Modifications to the Readiness Assurance Process of Team Based Learning

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Modified Team Readiness Assurance Process (M-TRAP)

- Modifications designed to
  - Increase amount and depth of intra team discussion
  - Address issues of certainty, confidence, source material
- Typically used with 25 MCQ questions RAT
Figure 1. Traditional approach versus the modified approach (no difference in time spent or number of questions)

Traditional approach

2 hours

GRA (same questions as IRA) [Closed book]

Faculty-led discussion

Facilitators select most problematic questions, drive discussion based on these questions

MTRAP

IRA

3 hours

GRA (same questions as IRA)

Choose up to two questions for Open Book

Do the remaining GRA questions [Closed Book]

Do the two Open Book questions

Student-driven discussion

Each team identifies issues and writes queries on board

Facilitator assigns queries to other team(s)

Students research answers (open book/internet)

Teams present answers, facilitators drive discussion, faculty provides closure

Application
Student Driven Discussion

• Queries must be written as specific questions
• (Not: “Explain q12”)
• Queries can be on the questions or the prep material
• Anything not written on the board as a query WILL NOT be discussed by faculty.
#4 I assume that a recent discharge from the hospital would lead to risk of suicide due to an abrupt change in environment. What’s being done to help smooth this transition?

Q12) Please explain the mechanism behind the development of tardive dyskinesia in patients on anti-psychotics.

Q9) Why don't cognitive deficits in schizophrenia resemble short-term memory deficits seen in Alzheimer's Disease?

Q9) Explain why c) Short-term memory deficits? Not included in the answer? Isn't there working memory deficits in schizophrenia?

Q12) Please explain how the excitotoxic hypothesis is implicated in Alzheimers & Parkinson's. Isn't Alzheimers due to plaque formation & Parkinson's due to accumulation of Lewy bodies? We acknowledge that Parkinson's is also due to loss of dopaminergic neurons. How is this related to excitotoxicity?
9) Is option C incorrect because working memory is not considered as short-term memory? If so, given that working memory can range from a few seconds to minutes, what is the distinction that separates its classification?

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07) Is there a reason why auditory hallucination is the most common type?
9) What is the difference between working memory and short-term memory? Which part of the brain is associated with each?

10. Referring to Table 5.5

'Features assoc. w. good & poor outcome in Schizophrenia'

Under 'Good Outcomes' heading/group: negative symptoms still show mild/moderate => thus choice 'E': presence of negative symptoms is not a correct statement.

12. We understand that

↑ sensitisation of post-synaptic D2R

⇒ ↓ inhibition of indirect pathway

⇒ tardive dyskinesia

Why does the symptom of hypokinesia present differently from other conditions such as Huntington's or ballismus?

15. How is excitotoxic hypothesis implicated in Parkinson's Dis.?

14a. Do pts w. schiz. exhibit ataxia, given that there is cerebellar vermis atrophy? Are other parts of cerebellum also atrophied?

14b. How is option D. determined, given that Rx directly affects neurochem. pathways → side effects that can resemble e.g. negative sx of schiz?