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WEB PAPER

A comparison of medical students' perceptions of their initial basic clinical training placements in 'new' and established teaching hospitals

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ABSTRACT *This study has examined students' perceptions of the factors influencing learning during initial hospital placements and whether differences in perceived experiences were evident between students attending new and established teaching hospitals. Five focus groups were conducted with Year III students at the University of Birmingham Medical School (UBMS): three with students attending three established teaching hospitals and two with students attached to a new teaching hospital (designated as part of the UBMS expansion programme). Extensive variation in student perception of hospital experiences was evident at the level of teaching hospital, teaching firm and individual teacher. Emergent themes were split into two main categories: 'students' perceptions of teaching and the teaching environment' and 'the new hospital learner'. Themes emerging that related to variation in student experience included the amount of structured teaching, enthusiasm of teachers, grade of teachers, specialty of designated firms and the number of students. The new teaching hospital was generally looked upon favourably by students in comparison to established teaching hospitals. Many of the factors influencing student experience relate to themes grouped under the 'new hospital learner', describing the period of adjustment experienced by students during their first encounter with this new learning environment. Interventions to improve student experience might be aimed at organisations and individuals delivering teaching. However, factors contributing to the student experience, such as the competing demand to teaching of heavy clinical workloads, are outside the scope of medical school intervention. In the absence of fundamental change, mechanisms to equip students with 'survival skills' as self-directed hospital learners should also be considered.*

Practice points

- Undergraduate medical students perceive variation in their initial clinical experience at the level of the teaching hospital, teaching firm and individual consultant teachers.
- The new teaching hospital was generally perceived to deliver a better educational experience than the established teaching hospitals.
- Students undergo a substantial period of adjustment during their initial experience of the hospital as a learning environment.
- Whilst student experience might be improved by interventions aimed at teaching organisations and individual teachers, interventions aimed at the students themselves may have more impact. This required further examination.

Introduction

Despite a shift towards clinical attachments in primary care, the mainstay of undergraduate clinical attachments in the UK remains the acute teaching hospital (General Medical Council, 2002). Initial learning experiences in hospital environments aim to transfer basic clinical skills, whilst giving students the foundations for clinical practice. It might be postulated that such periods are highly important in influencing student development. Indeed positive experiences at this time may impact on subsequent career choices and attitudes to certain specialties (Lambert *et al.*, 1996).

At present, periods of clinical training are being provided against the backdrop of a national expansion in the undergraduate medical population (Department of Health, 2000). Many district general hospitals (DGHs) are now becoming 'teaching hospitals' with, for the first time, responsibility for delivering basic clinical medical education to medical students.

We have previously reported staff perceptions of the likely impacts that this rapid expansion may have (Mathers *et al.*, 2003; 2004) but to date there have been few reports of students' perceptions of their initial hospital based learning, and how perceptions vary between students attending new (NTHs) and established teaching hospitals (ETHs) (Parry *et al.*, 2002). The purpose of this study was to address this deficiency; specifically:

- to examine students' perceptions of their experience of initial Year III hospital placements and of the factors influencing that experience;

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- to investigate if differences in perceptions of experience are evident between students attending a NTH rather than an ETH.

Methods

Study design and setting

At the end of December 2001, we conducted a series of focus groups with Year III University of Birmingham Medical School (UBMS) students who had completed their first of two fifteen-week hospital attachments at one of three ETHs and one NTH. In all, we conducted five focus groups: three with students attached to the individual ETHs (groups C, D and E) and two with students attached to the single NTH (groups A and B). Two focus groups were run with students from the NTH in order to provide sufficient data to enable valid observations based on hospital type (NTH or ETH).

Recruitment

Twelve students invited by letter to attend each group were randomly sampled from a list of all Year III students stratified by teaching hospital and teaching firm. Students were given assurances that no personnel involved in their teaching or assessments would be present at the sessions or would have access to non-anonymized results. Informed consent was taken prior to the sessions. The study was passed by internal UBMS ethical procedures.

The focus groups

Each focus group (facilitated jointly by authors JM and ES) lasted for approximately 1 hour and comprised of between five and nine participants. The focus groups were semi-structured and conducted according to a pre-devised schedule, encompassing discussion of the major elements of Year III hospital teaching and the educational climate in the hospital (Box 1).

Data analysis

Each focus group was tape-recorded with the consent of the participants and the recordings transcribed. The transcripts were first read in their entirety with reference to the tape recordings. Substantive comments were highlighted and coded within each transcript. Related codings were grouped into emergent themes (Morgan, 1988). Similarity and divergence was noted within each thematic area. JM and ES undertook separate blind analyses and then compared results, discrepancies being resolved with reference to the transcripts and tape recordings (Malterud, 2001).

