Author's response to reviews

Title: A survey of the practice and experience of clinical educators in UK secondary care

Authors:

    Robert I Norman (rin1@le.ac.uk)
    Nisha Dogra (nd13@le.ac.uk)

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Author's response to reviews: see over
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Dear Drs Ulep and Raytos,

Re: 1345883600125598 - A survey of the practice and experience of clinical educators in UK secondary care.

Thank you for your consideration of the above manuscript. We thank the referees for their encouraging comments and for their suggestions to improve our manuscript, which we address as follows:

Referee 1

1. While the survey results are important, some of the most valuable information comes from the free text comments. Did the authors analyse this for themes and did they consider a qualitative approach to understand these barriers in more detail?

Free text comments were invited concerning barriers to teaching only. Fewer than 8% of respondents made free text comments but thematic analysis was performed on this limited data. The reporting of this data has been extended in the section on ‘Perceived barriers to clinical teaching’ to demonstrate the congruence of free text comment with the survey results as follows:

‘Although fewer than 8% of respondents made free text comments concerning barriers to teaching, the main themes arising were the low time allocation and low prioritisation of teaching over clinical workload, competing priorities within limited SPA time and the need to work out of hours in their own time to complete teaching responsibilities. Lack of incentives, reward or recognition for teaching, poor teaching resources, low confidence in the curriculum and low postgraduate trainee availability due to clinical commitments and poor trainee attitudes were also repeatedly reported, reinforcing the findings of the survey.’

A qualitative approach was considered but discounted. The study was designed to document anecdotal knowledge that there was some dissatisfaction with the experience of clinical teaching and to provide evidence of the need for a reconsideration of the methods for allocation of or
commissioning of clinical teaching. A survey was considered the best method to achieve this overarching information and it was considered that a qualitative approach would have yielded an unwarranted granularity in the data to answer the research question. While increased detail in qualitative analysis may have been of interest, this would have reflected the disparity of local practice rather than overarching perceptions. A relatively large number of participants would have been necessary to give adequate representation from a disparate workforce and it was expected that considerable difficulties would be experienced in recruiting already busy clinicians.

2. In limitations, the authors acknowledge their low response rate and bias. Clearly the responders are biased towards teaching as evidenced by the low return of non-teachers. Barriers to non-teaching are also of interest, particularly as 'SPA' time includes teaching for the majority of consultants. How would the authors address this?

A low response rate of non-teachers would be expected since there is an expectation that registered doctors in the UK will contribute to undergraduate and postgraduate education (GMC Good Medical Practice (2013) [http://www.gmc-uk.org/static/documents/content/Good_medical_practice_-_English_0414.pdf]). Two sentences have been added to the limitations section to address this point.

‘The very high proportion of respondents with teaching responsibilities was suggestive of a bias against non-teaching practitioners in the study. There is a professional expectation on registration in the UK that doctors will contribute to the education and training of other doctors, medical students and non-medical healthcare professionals [1,16]. Moreover, the majority of consultants’ contracts include time for teaching within their SPA allocation, so the sample studied is likely to be a reasonably accurate representation of the distribution of teachers/non-teachers in the population investigated.’

Citation 16 has been added to the references.

3. There is a lot of number data in the text which makes some hard to follow. Could this not be summarised in a table which could be referred to? Are there any statistical analysis indicated?

Number data was included in the text originally to improve the accuracy of reporting. Most of the data was represented either in tables or figures in the original submission and so greater reference is now made to these. At the request of referee 1 most of the numerical data has been removed and more general comments made relating to the proportions of the population in the description of data. Three new tables new Tables 2, 3 and 4 have been included to summarise the data previously referred to in the ‘Formal training for clinical education’ section.

Numerical data relating to gender comparisons have been left in the ‘Teacher/trainer characteristics’ section, since the absence of relationship between the parameters prevented ready extraction into a table.

Table 3 from the original submission has also been split into two tables (new Tables 4 and 5) to better represent the different data.

