



The case for resurrecting the long case

Narci C Teoh and Francis J Bowden

BMJ 2008;336:1250
doi:10.1136/bmj.39583.596111.94

Updated information and services can be found at:
<http://bmj.com/cgi/content/full/336/7655/1250>

These include:

References

This article cites 10 articles, 3 of which can be accessed free at:
<http://bmj.com/cgi/content/full/336/7655/1250#BIBL>

Rapid responses

7 rapid responses have been posted to this article, which you can access for free at:
<http://bmj.com/cgi/content/full/336/7655/1250#responses>

You can respond to this article at:
<http://bmj.com/cgi/eletter-submit/336/7655/1250>

Email alerting service

Receive free email alerts when new articles cite this article - sign up in the box at the top left of the article

Notes

To order reprints follow the "Request Permissions" link in the navigation box

To subscribe to *BMJ* go to:
<http://resources.bmj.com/bmj/subscribers>

VIEWS & REVIEWS

The case for resurrecting the long case

PERSONAL VIEW **Narci C Teoh, Francis J Bowden**

Reports of the death of the long case as a tool for assessing medical students' clinical skills may be greatly exaggerated. Unfortunately, the unintended consequence of highlighting its poor inter-case reliability is that even the judicious use of the long case may be seen as being out of touch with modern educational practice. In the ongoing struggle to improve the reliability of our assessment of students, we may forget that knowing that a student will be examined in a particular way determines that student's learning behaviour.

Firstly, a definition: at our school a long case is where a student sees a real patient in a clinical setting, takes a history, examines the patient, makes a diagnosis, formulates a management plan, and then presents this information and discusses the issues arising from the case with a clinical tutor. Each long case is marked against a set of criteria and graded. Students must complete 14 long cases over two semesters in the third year; but because of historical concerns about validity we do not currently have a barrier long case examination in the final year.

It would be hard to argue against the proposition that the clinical method rehearsed in the course of a long case is the way that a good doctor should practise. The long case assesses a student's overall ability to carry out a medical interview, appraise and synthesise findings, and plan and decide on a course of action. Resistance to the use of the long case as an examination tool is predicated on its poor inter-case reliability—unless a large number of cases are offered. However, some evidence exists that the long case is actually a little more reliable than objective structured clinical examinations (OSCEs) if similar amounts of time are allocated to each type of assessment.

We have also taught at another university where final year students are not required to do a long case. After completing their summative long case assessment in the third year, many students stopped seeing patients and spent most of their time



Could we conceive of a professional music student who is told that her final acceptability as a musician will depend on a series of assessments of scales and short pieces but never on a recital of a complete piece of music?

studying for the written assessments. It was not surprising that their clinical skills in the final year deteriorated. We also shepherd young doctors from internship to specialty examinations for the Royal Australasian College of Physicians. Currently candidates for fellowship are required to sit a written and a clinical examination comprising a combination of long and short cases. The transition from hesitant, unpractised trainees to fluent, insightful, and decisive clinicians is achieved through the constant practice of seeing patients and being required to present their findings and management plan to a senior colleague for scrutiny and calibration. The candidates know that they will undergo a long case examination at the end of the process, so there is a direct match between the actual world of care of patients and the contrived world of the examination room. There is a spin-off here: the knowledge that candidates will sit a formal long case drives them to do their "real" job properly.

The long case can never be the only assessment of a graduating doctor, but to omit it in the spectrum of assessment procedures is another way of playing down the centrality of the patient encounter in medical practice. Problem solving skills and communication skills are intimately linked to the content of any problem and should never therefore be assessed separately. An OSCE based assessment system encourages a "reductionist" approach. Splitting the tasks of clinical medicine into their individual parts and testing them separately may be efficient,

but it has a consequence for more than just learning. Could we conceive of a professional music student who is told that her final acceptability as a musician will depend on a series of assessments of scales and short pieces but never on a recital of a complete piece of music?

We urge medical schools to resurrect the final barrier long case as a means of assessing professional competence but with the introduction of strategies to improve its reliability and validity, such as:

- Observing candidates' interaction with the patient, in addition to their presenting the case to the examiners
- Using a structured checklist to assess several measures of clinical competence, such as Gleeson's objective structured long examination record (OSLER)
- Training examiners of long cases and setting standards, and
- Formative assessment of several long cases over an extended time period.

We would like to suggest a corollary of the educational axiom "assessment drives learning": assessment drives practice. If we expect students to become doctors who take a "whole person" view of their patients, seeing them as more than the sum of their diseased organ systems, then we must push them to learn medicine in an integrated manner.

Narci C Teoh is senior lecturer in medicine and Francis J Bowden (frank.bowden@act.gov.au) is professor of medicine, Australian National University Medical School at The Canberra Hospital, Canberra

References are on bmj.com