“Digital Clinical Placements”: Challenges in a Lower Middle-Income Country

To the Editor: To adapt to the COVID-19 pandemic and a nationwide lockdown in Nepal, my medical school shifted in April 2020 from traditional classroom-based lectures to online theory classes. In these times, “digital clinical placements,” as proposed by Sam et al.,¹ seem like the most plausible way of allowing medical education to continue. However, such virtual clinical placements present a set of challenges for a lower middle-income country like mine.

The technologies required for digital clinical placements might not be as easily available in low- and middle-income countries as they are in higher-income nations. Before the pandemic, medical education at my institution relied on traditional lectures and “real-life” clinical placements. Technology use was largely limited to lecture slide presentations and occasional audiovisual aids. Online learning is a new method of teaching and learning in Nepal. Neither my country’s policies nor its infrastructure seem to have caught up with this novel modality.

The Nepal Medical Council has announced that it will not accept any substitutions for the usual in-person and hands-on training in a medical school. Therefore, virtual clinical placements will not be considered the same as hands-on placements for completion of medical training and eligibility for a medical license. But with an increasing number of COVID-19 cases and a second nationwide lockdown in place, my institution decided in August 2020 to trial some practical classes (online placements).

Unfortunately, the lack of reliable Internet access and the unreliability of mobile data proved to be a major constraint for some of my colleagues who returned to their villages during the pandemic. A few of them have not been able to attend any or most of the online classes. For the rest of us, poor audio and video quality due to slow Internet connections has affected the clarity and smoothness of the classes. For example, identifying clinical instruments and specimens is an essential part of our clinical placements and university examinations. Learning them through the pixelated video, because of poor connections and use of integrated webcams, has been difficult. Moreover, the very essence of clinical placements—patient history, examination techniques and findings, investigation and management plans—all of which should be included in a “digital placement”¹—seem to be lacking.

Therefore, while the uncertainties of the future are still in place, with COVID-19 cases rising and the possibility of a third lockdown, for now we are eager to resume in-person training in our institution in October 2020.

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In Reply to Guragai: We were delighted to read Mandeep Guragai’s letter, which is a timely reminder of the inequality of technological and educational access across the world. Guragai makes important points, and we wish to comment on 2. The first point is the position of the Nepal Medical Council in relation to not allowing substitution for hands-on training. In normal circumstances, we would be in agreement; however, we are not in normal circumstances. Training programs across the world are having to make numerous adjustments to cope with the challenges of the COVID-19 pandemic. The consequences of effectively pausing training need to be balanced against the anxiety that new technological solutions, such as digital clinical placements, are somehow not as good. This anxiety is legitimate, which is why it is important that the introduction of any new educational technology be subject to rigorous academic appraisal and formal validation. In addition, as clinical teaching is gradually reintroduced, clinical educators will face new challenges. We need to decide in advance what instruction should be face-to-face and what should remain online—and get the balance right—while protecting students and staff. At our institution, our planning process has allowed us to reflect on what is core medical knowledge and has provided an opportunity to review how we teach aspects of our medical curriculum.

The second point is that access to mobile data and the Internet is unequal across the world, which is illustrated by Guragai’s experiences. The Pew Research Center in 2019 estimated that more than 5 billion people have mobile devices, while the median smartphone ownership is about 45% in emerging economies, it is higher among young adult populations (e.g., 74% in the Philippines).¹ Furthermore the number of mobile phone owners continues to grow. This increased access to smartphones presents medical educators with an extraordinary opportunity, and we must learn from first-hand experiences, such as Guragai’s. Medical schools such as the Imperial College School of Medicine, in collaboration with students and doctors from countries like Nepal, will be able to innovate and validate new technological solutions to the challenges of delivering affordable and accessible high-quality medical education in both West London and Kathmandu.

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