Advances in Medical Education and Practice Dovepress

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Dual Coaching of Medical Clerkship Students' History-Taking Skills by Volunteer Inpatients at the Bedside and Faculty Physicians on Zoom during the COVID-19 Pandemic [Letter]

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Dear editor

The involvement of patients in medical education has long been recognized for its numerous benefits, including enhancing empathy, communication, and understanding of patient perspectives.[1] The article on "dual coaching" at Harvard Medical School highlights a novel approach that combines patient and faculty feedback to refine these skills in medical students.[2] While the results are promising, several aspects of the study merit further consideration.

One limitation is the lack of standardization in history-taking practices across medical schools. This variability can lead to inconsistent teaching methods and reduces the reproducibility of findings.[3] Furthermore, the absence of a control group makes it difficult to determine whether Improvements in students' abilities are entirely attributable to the dual coaching model, as natural skill development over time could also play a role.

Ramani and Krackov emphasize that effective feedback should be specific, timely, and actionable.[4] Although patient feedback is valuable, there are potential drawbacks. Patients, whether real or simulated, may feel uncomfortable delivering negative feedback, or may lack the clinical expertise needed to evaluate the accuracy of medical history-taking.[5] Additionally, subjective factors such as mood, previous healthcare experiences, or personal biases could influence the feedback provided by inpatients, thereby limiting its educational value compared to the more structured and objective feedback from faculty members.

A crucial, yet under-explored, aspect is the emotional impact of receiving feedback from patients. Research suggests that students often struggle with negative feedback, especially when it is perceived as overly harsh or personal.[6] The study does not provide details on how students were prepared to process this type of feedback, leaving a gap in understanding how to mitigate potential psychological strain. Furthermore, receiving feedback from both faculty and patients simultaneously may increase the cognitive load on students, which can overwhelm learners and hinder the effectiveness of the educational experience, as described by cognitive load theory.[7]

From a practical perspective, we have observed that clinical settings are frequently fast-paced and resource-limited environments. Physicians are often overwhelmed by their clinical responsibilities, and implementing a dual coaching model involving both faculty and patients may be time-intensive and difficult to scale across medical institutions. It is essential to recognize that while history-taking is an important skill, it represents only one facet of students' overall clinical competence. Including other areas, such as physical examination and diagnostic reasoning, would provide a more comprehensive evaluation of students' clinical abilities.

Moreover, the study may have overlooked the potential impact of the Hawthorne effect, wherein individuals modify their behaviour when they know they are being observed.[8] Students may perform better during history-taking under dual

Received: 7 October 2024
Accepted: 27 October 2024
Published: 29 October 2024

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coaching because they are aware they are being evaluated by both faculty and patients, which might not reflect their typical performance in less-supervised settings.

In conclusion, while the dual coaching model shows promise, addressing the limitations mentioned could strengthen its potential as a valuable educational tool. Further studies incorporating these considerations would enhance our understanding of how best to implement patient involvement in medical education.

Disclosure

The authors report no conflicts of interest in this communication.

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https://doi.org/10.2147/AMEP.S499646