

# Training for future generations: a medical student perspective

**Sir,**

We read with great interest the article *Training for future generations* by Dr Walker (vol 80(6), 2019, p. 306; <https://doi.org/10.12968/hmed.2019.80.6.306>). It prompted us to reflect on the increasingly diverse nature of undergraduate medical education.

As final year medical students, we have experienced several changes over the years: from a traditional lecture-based approach to e-learning, case-based discussions and virtual simulation. There is no consensus on the ideal approach among our peers, with each student having their own preferred learning style. Therefore, we believe that an effective teaching model requires a dynamic educator who is responsive to an active feedback process.

We find that the educators who request and respond to feedback on their teaching sessions are more successful in engaging students and produce greater student satisfaction. To further this, we feel that educators should proactively involve students when designing learning objectives and teaching sessions. This

demonstrates to students that the educator is invested in their development.

Information is now readily available through avenues such as the internet and mobile applications. The challenge no longer lies in the acquisition of knowledge, but in its application. We agree that the role of educators has evolved from dictatorial to facilitative, consolidating students' learning through challenging their understanding. Additionally, we believe that while technology is a valuable learning adjunct, there is no substitute for the doctor–student relationship, as guidance from seniors is integral in student development, and this must be safeguarded for future generations.

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## Corrigendum

In the article *The impact of work-related travel on trainee doctors* (vol 80(5), 2019, p. 246; <https://doi.org/10.12968/hmed.2019.80.5.246>), the third author's name was incorrectly spelt – it should have read Ela Aydin.

## Good use of 'BAD' guidelines

**Sir,**

The British Association of Dermatologists (BAD) guidelines suggest that, for small basal cell carcinomas, a 4–5 mm peripheral surgical margin should achieve a clearance rate of approximately 95% (Telfer et al, 2008), and this is the excisional margin that is usually taken for small basal cell carcinomas in the UK. Excision of basal cell carcinomas with or without local reconstruction is one of the earliest competencies that plastic surgery trainees are expected to achieve.

During the first half of a plastic surgery rotation, the first author excised 29 small biopsy-proven basal cell carcinomas with a 4 mm peripheral margin as the primary surgeon. However, on review of the histology, only 25 of the 29 lesions (86%) had a complete excision. Of the four patients that had an incomplete excision, three required re-excision to achieve clear

margins and one later had radiotherapy. The first author discussed these findings with his clinical supervisor (senior author) and it was concluded that whenever possible, a 5 mm margin for excision of a small basal cell carcinoma should be aimed for. This will still adhere to the BAD guidelines and may achieve a greater clearance rate. For the second half of the rotation, the first author excised 25 biopsy-proven basal cell carcinomas with a 5 mm peripheral margin and achieved a 100% clearance rate on re-audit.

This audit highlights the benefit self-review may have for trainee development and patient care. The authors advocate that when feasible, and assuming adequate skin cover, a 5 mm margin for excision of small basal cell carcinomas should be aimed for. It is hoped that this encourages other trainees to audit their practice in relation to current

guidelines, monitor their outcomes and make appropriate adjustments accordingly.

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Telfer NR, Colver GB, Morton CA; British Association of Dermatologists. Guidelines for the management of basal cell carcinoma. *Br J Dermatol.* 2008 Jul;159(1):35–48. <https://doi.org/10.1111/j.1365-2133.2008.08666.x>