Where possible each participant was given a unique identifier according to the sex of the participant and the focus group session that they had attended. For example—F1, Group A—refers to a female participant in focus group A. Where it was not possible to identify individual respondents during transcription, for example where several participants talked at once, participants were identified solely by gender, e.g., F, Group A.

Box 1. Focus group topics.

Student aspirations for Year III
Relationship between aspirations and hospital attachment
Experience of teaching, teachers and teaching content
Experience of teaching firms
Experience with patients
Experience of examinations and assessments
Perception of comparative experience of other students
Other topics as deemed appropriate by the participants

Table 1. Focus group composition by gender and ethnicity.

	A	B	C	D	E	Total
Male (*n*)	3	3	3	4	1	14
Female (*n*)	4	3	6	2	4	19
White (*n*)	6	4	8	4	3	25
BME* (*n*)	1	2	1	2	2	8

*Black and minority ethnic group.

The results were fed back to a multidisciplinary group within the medical school that included Year III teaching co-ordinators and students. Results were also cross-referenced with Year III education facilitators who work closely with the students and hospitals concerned, and through data generated by a questionnaire survey conducted by the research team (Parry *et al.*, 2002).

Results

Thirty three (55.0%) of the 60 students invited attended the focus group sessions; fourteen (42.4%) were male and 25 (75.8%) were white (Table 1).

The students' perceptions of variation in their hospital attachments was an overarching theme recurring, without prompting, in all groups. There was extensive discussion of variation in experience within hospitals and evidence of a perception of variation between hospitals (Table 2).

The themes are split into two main categories:

- Students' perceptions of teaching and the teaching environment—themes related to perceptions of specific elements or characteristics of teaching or the educational environment.
- The new hospital learner—overarching themes related to the students' perceptions of their first experience of learning in a hospital environment but not specific to individual elements of teaching or the educational environment.

Student perceptions of teaching and the teaching environment

Five major themes emerged within this category: (a) structured teaching (amount/cancellations); (b) enthusiasm of teachers; (c) grade of teacher; (d) specialty of designated firms; and (e) number of students (Table 2).

Table 2. Emergent themes from the focus group discussions.

Main emergent themes	Unit of perceived variation		
	Teacher	Firm	Hospital
Student perceptions of teaching and the teaching environment			
Structured teaching (amount/cancellations)	√	√	√
Enthusiasm of teachers	√	–	√
Grade of teacher	–	√	√
Specialty of designated firm/s	–	√	–
Number of students per firm	–	–	√
The new hospital learner			
Syllabus/learning objectives	NA	NA	NA
Self-directed hospital learning	NA	NA	NA
Tutor assessments and feedback on progress during attachments	NA	NA	NA
OSCEs	√*	–	√**

√ variation present at this level.
– no variation present at this level.
NA theme not discussed in relation to variation by teacher, firm or hospital.
* referring to examiners rather than teachers.
** participants in one focus group felt that the OSCE format at one hospital differed substantially to that at other hospitals.

Structured teaching (amount/cancellations). One of the principle points of discussion in each of the groups was about variation in the amount of structured teaching time that students had received. Many of the students thought that they had received an appropriate amount of structured teaching. However, some students in each group felt that in comparison to their colleagues they had significantly less opportunity to attend teaching sessions, either because they were allocated less timetabled teaching or as a result of teachers cancelling or not turning up to scheduled sessions. This perceived variation was often attributed to individual teachers or the teaching firm/s that the students were attached to and was clearly a primary issue for some group members. In comparing their attempts to secure teaching, some students used adversarial language such as 'fighting' or 'bullying' for teaching. When discussing whether students should stay with one firm throughout the year in order to develop a relationship between a student and the teachers, some students disagreed vehemently citing their experience of the amount of structured teaching as the reason:

From Group C (an ETH)

F1 'Yeah, just to stay with one firm so at least they got to know us a little bit better.'
F2 'But then they said, yeah, they said that they should do that (referring to rotating students between teaching firms) because there were some good firms and some bad firms and if you got stuck with a bad firm—'
F1 'But then wouldn't it be off your bat to go and sort it out.'
F2 'Yeah but were you stuck with a bad firm where you have to fight for your teaching?' (F2 makes this point very forcefully.)
F1 'Not really.'
F2 'It's really hard work . . . you've not got the time to do it all the time, to be fighting for your teaching.'

The impact for those students who felt that they had received less structured teaching was not considered to be confined to this particular hospital attachment. Some students were concerned about the effects it would have during their subsequent attachments, feeling it could disadvantage them in comparison to colleagues who had received more teaching.

