

Title: Making a GP longitudinal integrated clerkship in the UK at scale and sustainable - a Realist analysis.

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Introduction:

Longitudinal integrated clerkships originated in the US (1) and have been adopted internationally but have only limited uptake in UK primary care settings. (2) (3) This model of teaching medical students in UK primary care settings could have important benefits for students' skills, attitudes and may have a beneficial impact on general practice as their career choice. (4) However, UK models have often been for partial or select cohorts and have often not been sustained. The UCL "Medicine in the Community" programme in general practice (5) has placed the full cohort 350-400 students in a year-long GP attachment during the first full clinical year to the same general practices and has been sustained over 8 years.

Methods:

We have used a Realist analysis (6) to develop an initial programme theory and tested this using data from a mixture of stakeholder interviews (students, patients, GP tutors & faculty), student evaluations and correspondence (management meetings) to explore "what works, for whom, in what circumstances, and how?" in our context of a traditional block style curriculum in research intensive university. We have developed multiple Context-mechanism outcome (CMO) configurations to unpick how a UK GP based LIC at scale can be sustained.

Results:

We developed multiple CMOs. These configurations were organised by stakeholder groups with the outcome of a sustained GP LIC. For students, mechanisms included developing continuity with tutors, and receiving high quality patient based teaching that responded to their learning needs. A negative mechanism was the pull of "hard clinical teaching" in hospital and travelling time & cost to practices remote from central campus. For GP tutors mechanisms were receiving (teaching, organisational) support and administrative and academic continuity from faculty, adequate remuneration for protected teaching time and supportive practice environments. Patients were not aware a longitudinal presence of individual students but some identified their role to regularly "help out" with teaching. Patients wanted to know who students were, their stage in medical school and for the students to interact and talk with the patient educator. For faculty, mechanisms included multiple local schemes to recruit & retain GP tutors to continually sustain the 40-50 GP tutors required, needing a presence "at the table" of medical school committees and the role of supportive school leadership to resist pressure to have students on campus and continually on the wards, by prioritising the LIC placement. The negative mechanism of a LIC interweaving with a traditional block curriculum meant constant timetabling clashes. Faculty presence on assessment committees also helped drive assessments that would reinforce student engagement and perceptions of relevance with the "GP days". Sore tutors and faculty came "through the system" and perceived the course as central to determining their career choice.

Discussion and conclusion:

A Realist analysis enabled us to examine this programme as "social systems and structures that are 'real' (because they have real effects)" (6) and helped analyse it in a way that other research

paradigms would struggle to unpick. Sustainable “at scale” LIC programmes require high level institutional support, strong faculty/ GP tutor relationships, adequate resourcing and student engagement.

Presentation preference:

References:

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