The need for outcome measures in medical education

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Notes
Learning in practice

should be a priority for the national programme for IT

to infection control. Improving such systems
are hampered in collating and manipulating data perti-
mean, however, that NHS trusts’ infection control teams
includes information on where bacteraemia was
H

Complex educational interventions demand complex and appropriate evaluations

prohibits superficial interpretation of the results.

duties. This necessarily introduces limitations and
surveillance, cannot be exhaustive because it is

collaboration and which can allow hospitals to suffer at the
stands and which can allow hospitals to suffer at the

merely for the sake of change is futile. Changes in

methods suffice, but more complex questions require

what is the best way to show cause and effect?

Some authors would say that a randomised
controlled trial is the best way to answer a question

How can we ever be sure that educational
approaches such as problem based learning
are better than traditional ones? Change
merely for the sake of change is futile. Changes in
medical education should lead to better outcomes, but
what is the best way to show cause and effect?

For simple research questions straightforward
methods suffice, but more complex questions require
more complicated study designs. A question such as “Is
drug A more effective than a placebo?” is highly
relevant, and the methods needed to answer it may be
relatively straightforward. However, the question “Why
does drug A lead to a better outcome than a placebo?”
is more complicated, and “Does using drug A lead to
better health for the population?” even more so.

Some authors would say that a randomised
controlled trial is the best way to answer a question
such as “Is problem based learning more likely than

The need for outcome measures in medical education

Complex educational interventions demand complex and appropriate evaluations

1 Willie DH, Petro TFA, Crook D. MRSA bacteraemia in patients on arrival in

2 Spiegelhalter DJ. Problems in assessing rates of infection with methicillin

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6 Cox RA, Mallaghan C, Conopseg C, King J. Epidemic methicillin-resistant

7 Grundmann H, Tami A, Hori S, Halwani M, Slack R. Nottingham Staphy-
lococcus aureus population study: prevalence of MRSA among elderly

prevalence and risk factors of methicillin-resistant Staphylococcus aureus (MRSA) in older people living in their own homes: implications

9 Community MRSA in England and Wales: definition through strain

10 Bland JF, Teare EL, Williams WW, Teare JD. Eradication of methicillin
resistant Staphylococcus aureus by “ring fencing” of elective orthopaedic

11 Cooper BK, Medley GF, Stone SP, Kibbler CC, Cookson BD, Roberts JA,
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13 Department of Health. MRSA—Learning from the Best conference.
Detecting fabricated or induced illness in children

May now necessitate controversial surveillance tools

Fabricated or induced illness, sometimes called Munchausen syndrome by proxy, occurs when a carer fabricates the impression of illness in a child, sometimes deliberately harming the child to produce signs.1 The syndrome is uncommon but is associated with mortality of around 10%.2 The increased risk of unexplained death in siblings of children identified as having fabricated illness3 shows that the syndrome may be underdetected and current methods for identifying it are underdeveloped.4 The validity of the concept of fabricated or induced illness is accepted by expert professionals but has been rejected by some medical correspondents, senior politicians, and members of the public.

The commonest methods for inducing illness seem to be poisoning, including the misuse of prescribed medication, and suffocation (which is also the cause of some cases of apparent sudden unexplained death in infancy—cot death).5 Poisoning—although not the identity of the perpetrator—may be confirmed by toxicological testing of specimens from the child but with suffocation, should the child survive, observation of the abusive act seems to be the only method of confirmation.6 Covert video surveillance of infants in paediatric units is one such form of observation. Although in principle an ethical investigation, it potentially infringes civil liberties and risks exposing a child to harm, and currently is rarely practised in the United Kingdom. Its use is governed by the Regulation of Investigatory Powers Act 2000 under the European Convention on Human Rights. The accompanying guidance identifies “public health,” “public safety,” and “preventing and detecting crime” among acceptable reasons for such surveillance outside the home,7 so its use in hospital may be motivated by appropriate health or safety concerns. Unhelpfully, only crime is mentioned in the guidance for its use in fabricated or induced illness.8


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