> 'I think if you're on a different firm you can have an entirely different experience, because some firms have had ten hours of teaching, and others have had two hours of teaching a week, and, you know, that's a bit too much of a disparity, and I'm quite anxious going into my second semester that I'll be on a firm at my next hospital where there'll be some people who got the ten hours and some people got the two, and, you know, I personally feel like I might be slightly disadvantaged in the amount of teaching I got, relative to other people.'
>
> (M6, Group D, an ETH.)

In two of the focus groups (both with students from ETHs) there was extensive discussion of cancelled teaching sessions and teachers not turning up. This was frustrating for all of the students, especially the lack of communication between students and teachers in these instances, where they felt they had missed out on other learning opportunities:

> 'That's one of the things that has been really frustrating, that you'll have some timetables and you'll turn up and you'll wait for like ten minutes or something and no-one turns up and then you'll bleep them and then you'll be told that actually they're on annual leave for three weeks and tough s**t. But you know, they don't have the courtesy to tell you that they're not going to be there. Like fair enough if someone's, you know, something major happens and they're in an emergency, we all understand that like if you're a surgeon, if you

> have to go into surgery, that's a different matter, but if it's something like annual leave which they know they're not going to be there for three weeks out of a five week firm, then A, why put them on a timetable, and B, if they're not going to be there then arrange for someone else to be there instead but we just have no teaching for this week and that's just frustrating, and you're standing up and you're like ''Right teach me something''.' (F, Group C, an ETH.)

Enthusiasm of teachers. The enthusiasm of individual teachers and their perceived 'willingness' to teach was also perceived to be an important determinant of the quality of teaching received. In part, this is a product of the students' experience of structured teaching, with tutors who provide less teaching (or who didn't turn up or cancelled sessions), perceived to be 'unwilling to teach'. F2 (in an ETH) suggested the link between this and the perception of teachers' attitudes to teaching:

> 'It's whether they want to teach you as well isn't it? The consultants and you know, people actually want to teach you then you'll get good teaching. But if they're not bothered.'
> (F2, Group C.)

Comments regarding the attitude of teachers towards teaching were obviously related to individual tutors, but were also made in relation to individual teaching hospitals. During both of the groups run with students from the NTH, participants suggested that staff were particularly keen to teach and to help the students. This included non-teaching staff such as nursing staff. The group members attributed this to it being the first year that Year III students had been attached to the hospital and also to the fact that there were fewer students overall in the hospital. One student suggested that these students had enjoyed 'minor celebrity status' during their attachment at the NTH. Indeed, during the sessions with students from the ETHs, the NTH was singled out as somewhere they thought to be particularly friendly towards students and enthusiastic about the teaching role.

> 'It was like third years, we wanna teach you—jumping out from corners trying to teach you . . . who's the consultant guy down in casualty, and he was absolutely super, I mean he wanted to teach at any point—you know, he'd be dragging us down there practically to teach, and you know, it was brilliant—I haven't heard about that in any other place . . .' (F4, Group A, the NTH.)

> 'Yeah, [names the NTH]—I'd like to know what the NTH's like, because my flat-mate's there, she says ''oh, they're so lovely, they're looking after us et cetera''.' (F3, Group D, an ETH.)

Grade of teacher. Another issue emerging from the focus groups was a perceived variation in the proportion of teaching undertaken by consultants and junior staff. This was suggested to vary across teaching firms and also between different hospitals. Students at the NTH thought that in comparison to the other hospitals, far more of their teaching was consultant led:

> 'I think one thing about [names the NTH] is, which is unusual, is that I certainly found that 90% of our teaching was all consultant led, that rarely did we have fixed teaching sessions with any of the SHOs, the reg's or even the house officers, which is—I think it's good, but I think—I dunno, maybe that if you got more involved with the rest of the team you'd get different perspectives. And certainly if you go to the house officers, they have a different—not only a way of doing things, but also a different perspective. So I don't know whether that would help, or—but I mean I suppose, you know, you can't really complain, 'cos a lot of people complained that they didn't have a lot of—at other hospitals, they didn't have much time seeing their consultants.' (M4, Group B, the NTH.)

In contrast students who had been attached to two of the ETHs said that teaching was more often delegated to junior staff or that juniors were more likely to turn up to scheduled sessions. But as the quote above from M4 (Group B) suggests, it is not a case of junior and consultant teaching being 'good' and 'bad' (or *vice versa*). Students clearly appreciated the respective merits of consultant and junior led teaching: consultant-led teaching was considered to be more knowledge-based, whereas junior teaching was more practical and in some ways closer to what the students thought they required in Year III. This observation was forthcoming at both the NTH and ETHs with students wanting a suitable balance of consultant- and junior-led sessions.

