

**THE EVOLUTION OF TEACHING THE BASIC CLINICAL SKILLS  
COURSE AT THE UNIVERSITY OF KHARTOUM, SUDAN****Sulaf I. Abdelaziz\*<sup>1</sup>, Rihan M. Alhassan<sup>2</sup> and Saniya Shadaad<sup>3</sup>**

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**INTRODUCTION**

The concept of learning outside the real situations i.e. 'simulations' and 'visual Classrooms' and then applying the acquired knowledge in real practice has existed for a long time. Worldwide, the Basic Clinical Skills (BCS) course has been introduced into the curriculum as a separate entity and course in the immediate preclinical year.<sup>[1]</sup> Its importance enhances with the increasing number of students, newer concepts in curriculum implementation such as problem-based learning and genuine concerns of inflicting unprepared students on already

suffering patients. Since the implementation of the new curriculum in 2009 in our University, the BCS course continued to be taught as usual clinical rounds in Internal Medicine at academic year 3, Semester 5/6. The end of year exam was multiple choice system questions (correct answer) which students found easy and managed to pass easily. This was basically useless and did not serve the objectives of the course as we don't test the skills, and the marks were not considered and students got promoted anyway.

At one time failing this subject was considered a cause for repeating the year. Eventually, this rule no longer abided and students felt the flexibility of the subject with no restraints and no penalties and their attendance of the course became very poor as they had nine other subjects more important to study, namely pathology, microbiology, neurosciences and others. As the students attendance deteriorated and their end of year evaluation was getting very poor and they got away with it and were promoted to the following year, the effect of that was noted when they got to 6<sup>th</sup> year in 2012 and their performance in that year was very bad and instead of discussing disease integration, differential diagnosis and management, the staff were teaching exam techniques and BCS. This led us to pause and review what went wrong. So in the following year, 2013, we decided to conduct the course in a different way, with a

simulation-based method of delivery and assessment. In this paper we describe the implementation and evaluation for the new course.

### **Methods**

The aim of the course is to introduce medical students to basic clinical skills of history taking and examination. The course was 14 weeks, and we allotted each system to a whole week and on 2 days a week. The first 2 weeks were lectures on history taking for the whole class.

The following 4 weeks were in the skills lab where tutors, specialists and junior staff would demonstrate system examination on a role player and test the students' performance. Here, audiovisuals to assist in the learning process were supplied. The remaining 8 weeks were regular hospital rounds to encounter real patients.

All tutors underwent an induction lecture on the new methods. Assessment was by using attendance forms and logbooks.

Final assessment was by an OSCE exam formed of 5 stations, CVS, chest, CNS, Abdomen and a vital signs station. Each station was 3 minutes and consisted of a short skill demonstration.

An overall students and tutors evaluation form was filled. The questions included: what they thought of the course, if they benefited from the course, their preference on learning on simulators as opposed to real patients. How much they benefited from the lectures and videos.

### **RESULTS**

The total number of students in the class were 414. Their attendance throughout the year was very poor. 11% of the students at Semester 5 did not attend most of the clinical rounds while 51% of those in Semester 6 were absent. Forty-eight students were debarred as they had not attended 80% of the clinical rounds. 17 were absent and 2 had frozen the year.

Three hundred and one students (86%) passed, 46 (14%) failed.

Out of those who failed, 59 (17%) failed the cardiovascular system, 55 (15.8%) failed the chest station, 46 (13.2%) failed the vital signs station, 37 (10.6%) failed the nervous system station and 23 (6.6%) failed the abdominal station.

Examiners said that they noted a variation between students and it was easy to pick up those who attended the rounds from those who did not. They thought the students needed more coaching, the assessment tools for the coming exams needed revision and improvement and the skills and exam techniques had to be unified as they noticed there were many different ways of doing the same maneuver. Ninety percent preferred OSCE and 10% wanted correct answer questions. Forty-seven percent of the students thought the exam easy, 51% average and 2% difficult (Fig 5). Sixty-eight percent preferred faculty staff to test them, while 32% like to be tested by registrars. Ninety eight percent of the students learned from the experience.

### CONCLUSION

This review outlines the importance of basic clinical skills and how different facilities conduct the course. It also reflects our successful trial and experience and rewarding outcome.

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