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Response to "Medical student satisfaction and confidence in simulation-based learning in Rwanda – Pre and post-simulation survey research"

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May we begin by extending our sincerest thanks to Turatsinze et al. [1] for their paper evaluating Rwandan medical students' attitudes, satisfaction and confidence level with simulation-based learning (SBL). As medical students in our fourth and penultimate year of study in the UK, we are greatly familiar with simulation-based teaching as it is modestly incorporated into the medical school curriculum, emphasised from the first year of study [2]. With such experience, we hope to provide a valuable insight to those in resource limited settings such as Rwanda, for whom SBL is still in its infancy [1].

A balanced 5-point Likert scale questionnaire was used to assess clinical skills confidence levels pre and post-simulation. Responses ranged from 1 being not confident, to 5 being highly confident [1]. The use of such a measurement tool with an odd number of scale points and a middle neutral point (3), can be potentially problematic in assessing confidence. Shrauger and Schohn define confidence as a self-perceived sense of competence and/or skill to deal with various situations effectively [3]. Respondents may therefore become cognitively lazy when completing such styled questionnaires and be tempted to respond 'neutral' more frequently, instead of carefully considering whether they feel slightly more favourable or unfavourable towards a question [4]. This could therefore be of benefit for understanding why the probable acquiescence bias occurred in the research project [1].

It is worth noting that clinical simulation methods may not always be well received when assessing student satisfaction and confidence, unlike the authors strongly conclude. We have felt from our experience as medical students that even practising simulation assessments in a role-play manner, in front of peers, can become quite daunting. Especially when they mimic real-life situations and are an immersive process, much like the scenario described in this paper [1]. Simulation exercises can be uniquely stressful in that students are required to make patient care decisions and perform procedures in real time, particularly in cases involving emergencies [5].

It can often feel tense to enact these high-pressure scenarios in front of peers for fear of embarrassment in making errors, or not performing to the best of one's ability. This emphasises the high level of anxiety potentially caused by simulation assessments [5], which in turn may lead to a negative effect on performance. This could ultimately decrease confidence in future clinical skills if not addressed accordingly in the planning of simulation exercises.

In conclusion, we agree that SBL has been of great assistance in developing our medical competencies. Since we have been familiar with the process from early in the curriculum, we have had the chance to consistently apply and update our knowledge throughout the years. This has made it ever more useful in supplementing existing knowledge when new competencies are gained. We hope students in Rwanda can continue to reap the benefits of SBL and echo the recommendation put forward, that an increased use of simulation-based learning methods should be implemented in undergraduate medical education [1].

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