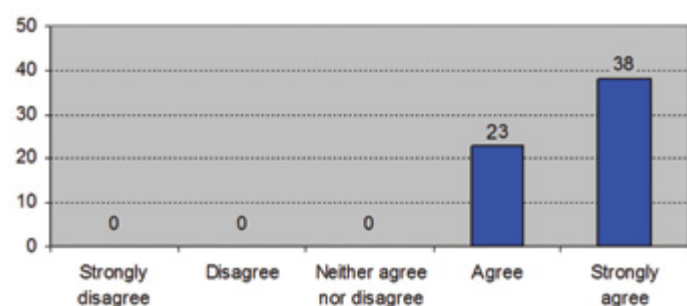
The students follow a given scenario when they are asked to conduct an examination of the simulated patients' testicles. This scenario has been devised to be as realistic as possible and follows a patient attending a GP surgery for a routine testicular examination. The results from this question (Figure 5) show that the scenario is useful and relevant with 67% (n=41) of the students strongly agreeing with the statement, and the remainder agreeing 33% (n=20). No student offered any comments regarding the scenario.

Figure 6: "I was given enough time to complete the testicular examination?"



These results show that 66% of the students (n=40) strongly agreed that they were given enough time to conduct the testicular examination and did not feel rushed (Figure 6). The remainder of the students 34% (n=21) agreed that enough time was given to conduct the examination.

Figure 7: "The feedback given to me following the testicular examination was useful and constructive?"



The results shown in Figure 7 highlight that 62% (n=38) felt strongly that the feedback given to them by the simulated patient and clinical skills facilitator was useful and constructive. The remainder 38% (n=23) agreed that the feedback was useful and constructive. The importance of giving feedback to medical students, when simulated patients are involved in their teaching, has been noted [26, 27, 28].

Conclusion

These teaching sessions have been designed and delivered in an attempt to improve undergraduate medical student's ability to 'communicate clearly, sensitively and effectively with patients' [1]. Following evaluation of the questionnaire data, the evidence suggests that the session has increased students' abilities to conduct a testicular examination and communicate with a patient whilst doing so.

The use of a given scenario with appropriate feedback has contributed to the success of this programme. Furthermore, the sessions have evolved in response to high profile malpractice cases that have placed a huge responsibility on medical educators to ensure these unethical practices are prevented and challenged. Further research is needed to assess whether such simulation teaching can help increase the detection rate of testicular cancer.

Additional developments within the clinical skills department at Southampton School of Medicine have involved working with male simulated patients in the delivery of digital rectal examinations (DRE) for undergraduate medical students. This has been delivered since the start of the new term (September 2009) and will be evaluated in due course.

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