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LETTER

Key Learnings and Perspectives of a Newly Implemented Sex-and Gender-Based Medicine Modular Course Integrated into the First-Year Medical School Curriculum: A Mixed-Method Survey [Letter]

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Dear editor

We thank Bragazzi et al[1] for their research into Sex- and Gender-Based Medicine (SGBM) teaching. SGBM integration into early-stage training is a step towards improving patient health and interaction with healthcare. Being passionate about medical education, we aim to offer our thoughts.

The authors developed an innovative SGBM course aimed at complementing students' teaching during medical school. The centre's system of separating teaching into preclinical and clinical education mirrors the United Kingdom's experience. Content traditionally covered within these areas differs, and so, any SGBM course launched should reflect this to allow easier adaptation to existing curricula. For example, pre-clinical students could focus on SGBM for medical research whereas clinical teaching could extend to the presentation and perception of disease. The authors highlighted that this was a first-year trial of what is intended to be a four-year course, but no course outline for other years or in-depth breakdown of course development were included to allow for comparison.

Substantial effort is required to integrate novelty into the medical curriculum, so it is commendable that teaching was provided. However, concern regarding the generalisability of the results remains, given a small sample of 30 students from a single centre. To reduce potential type 2 errors, larger cohorts are needed. Additional cohorts from multiple schools are also needed to assess the feasibility of widespread course integration.[2] The lack of control group and prior assessment of SGBM knowledge, further hinders the ability to attribute changes in perspectives primarily to this SGBM course as there is no comparison to baseline.[3]

The study's use of immediate post-course evaluation via questionnaires captures initial feedback and short-term learning which is necessary for evaluation of pilot programmes. However, it fails to assess the long-term retention of the SGBM principles and their clinical application. Course effectiveness should be measured by changes in behaviour[4] and clinical practice, which can only be observed over time. First year students lack clinical experience, so a follow-up survey during clinical years would provide insight into the integration of SGBM principles into patient care. Additionally, the questionnaire used may not have been validated. This is understandable due to the paucity of evidence in SGBM research but with an unvalidated questionnaire, questions may have been misunderstood leading to inconsistencies in answers.

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The authors' use of qualitative evaluation methods allowed for thematic analysis which offered valuable insights into course impact. Whilst the study provides descriptive statistics, the lack of inferential statistics makes it challenging to draw comparative conclusions about student experience and the absence of statistical significance testing weakens the robustness of the findings. There was missed opportunity for subgroup analysis, such as between male and female attendees. Sex and gender differences impact perceptions and learning experiences;[5] therefore, subgroup analysis could reveal how different groups responded to the course. This may further contextualise course content, for example in how the topics of feminism were perceived differently.

In conclusion, the study provides valuable insight into SGBM and its integration into medical education. Addressing the limitations mentioned will enhance future research into this critical field.

Disclosure

The authors report no conflict of interest in this communication.

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