Specialty of designated firms. Teaching content and patient access was often seen as dependent on the specialty of the firm that the students were attached to. Several comments were made about a lack of access to or teaching on patients in particular areas of medicine because students were attached to firms with other specialties.

> From Group C (an ETH)
> Facilitator 'You mentioned learning objectives as well. Do you see a variety of diseases and conditions which relate to your. . .?'
> M 'Not really, no—'
> F 'No because I was on an endocrine firm followed by a clinical pharmacology firm . . . you know someone comes in with a respiratory problem, they go to a respiratory ward and are generally under a respiratory consultant and so I definitely don't feel I've grasped the sort of the big area, it's like the respiratory, cardiology. We have an hour a week of teaching in cardiology for five weeks. So I'd have five hours of cardiology and obviously you do get practice on people. I know how to do the examinations but I don't think that I'm going to be particularly competent at picking up signs because in my base ward I have lots of people who come in with diabetic crises and whatever which is useful but then it's just not the basic medical stuff that you need to know.'

To rectify 'gaps' in their learning, some students felt able to approach other firms in order to gain the relevant experience. In contrast, others thought it was difficult for them to 'go beyond' their firm. Access to the whole hospital appeared dependant, in part, on the hospital with students at the NTH commenting that they felt able to find patients outside their designated firms.

Number of students per firm. Students from each of the hospitals were sensitive to the effect on patients of large groups of students present for bedside teaching. This was particularly the case for frail patients, those who were in obvious pain or discomfort, and those with 'interesting' signs who were often a target for students' attention.

> 'The number of times we'd see a quite frail patient, the doctors say: ''I'm just gonna invite a couple of my medical students in—is that alright?'' and six of us walk in, and you know, and obviously it's great for us, but can you imagine this patient stuck in bed, you know, seven people towering round them, asking them questions and prodding them.' (F3, Group B, the NTH.)

> 'Ethically, you really feel like you're treading a fine line, out of seven people feeling a tender abdomen, I was like number seven once, and I came really close—just telling the—this consultant, who I think—I can't remember what grade it was—and I just felt like saying ''look, I'll come back another time and do it, because I feel this is just not for me''.' (M6, Group D, an ETH.)

> 'Me and my firm kept looking at each other as if to say ''you know, surely we can go and leave, and let this guy have a snooze, cause he's absolutely knackered''... cause sometimes it makes you feel bad around the patients, because of the way that they try and teach you things.' (M5, Group D, an ETH.)

In addition to concerns for patients, the students also worried that the large numbers on firms restricted the type of teaching they received, thereby leaving the students without experience of certain examination techniques:

> 'All our teaching's been on the male patients because to expose a female patient to do a chest examination, very few females other than like really, really old mad people are going to be happy with like seven students round their bed like with their boobs out basically you know, and it's ridiculous because like we literally have no teaching on females and then you've suddenly like got it in the exam and they might be like well examine this persons chest and your like well what do I do there's a boob there, even stuff like an abdominal examination they'll always go, ''Right you'll now go on to examine the external genitalia'', I've never once seen it being done, I wouldn't have a clue what to do because they can never do it because there's always so many people watching that no-one's going to let you examine their external genitalia, you need to do that in groups of like one or two or three, and so it just means that I've never seen it.' (F, Group C, an ETH.)

The issue of too many students examining individual patients was thought to be less problematic by students at the NTH where student numbers were lower than in the ETHs. However, they were aware of the uniqueness of their attachment:

> 'I think if there was any more students at [names the NTH], I think it would become increasingly different, and I think 33 out of 35 of us that were there, I think it was a good number for the number of wards and number of patients... I think if you had a situation where, I dunno, they have at [names an ETH], or [names another ETH] where there's double the number, I think it would be impossible—absolutely impossible.' (M4, Group B, the NTH.)

The new hospital learner

Several of the themes emerging from the analysis of the focus group materials did not relate to specific elements of hospital teaching or of the educational environment *per se*, but rather to the fact that Year III students are new to learning in a hospital setting and hence naturally undergo a period of adjustment (see Table 2). These themes included the following: (a) self-directed hospital learning; (b) learning objectives/syllabus; and (c) end of attachment assessments.

