All speakers had an educational brief. This set out the concerns and questions about the proposed subject from a GP’s point of view. For example, not ‘Ménière’s disease update’, but rather what are the useful signs and symptoms to confirm or refute the diagnosis in primary care? Is there a risk of overdiagnosis? Is referral needed or not?

At the session, participants were invited to raise their learning needs, reflections, and concerns before the speaker started. Speakers were instructed to prepare not more than 20 minutes worth of talking so that the rest of the time would be taken up with discussion, where the real learning occurred. Some speakers were puzzled or hesitant at first, but soon realised the benefits, and many commented afterwards that they had learned far more themselves. The record shortest time a speaker managed was about 15 seconds, when the evidence base for a statement they made was challenged from the floor as to its accuracy and applicability to primary care. The debate was lively!

Occasionally speakers had to cancel at the last minute; we used a crowdsourcing method then. Putting together the questions from the floor and sharing the knowledge in the room from attendees meant really useful learning happened with no ‘expert’ in sight.

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REFERENCE

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Addendum
In the October article by Astin MP et al. Diagnostic value of symptoms of oesophagogastric cancers in primary care: a systematic review and meta-analysis. Br J Gen Pract 2015; DOI: 10.3399/bjgp15X687817, the authors would like to add the following text to the penultimate sentence of the abstract’s Results section: Sensitivity was lower for: anaemia 0.12 (95% CI = 0.08 to 0.19) with specificity 0.97 (95% CI = 0.94 to 0.99); nausea/vomiting/ bloating 0.17 (95% CI = 0.05 to 0.44) and 0.84 (95% CI = 0.60 to 0.94) respectively; reflux 0.23 (95% CI = 0.10 to 0.46) and 0.70 (95% CI = 0.59 to 0.80); weight loss 0.25 (95% CI = 0.12 to 0.43) and 0.96 (95% CI = 0.88 to 0.98).

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