Statistical analysis was largely unwarranted as sub-group sizes were too small to permit comparisons. Comparisons for the relationships between frequency of response and gender have been made. P values are now quoted, where appropriate in the ‘Teacher/trainer characteristics’ section, and a small change in the text has been made in relation to proportions progressing to a higher degree, where the analysis was not significant.
‘There was little gender difference in the responses with the exception that female respondents were significantly nearly twice as likely to have obtained formal teaching and or medical education qualifications at certificate or diploma level (Male, 9.0%; Female, 16.2%; p < 0.02) but proportions progressing to a higher degree were not statistically different (Male, 7.5%; Female, 3.8%). Although numbers reporting a lack of confidence as a clinical educator were low, females were three times more likely than males to indicate a lack of confidence in this role (Male, 4.2%; Female, 13.0%; p < 0.001), while there was no difference between the genders regarding perceived lack of competence as clinical educators (Male, 3.0%; Female, 3.2%).’

4. How would the authors address further work in this area?

It is our view that continuing focus on clinical educator perspectives of their educational provision would not be productive at a strategic level, since further qualitative analysis would tend to reveal local issues rather than generic issues affecting the profession as a whole. The study reveals the concern that insufficient time may be being given to educational activity, raising the question of whether this is detrimental to the student or trainee and we would propose interventional studies to address this. A new section has been included in the manuscript on page 14, as follows, to address this issue.

Further Studies

‘Further studies with qualitative methodology could be undertaken to provide increased understanding of the perceptions and experience of clinical educators. Such findings would likely reflect the disparity of local practice and give information as to how localities might improve the experience of their teachers. Of most concern is the major proportion of respondents reporting that they have insufficient dedicated time for clinical teaching due to competing clinical service pressures and/or other responsibilities, raising the question of whether this has a significant detrimental influence on the outcomes of training for students and trainees. The effect of inadequate preparation and low contact time on the quality of student and trainee experience and outcomes is likely to be significant but this is currently unknown. Studies are required to explore the hypotheses that increasing time for educator preparation or student contact time with clinical educators leads to an improvement in student and trainee outcomes and satisfaction. Designing an intervention that could be linked clearly to a predicted outcome without the possibility of confounding interpretations will present a considerable challenge.’

Referee 2

1. To further increase the impact of this study, authors should also think about including the students into the survey. Alternatively authors should discuss these aspects in the conclusion section.

We agree that seeking the views of students and, additionally, trainees would have added a further perspective to this study. This was not part of our original study design and was not conducted synchronously with the educator survey. We have added some comments on this aspect under ‘limitations’ as follows

‘A further limitation of this study was that the teaching practice of clinical educators was surveyed only from the perspective of consultant educators. The study could have been broadened to investigate the contribution made to clinical teaching by postgraduate trainees, both in peer teaching and the teaching of undergraduates. In addition, the perceptions of students and trainees concerning the quality of clinical training provision could have been surveyed to allow triangulation with the views of those responsible for providing the clinical
training environment. It is noteworthy, however, that the proportions of students reporting satisfaction overall with their training during the time frame of the survey was high (Leicester Medical School, 90%; Nottingham Medical School, 94%)[17]. Similarly, postgraduate trainee satisfaction in the East Midlands Deanery was generally high (Overall satisfaction, 79.6%; Clinical supervision, 87.8%; Educational supervision, 88.4%; quality of experience, 80.1%), although quality of teaching rated somewhat lower (63.4%) and similar to national levels [18]. These findings suggest some disjunction between educator perceptions and student/trainee experience, which is worthy of further study.'

2. Authors should expand in the “discussion” and “conclusion” section --- how the outcome of this paper will help to improve the education system for medical school students?

This paper was not concerned with direct improvements to medical student outcomes but the potential for responses to the concerns and recommendations of this paper to do so has been recognised by two additional sentences in the discussion on page 13:

‘The challenge to clinical education commissioners and providers is to respond to the concerns evidenced by this study to improve the status and quality of clinical educational provision. A key action would be to have clear time allocated to teaching activities within job plans. This should lead to improvements in both the teaching delivered (as teachers could prepare more effectively) and recognition of the value of teaching within the organisation.’

We trust that these responses address satisfactorily the comments raised by the referees and thank you for your consideration of our revised manuscript.

Thank you for extending the deadline to allow us to make this resubmission.

We look forward to your response.

Yours sincerely

Dr RI Norman