Self-directed hospital learning. One theme that recurred in different guises in each group concerned the issue of self-directed learning in the hospital environment. As this is the first extended experience of working in a hospital for most of the students (and during their first two years they are accustomed to a highly-structured, predominately taught course), there is a transitional period whilst they adjust to this new learning environment. F2 in Group E described her personal experience at the start of her attachment:

> F2 'Well, I was really excited to start the third year. I'd spent two years in the lecture theatre virtually, and it was just good to get out and have a taste of medicine, but I think to begin with, I don't know about anybody else, but I felt a little bit lost, not knowing what I should be doing, when I should be doing it at times. But after the introductory period, we sort of settled in and it was good, I really enjoyed it.' (Group E, an ETH.)

Similar comments were made describing the students' unfamiliarity with their role and insecurity in approaching patients in the early stages of their attachments. One student articulated the view that Year III was partly about learning to learn in a hospital. The students must use the time to acquire new learning skills in order to become effective 'self-directors'.

> 'But also I think by the end of this year I want to know where to go to get the information I need because it's one thing being told that you need to know, you know, most of the things, but you need

> to know how to get the experience and how to get that information, and so part of this term's just been finding out that if I want to see this, I need to go and see this clinic, or if I want to see this, I need to go and speak to these doctors, and that it's taken me a term just to work that out, and probably will take me longer to still work out where to go to get the information.' (F3, Group B, the NTH.)

This viewpoint also tallied with students' discussions about making their own learning opportunities as part of the self-directed learning ethos. This style of learning, requiring self-motivation and particular learning skills, may be more easily adopted by some students than others. M5, who attended two hospital sites (as part of one ETH) during his first semester related his contrasting approach at each one:

> '. . . cause it is self-directed, and it took me a while to realise that, so I didn't take up the opportunities early on. In Hospital Y (part of the ETH), the first half, I achieved little, and then at Hospital Z (also part of same ETH Teaching Trust) it just suddenly hit me that actually, you know, you've got to do stuff. It's very easy if teaching's cancelled to say ''oh, an afternoon off'', and at Hospital Y, I was always strolling off in the afternoons, whereas at Hospital Z, it just suddenly hit me that I've got to learn stuff and you've got to make your own 9 till 4/5 day . . .' (M5, Group D, an ETH.)

The induction/introductory period at each hospital was viewed as very important by the students. Comments about this period demonstrate that it influences the way in which the students approach their subsequent learning during the attachment. For example, students who are not given a face-to-face introduction to all the members of a firm may find it difficult to approach juniors or other staff for teaching or access to patients. A good introductory period was seen as facilitating effective learning. The experience of introductions and induction periods was thought to vary between firms and hospitals.

Learning objectives/syllabus. In order to direct learning, all students are provided with a booklet by UBMS containing a set of learning outcomes. These outcomes relate to the learning objectives of Year III and outline the diseases and conditions that students should familiarise themselves with during their clinical placements. In all groups however, students reported the objectives to be vague leaving them unsure of what they need to learn, to what depth and by when. A discussion in Group E (an ETH) exemplifies this:

> F3 'They give us a set of learning objectives, but they are just like a list of things, and they don't actually go into any detail of what we need to know about them, so maybe a lecture to start off the course, in the introductory period or before, would help you to understand what you needed to know.'
>
> Facilitator 'So those objectives on the—you don't think they're—they're. . . ?'
>
> M1 'Well, they just—it says that you need to know about cardiac . . . treatment, blah blah blah—and you don't know where you're going to get that from.'
>
> F3 'It's not—it's not really split up into what you need to know for like the December OSCE, and what's needed for the OSCE in May or June, it's just kind of a big list of everything you need to know.'
>
> F4 'I think that list is quite frightening as well.'
>
> F3 'Yeah, cause it involves—it includes all the pathology as well that we need to know for our—like MCQ's (multiple choice questions) and stuff, so when you look at it you're like—you know, you don't actually sort of sit down and think about what's needed for what.'

Similarly, another male student commented on the scope of the learning objectives and their utility to the students as a guide for their learning:

> 'You don't know what depth either, it says ''Understand peripheral vascular disease'' or something like that, but you don't know what depth you need to go in, whether you have to do examinations or anything like that, it just says ''Understand it''.' (M, Group C, an ETH.)

Tied in with the issue of learning objectives was a perception on the part of the students that there was a lack of a structured syllabus for the hospital teaching that the teachers were either aware of, or adhered to. There was reference in each focus group to teachers who didn't know what the students were required to learn. For example M4 who had been attached to the NTH commented:

> 'I mean I can only sort of guess, but sometimes I got the impression that they sort of, you know, weren't too sure about exactly what we need to know. And certainly as the OSCE was approaching, the clinical exam, we were sort of discovering things that we hadn't done, and so you had to quickly rush off and find these patients so you could, you could practise the examinations and know all the theory. So I think that's one thing that in terms of what we have to achieve in the third year, I think that we, we didn't have much guidance, and also the consultants were unsure—I can't say what sort of guidance they had, but . . .' (M4, Group B, the NTH.)

