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RESPONSE TO LETTER

From Simulation to Bedside: the Missing Link in Pediatric Training Research [Response to Letter]

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Dear editor

We thank Dr. Sodeinde for her thoughtful and insightful letter regarding our article, "Enhancing Pediatric Interns' Clinical Skills Through Simulation-Based Training".[1] We appreciate her engagement with our work and her valuable comments, which raise important methodological considerations for simulation-based education research.

We would like to take this opportunity to address the key points she has raised.

Regarding Skill Retention and Transfer to Clinical Practice

Dr. Sodeinde rightly points out the lack of longitudinal follow-up in our study to assess the long-term retention of skills and their transferability to actual patient care. We acknowledge this as a limitation, which we also noted in the discussion section of our paper. The goal of simulation-based training is indeed to achieve sustainable improvements in clinical practice and patient outcomes, not just short-term performance gains.

We agree with Dr. Sodeinde and the meta-analysis by McGaghie et al[2] that skill durability depends on continued practice and reinforcement. Our study was designed as an initial, controlled efficacy trial to measure the immediate post-intervention difference between two pedagogical approaches. We are currently planning a follow-up study that will include assessments at 6 and 12 months to evaluate skill retention. Furthermore, we aim to incorporate higher-level Kirkpatrick outcomes, such as direct observation of clinical performance in real settings, patient safety indicators, and diagnostic accuracy, to better understand the true translational impact of our training.

Regarding the Reliability and Validity of the Mini-CEX Assessment

We understand the concerns regarding the use of a single evaluator for all Mini-CEX assessments and the potential for evaluator bias. While we implemented a blinded assessment protocol to mitigate this, we recognize the inherent challenges in maintaining perfect blinding in a simulation context where the teaching method might be inferred.

Concerning the Mini-CEX tool itself, we selected it for its established validity and widespread use in assessing clinical competence. However, we agree with Dr. Sodeinde that its application in a simulated pediatric environment may benefit from context-specific calibration to enhance its sensitivity. The study by Cook et al[3] that Dr. Sodeinde cites aptly highlights the challenges in achieving high inter-rater reliability, even with training.

To strengthen the methodological rigor of our future work, we will consider employing multiple, rigorously trained evaluators and exploring the use of more granular or adapted rating scales. We will also complement the Mini-CEX with other objective measures, such as standardized patient encounters and video-based assessments, to triangulate our findings and provide a more robust evaluation of clinical competencies.

Conclusion

Once again, we extend our sincere gratitude to Dr. Sodeinde for her constructive critique. Her comments not only provide a valuable perspective on our current study but also offer essential guidance for our future research direction. We are

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committed to advancing this field by designing studies with longitudinal follow-up and more robust, multi-method assessment protocols to conclusively determine the sustained impact of simulation-based training on clinical competence and patient outcomes.

Disclosure

The authors report no conflicts of interest in this communication.

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