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GP-Facilitated Teaching in Hospitals: The Way Forward? [Response to Letter]

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Dear editor

Thank you for an opportunity to respond to the comments made by Ms Veliah and Ms Sharma in their letter titled “GP-facilitated teaching in Hospitals: The way forward?” The authors of this letter have raised a few questions which we will address in turn.

Firstly, they mention that our data shows that 12% of students thought the sessions were of little or no benefit to their clinical reasoning and ask if we have done further analysis to identify the cause. However, in Table 1, one can see that only 4% of students disagreed with the statement that the sessions had “improved my ability to consider differential diagnosis for a presenting problem across a broad range of clinical specialities.” This is supported by the fact that of the 141 students who entered comments in the free-text box to explain their answer to this question, only eight comments were not entirely positive. One comment related to ward-based teaching, suggesting the student had misread the question, two students wrote that they would have preferred GP tutors to provide cases for discussion and two students did not feel the topic had been adequately covered. Three comments stated that clinical reasoning had improved but not across a broad enough range of specialities. The focus groups revealed that in a small number of groups there had been a concentration of students from similar clinical specialities which may have explained this last finding and guidance was issued to trusts for the following year to ensure groups were composed of students from different speciality placements.

In terms of standardisation, we recognise that faculty training is a key factor and have described the tutor training we delivered in the methods section and the guidance tutors received (appendix 1). There was one outlier group in terms of a lower average score for broad clinical diagnostic reasoning. Through our internal QA processes, we were able to take action relating to this one particular tutor who had focussed on supporting student reflections on placement experiences rather than clinical reasoning. Other outcomes were not particularly different across groups.

The answer to whether the learning objectives were developed in conjunction with the medical school is yes. Also, our pilot study, the previous year, confirmed that students perceived that learning was appropriate to stage.

The authors suggest that we should have measured student performance to ascertain if the learning objectives were indeed achieved. As our intervention

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was delivered to a whole cohort of students, it would have been very difficult to isolate the effect of our intervention on student performance. We have mentioned the lack of a comparator group as a limitation in this regard.

They also express concern at a possible lack of teaching resources in hospitals. Our small group intervention did not require any technology; only rooms that could accommodate up to 10 people and a flipchart. This was easily available in hospitals. Indeed, we feel this is one of the core strengths of our intervention as teaching was integrated within the hospital placements both in terms of location and material (patient cases brought for

discussion). It was important that students did not lose precious placement time travelling back and forth to central medical school facilities.

As the title of their letter response suggests, we believe that our educational innovation of GP-facilitated small group teaching in hospital placements offers a way forward in terms of facilitating person-centred, broad clinical diagnostic reasoning for medical students.

Disclosure

The authors report no conflicts of interest in this communication.

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