This observation was not particular to any hospital or teaching firm. A participant from Group C (an ETH) also noted this:

> 'There doesn't seem to be any syllabus or any, I mean, like F1 said, you've got SpRs turning round to you and saying ''So what would you like to get taught today?'', what, out of anything? Out of the whole you know, any system you like, oh well we'll just pick something and in the end it's up to them you know.' (F, Group C, an ETH.)

End of attachment assessments. In each focus group there was discussion about the students experiences of their assessment. This comprised both an end of term clinical assessment (an Objective Structured Clinical

Examination—OSCE—in the hospital in which they had undertaken their attachment) and feedback with a formal grading by their lead consultant tutor. Although the OSCE contributed only a small element of the overall Year III mark, being their first clinical examination it naturally assumed great importance to the students.

In all hospitals students felt there was variation in the OSCE content and the examiners requirements with some going beyond the students expectations, for example, by asking for differential diagnoses or seeing more patients than expected. Although well-recognised elements of post-graduate examinations this was evidently quite disconcerting for certain students [10]. An excerpt from Group B (the NTH) gives an interesting example of this:

F2 'I was gonna say that the history I took, I took a history and then the doctor examining me sort of started asking me about investigations and things like that, and it boiled down to what exactly, what pattern of enzymes I'd expect to see in this man's liver, and I really didn't know, and she was sort of looking at the other consultant as if to say, you know: ''We've got a bit of a stupid one here'', and that really put me off. So when I sort of came out of that and I had to go straight into the other examinations, if the consultant wasn't really friendly with me then I don't think I'd have done very well—but thankfully they were, but the doctors seemed to get a bit carried away sometimes with sort of saying: ''So that you've seen this—what could this be—then what would you do, what would you do, and what would you expect?'' when you're not really supposed to know.'

M4 'I got a bit of a different impression—I got the impression that when they were asking you questions they were just trying to find your limit. I think when they were examining you, the first—this is the impression that I got—that the first thing they do is work out whether you've passed or not, whether this is, you know, someone who's, you know, basically gonna pass, whether they're a C grade student, and then the questions are there just to push you to see how far you can go, and that's how they differentiate the difference between someone who's gonna get an A, someone who's gonna get a B and someone who's gonna get a C. So I think because a lot of people think: ''Well they're asking me difficult questions I don't know the answer to, that means I'm failing'', I think it's the exact opposite, that if they're asking you more and more difficult questions, it's probably an indication that you're doing better than, you know, you're expected to, and they're pushing the limits so far to see how far they can take you.'

M7 'But [what's] that's got to do with taking a history?'

M4 'But the thing is, you can take a history, but you can take a C grade history and you can take an A grade history, so—'

M7 'Yeah, but questions about your medical knowledge are not testing your history skills.'

M5 'No, certainly not, and the way sometimes these questions were asked—I mean I agree with M4 to some extent, yes, it's to differentiate grade boundaries, but there were a few consultants in the exams and the way in which they asked the questions and the way in which they received the answers that you gave were somewhat sarcastic an approach almost trying to belittle you to some extent. Which I think maybe is a good way with pressure, sure, cause it's a pressure job, but I think it's a bit off when we first start.'

Whilst suggesting that examiners are attempting to distinguish between grades by asking students the kind of questions that F2 provides in her example, M4 is countered by three of his colleagues in the group. They feel that the questions are beyond the scope of the examination. It is apparent from F2 and M5's comments on the tenor and tone of the examiners questions, and their reception of the answers, that some students see the examiner's attitude in a negative light.

End of term tutor assessments, given by the consultant who leads the firm to which the student is attached, were also seen in an unfavourable light. Assessments were perceived as often being made in an arbitrary or *ad hoc* manner. Some of the students recounted how the consultants undertaking the assessments did not necessarily know the students and therefore assigned uniform grades. This was a source of frustration for the student and many believed that the grades and feedback that they received were neither an accurate reflection of their performance nor a constructive method by which to encourage their development. All of the groups thought that feedback would be more usefully given at an earlier stage, by staff familiar with their progress (more often junior staff). Such feedback, while important for all the students, may be particularly valuable for those who are not performing or progressing as well as others. An excellent example of the impact of a lack of regular feedback was provided by M5 in Group D. He described a particularly poor personal experience of his hospital attachment, culminating in failure in the end of semester tutor assessment. M5 thought that he should have been given the opportunity to address his tutors concerns earlier during the attachment, but due to a lack of feedback had not been able to do so:

'When I was at [names hospital] as well, assessment was, you know, very sporadic—I mean the doctors failed me, and I didn't have a problem with their criticism of me, but they told me this two days before my exam, whereas—and they told me at the time, they sat down and said ''we had worries about you from day one'', but they didn't tell me that, they should have just told me that and then I could have done something about it. They told me two days before an exam . . . and they always said as we went along, like ''we've had problems with people before,

> but we'll always pull them to the side and have a word with them'', but they didn't do that to me, and I felt a bit betrayed by that . . .' (M5, Group D, an ETH.)

