Response to review: Patient perceptions of innovative longitudinal integrated clerkships: Hudson JN, Knight PJ and Weston KM

Dear Editor,

Thank you for your review and the reviewers’ constructive reports. As you note in your editorial comments the paper’s most important contribution is patients’ perceptions of the LIC model. An interesting finding that emerged from the qualitative data was that they describe the benefit of the learning environment for patients, as well as students. That is why we feel it is an interesting and important paper in the LIC field (previously most data has related to the student, provider or faculty perspective). However, the reviewers’ comments imply that this was not clear so changes have been made to clarify and illustrate the situation. The aim of the research was not to see if patients liked being involved with students, nor was it about “patients as medical educators”. but it was to question how patients perceive this model of clinical education.

Response to Reviewer Bates:

1. The paper is about patient perceptions of the model so the introduction is about the LIC model, how placing a student longitudinally in a microsystem of care can be beneficial, especially if the patient feels included. We have briefly described the learning theory that underpins the learning environment (as described in an earlier paper). Several hundred words (2-300) have been removed from the introduction with references to the model, but we wish to retain the underlying theory so the work can be placed in this context.

2. The Prystowsky and Bordage article was quoted as they reported some years back that the predominant themes in medical education research are trainee, faculty and provider performance and satisfaction. These authors did a content analysis of almost 600 articles published in 3 leading medical education journals, using a 3-dimensional conceptual framework borrowed from health services outcomes research, namely participants, outcomes and levels of analysis. Their
analysis wasn’t about health services research, but about medical education research and the comment holds to this day. They showed in relation to the 4 groups of participants (trainees, faculty, providers and patients, the latter being the theme of the current article), that trainee performance and satisfaction were the predominant themes of medical education research. The current research attempted to ask patients what they thought about the LIC model of medical education and they responded. We are happy to remove this reference and just make the comment that there is a paucity of students in medical education research that asks patients for their perspective. However we do feel it is appropriate to reference it.

3. The reviewers rightly comment: the methodology was confusing. The study was designed and conducted as a qualitative investigation of patients’ perceptions of the LIC model. Semi-structured interviews were conducted in 3 regions to investigate themes arising from patients’ views. Given the 3 regions, there was an inappropriate attempt to apply a collective case study framework to the research. However, as reviewer 3 reported, it is not possible to reach saturation for each case with the small number of participants from some regions (given the confines of the study). In a case study, one needs to provide considerable information / perspectives to qualify the case, and in the confines of this study that was not possible. The paper has been modified to reflect exactly what was done and the original intention to conduct a qualitative study and thematic analysis of the patient data. Reference to the collective case study methodology was removed and emergent themes are reported. The slightly different emphasis from each region was merely mentioned as a trend.

4. Further explanation of the sampling method was given. It was originally shortened to make the paper more concise, but clearly the rationale needed further explanation. The cross case comparison could not be supported and has been removed. As the interviewer allowed patients considerable leeway to ‘chat’, it was felt they were free to express their perceptions. While this resulted in considerable data, immersion in this data resulted in the categories described.

5. This reviewer implied that the patients recruited would only be those who are positive about student involvement as they were patients who would agree to be seen by students. A sentence has been added to the critique to advise that in these settings, it is very rare for a patient to refuse a student consultation. All regions report that patients willingly see students, especially given the workforce shortage. There were no contrary views that could be reported.

6. We do believe that the theme of ‘becoming’ applied to the patient as well as the student. A colleague who read the paper suggested qualifying this theme as ‘becoming a professional’, while it was originally only qualified as ‘learning as becoming’. We don’t believe that this change was a good one, and have reverted to the original theme: learning as becoming. The student is undergoing professional identity formation but several patient citations illustrated that the patient felt they were able to become a more active participant in student education, and as a result in their own care. Unlike many health care teams, the patient was active in the microsystem, and they reported pleasure in the
enhanced role. We offered the quote provided as the patient clearly valued how the doctor confided in her: how they both were trying to help the student learn more about the patient’s condition. The patient valued this partnership with the doctor when patients are often viewed as ‘material’ for student learning. Another sentence has been added here to emphasise why it was included as evidence for the theme.

7. The claim that the student guided the patients’ choices for their care arose from the time the students were able to give the patient, unlike the busy doctors. Students learn the patients’ perspective which can influence them providing future patient-centred care, but citations illustrate how the student imparted knowledge to the patient (especially in the time before the preceptor supervision) and empowering patients with knowledge and consideration can surely guide them in choices about care. They also benefited from doctor-student discussions with the patient present. We feel this is a reasonable conclusion, and that the paper does offer insights into what the patients think about longitudinal integrated clerkships rather than what students, doctors or medical schools claim for them. We aim to develop patient-centred doctors and train them in patient-centred and learner-centred learning environments, and it was pleasing to hear that patients saw the environment as this.

Response to reviewer Hays:
Comments have been addressed above and following. The analysis has been described as manual as no software was used. The introduction has been reduced as described above.

Response to reviewer Coventry:
1. Methodology has been changed and described above.
2. There were no contrary data other than a few patients comparing the LIC model to short-term hospital rotations. The patient perceived that these were less favourable for student learning, given student numbers and opportunity to see a patient alone. It was thought too ‘political’ to report this but as it is what 2 patients said, it has been mentioned in the Discussion.
3. Given the journal is international, a deliberate attempt was made not to include Australian classification systems—rather the setting was described. This has been added to Table 1 for the benefit of readers aware of the classification and reference given.
4. Limitations of the study have been expanded, justification for the number of participants given and the rationale for using the interviewer given. The inter-context comparison has been phrased cautiously as a trend.
5. The propositions have been removed. Originally there were none but just to see what patients thought about the CLIC model.
6. The number of students has been described in the methods.