■ Student competency assessment in neurology clinics

Using a standardized form, in assessing new clinic patients, Davis and King evaluated medical students' clinical performance vs that of faculty in terms of: anatomic localization of the problem, establishing the diagnosis, recommending diagnostic tests, and suggesting management. The form improved student clinical competency assessment and enhanced teaching.

see page 597

■ A new tool for outpatient teaching: Helping students overcome their fear of commitment

Commentary by Douglas J. Gelb, MD, PhD

As a setting for medical student education, hospitals are growing ever less hospitable. Sicker inpatients, shorter inpatient stays, and house officer work hour restrictions encroach on teaching rounds and even on opportunities for students to interview and examine patients. The outpatient setting poses its own challenges.^{1,2} Limited space, fixed clinic hours, productivity demands, and patient expectations combine to make traditional teaching rounds nearly impossible. Even one-on-one teaching disrupts the flow of a busy outpatient clinic.

Davis and King describe a form that students must complete before presenting to an attending, stating their conclusions regarding lesion localization, likely diagnosis, and plan for evaluation. While it is un-

clear whether the responses are menu selections, write-ins, or a combination, the key point is that students must commit to their responses, which helps to counteract the temptation for students and faculty to slip into a mode in which students become pure data-gatherers who do not synthesize or analyze the information they obtain. The form facilitates a brief, directed educational exchange. Davis and King have also used the form to evaluate their curriculum by noting general trends across students.

The form is not a panacea. Some students will manage to be noncommittal despite it. Students may use information already in the medical record to guide their assessment, making it difficult to determine how well they can analyze a clinical situation from scratch. This

could explain why students do better with localization and diagnosis than with plans for evaluation and treatment. In fact, any conclusions about curriculum must be tentative, as Davis and King acknowledge. Nonetheless, the form is a useful tool for generating hypotheses about the curriculum. It is clearly useful for teaching individual students. Most importantly, Davis and King have highlighted the value of thinking creatively about ways to adapt teaching techniques to the rapidly evolving structure of clinical care.

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see page 597

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