Interestingly one of M5s colleagues in the same focus group put this perceived lack of constructive feedback and assessment in the context of the current expansion of student numbers at the medical school. Larger numbers of students was suggested to result in increased 'student anonymity' and a decreased ability on the part of the medical school to monitor student progress.

> 'It's symptomatic, with this med school increasing student numbers, it's exactly that, you could go through—in the second year you could not turn up to every one of your small group teachings and then fail the year, and you wonder why you may have failed a year, and no-one had picked up the fact that you weren't attending, that something wasn't right, and it's because, you know, you're a small fish in a big sea, and if there was one teacher who looked after a smaller number of students, they would be able to monitor their progress better.'
>
> (M6, Group D, an ETH.)

Discussion

In this study we explored perceptions of basic clinical training among a random sample of medical students undertaking their first attachments in ETHs and one NTH. The findings suggest that there exists marked variation in the experience of Year III students with regard to their basic clinical training. Overall, students at the NTH appear the more satisfied due in part to more enthusiastic teachers, fewer students per firm and a more friendly hospital environment. Nonetheless, intra-hospital variation was also apparent with some NTH students faring better than others, and some students at ETHs experiencing an excellent introduction to hospital medicine.

By using random sampling, stratified by hospital and teaching firm, we aimed to avoid selection bias whilst ensuring representation of a range of teaching firms in the hospital-specific focus groups. As compared to the entire 2002/3 Year III UBMS student cohort, the proportion of female and minority ethnic participants was similar; 57.6% vs. 58.4% and 24.2% vs. 29.9%, respectively[1]. Nonetheless, the possibility of some response bias must be acknowledged: for example, students with extreme experiences may have been more or less likely to agree to take part in the study.

By anticipating recruitment attrition and targeting more students than required, we were able to secure sufficient participants at each of the sessions to develop discussion and an effective group dynamic. We chose focus groups as our method of inquiry to acquire data that provided in-depth insights into the perceptions of the students taking part in the study (Kitzinger, 1995). Focus groups enable observers to witness group interactions and allow participants not only to contribute personal experience, but also to comment on other participant's experience and so develop perspectives accordingly. Interactions in a focus group also provide valuable data relating either to complimentary or contrasting experience of the same issue by two or more participants (Kitzinger, 1994). We felt this methodology provided the most appropriate means to understand general and comparative accounts of student experience. We do, however, recognise the limitations of this approach, for example in tapping publicly acceptable rather than private accounts.

This study's key finding, common to all the focus groups, was the students' perception that there had been notable variation in the teaching and the way in which it was delivered. Recent studies from other schools have also demonstrated variation in student experience of some elements of teaching (timetabled teaching, cancellations) (Stark, 2003; Seabrook, 2004). At UBMS, variation primarily arose at the level of the individual consultant (likelihood of cancelling, or not turning up for, sessions; his/her enthusiasm for teaching; consultant or junior staff) and of the firm (amount of formal teaching timetabled; clinical specialty; number of students). However, there was also clear evidence of inter-hospital differences, especially between the ETHs and the NTH: students who had attended the NTH seemed, in general, to have experienced less variation in the amount of structured teaching, fewer cancellations of sessions, and were more satisfied with this aspect of their training than their colleagues in ETHs.

It is important to stress that the purpose of this study was to describe perceptions of students undertaking their first clinical placement, and to compare perceived experiences at different 'types' of hospitals (established and new teaching hospitals). The study does not in any way set out to validate these perceptions nor indeed to explain any differences in perceptions. Rather, our methodological approach was consistent with an attempt to elicit and report student perceptions of experience, perceptions that we believe are important in their own right and as such need to be understood. Nonetheless, it is interesting to postulate on the reasons for perceived variations in student experience. Firstly, it is possible that the NTH in its first year of Year III teaching may be more able to offer protected teaching time within the duties of the consultant staff whereas in the ETHs, protected time—although available in principle—has become compressed due to the competing demands of clinical work and research activities. Other medical schools have recognised these pressures and sought alternative approaches to consultant-led teaching (Kilminster *et al.*, 2001). Secondly, as undergraduate teaching may be new to staff at the NTH, the 'novelty' of this duty may generate initial enthusiasm that is translated into the fulfilment of formal teaching commitments. Indeed, this enthusiasm is referred to both by students attending the NTH and by colleagues at ETHs who heard good things about the NTH through the 'grapevine'. Consultants in ETHs without the 'novelty' factor may be more likely to prioritise competing work demands to the detriment of their teaching commitments.

