Advances in Medical Education and Practice

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LETTER

Simulations and Virtual Learning Supporting Clinical Education During the COVID 19 Pandemic [Letter]

This article was published in the following Dove Press journal:
Advances in Medical Education and Practice

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Dear editor

We read with great interest the article by Tabatabai regarding virtual learning supporting clinical education and examination during the COVID-19 pandemic.[1] As final year medical students, we have experienced months of remote teaching followed by online exams. It is interesting that we share same similar benefits of virtual learning in the UK. However, we believe that virtual platforms fail to meet the practical needs of students and could leave significant gaps in our clinical competency.

In Iran, there has been a national partnership between medical schools to provide standardised massive online open courses. Conversely, in the UK, universities have differed in each decision, from date of closure, to the commencement of online teaching and from the format of exams to the return of students to placement: it has not been a unified approach. The controversy of some universities returning their students in July, but others waiting to 2021, raises questions on the impact of prolonged virtual learning on the clinical competency of a student.

Tabatabai correctly emphasises the need for universities to have the right tools to keep the education of medical students on track. Additionally, we would like to bring the reader's attention to a more current, revolutionary example: virtual reality ward rounds.[2] In this example, education goes beyond simulation and provides a live-stream of the consultant–patient interaction on the ward, whilst the remaining clinical team observes from an isolated area, allowing students to take histories from patients. This allows for dynamic interaction that is superior to the one-way dialogue of live lectures and better prepares students for clinical scenarios and exams.

The author states that simulation-based, virtual objective-structured clinical exam (OSCE) provides the perfect platform to address all clinical education needs. However, Tabatabai fails to explain how this extends to the practical element of the OSCE. Unlike other exams, the OSCE is unique in its assessment of bedside manner and practical skills, ranging from demonstrating venepuncture skills to diagnosing heart murmurs. Students need to develop and be assessed on practical skills in a competent and, more importantly, safe manner. This is evident as, during the pandemic, medical schools have chosen to repeat uncompleted practical assessments to ensure that students demonstrate the skills required by the General Medical Council to graduate (eg, catheterisation or intramuscular injection).

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DovePress
http://doi.org/10.2147/AMEP.S276699

At present, technology cannot replicate the assessment of these skills, which is a fundamental flaw in the simulation-based virtual OSCE. For this reason, we disagree with Tabatabai, as a virtual OSCE would not increase objectivity, but instead make the exam more incomprehensive and provide an inaccurate score of the student's capabilities with the potential of graduating unsafe doctors. This is highlighted in the mistakenly interpreted cited article that actually expresses the importance of in-person, as opposed to virtual, OSCE conducted by a Singaporean medical school.[3]

This commentary highlights an important issue that faces all universities: the need to continue medical education and assessment, whilst maintaining patient and student safety. However, we must acknowledge the limitations of virtual education and adapt accordingly.

Disclosure

The authors report no conflicts of interest in this communication.

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