But, if this is the case then not all teachers within a single hospital unit are equally affected by the 'novelty' factor. Variation in the delivery of teaching, though mentioned much less, was still apparent in the NTH, with students attached to one particular firm stating that they had received less teaching than their peers in the same hospital. Similarly, within ETHs, although student dissatisfaction appeared greater than in the

NTH, many ETH students still reported excellent experiences. Thus, although variation at a hospital level is present, our findings strongly suggest that within each hospital there exists a range of student experience and that this can be attributed in part to the attitudes and characteristics of individual teachers. Such an observation is not new (Metcalf & Matharu, 1995; Prideaux *et al.*, 2000; Mclean, 2001).

Other factors also operate to influence student experience. The number of students per firm clearly causes some difficulties for students, for example, in terms of clinical learning opportunities. Work we have recently undertaken suggests that consultants too recognise problems with large numbers of students (Hendry *et al.*, 2005). Again, students at the NTH were advantaged with there being fewer students overall during this initial year as a teaching hospital.

The overarching themes grouped under the 'new hospital learner' demonstrate the transitional phase that students undergo from more structured 'pre-clinical' training in the first two years of the UBMS course. This is reflected in a need for time to adjust to the hospital-based application of self-directed learning. This is also echoed in assertions by students that the learning objectives are overly vague, and in their frustration that teaching staff appeared unaware of the Year III syllabus. The students' desire for earlier constructive feedback may also be a response to this. Similar experiences have been reported elsewhere, despite the recognised importance of regular feedback to students (Duffield & Spencer, 2002). Some students also commented on the increasing student numbers and the negative impact this might have on 'teacher–student' relationships.

Frustrations were also expressed at the methods of assessment adopted by the school: while the exchanges about end-of-term OSCEs may be seen as an inevitable response from exam-fraught students, it is clear that the experience of students in the examination varied considerably. Work from Newcastle-Upon-Tyne has also noted perceived unfairness among medical students with regard to OSCEs (Gordon *et al.*, 2000).

So what might UBMS do to address student frustrations? Gordon has suggested a number of mechanisms for enhancing the learning environment in clinical settings (Gordon *et al.*, 2000). Actions might reasonably be directed at the organisation. Indeed, students in the focus groups espoused the benefits of structured introductions to hospital life and face-to-face introductions to firm members, as well as the positive role that student co-ordinators played in their first attachments. Action might also be directed at the teachers, including the reinforcement of the need for appropriate behaviours, enhanced provision of support and training to ensure well-developed teaching skills as well as clear dissemination of the curriculum and specific learning objectives. Stark has also called for enhanced links between medical schools and hospitals providing undergraduate teaching (Stark, 2003).

However, it is clear that there are contributory factors influencing the student experience that are outside the scope of the medical school. The competing demand to teaching commitments of heavy clinical workloads is not easily amenable to change. It is also clear that the experience of students and their consequent frustrations are partly a result of the 'power' relationship between themselves and their teachers. Students often feel unable to influence adequately their educational experience. Teachers are perceived to be able to miss or cancel teaching at will or to delegate to juniors, to decide what they feel is appropriate to teach and in what manner. They are seen by the students as able to assign assessment marks without a detailed knowledge of student performance or attitude. From a student perspective, there appears to be few lines of accountability for teaching performance within teaching hospitals or to UBMS. The teachers appear to be in a position of power that determines the experience that individual students undergo and students have few, if any, forms of redress in order to counter that power.

Clearly without the inclusion of teaching and medical school staff in this exercise we are only reporting one side of the story, and further investigation of others' perspectives is required. But perhaps the most effective mechanisms to bring about change may be those that in some way attempt to re-orientate the 'power' relationship between student and teacher. In the absence of fundamental change, this might include further initiatives to equip students with 'survival skills' as self-directed hospital learners in the hierarchical hospital environment. These might include enhanced training in time management, communication skills, assertiveness skills and in receiving and giving constructive feedback (Duffield & Spencer, 2002).

Note

[1] Comparison with University and Colleges Admissions Service data provided for UBMS.

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