Countess of Chester Hospital NHS
NHS Foundation Trust

University of Chester

Educational Practice Development

An Evaluation

An exploration of the impact on participants and their shared organisation of a Postgraduate Certificate in Education for Postgraduate Medical Practice

Evaluation Report: The First Year

2010 – 2011

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Medical Education : The Countess Way

Professional development of staff is a key priority of this Trust.

This evaluation report, about the first year of our innovative Master's pathway in Education for Postgraduate Medical Practice, is an example of our commitment to educating clinicians to be safer and better practitioners.

I am pleased to support this report being shared in the wider healthcare community so that we can all benefit from the lessons learned here.

Peter Herring

Chief Executive

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Acknowledgements

I would like to thank all the participants for the their willingness to talk and engage with the process of this evaluation. Thanks particularly to the learners for giving me time to talk with them about their appreciation of the programme.

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Executive summary

1. This evaluation considers the first year of the MA in Education for Postgraduate Medical Practice (MA EPMP) validated by the University of Chester. The ongoing evaluation during the second year will focus further on organizational changes that may result from this educational process.

2. The MA in Education for Postgraduate Medical Practice (MA EPMP) is a new three year Masters Programme. This innovative project is taking place at the Countess of Chester Hospital NHS Foundation Trust and is run in partnership with the University of Chester. The course started in October 2010 and is taught face to face. The entire first cohort was drawn from the Countess of Chester Hospital.

3. Cohort one, the focus of this evaluation, consisted of ten senior medical staff and one senior nurse (whose job includes the education of more junior medical staff), who were enrolled on the programme following interview and selection. Usually courses of this kind recruit from diverse locations so participants do not have the opportunity to return to practice with a group of colleagues who have undergone the same educational experience. The fact that all course members come from the same institution is important in terms of the impact the course has on practice and on the changes it brings to an organisation. This is a novel feature of the course.

4. The MA aims to enable doctors and other senior clinicians to become better teachers of doctors, in the clinical setting. The course promotes a deep understanding of educational issues, principles and values and through this process of enhanced post-graduate medical education, aims to improve patient care.

5. This report evaluates the changes and challenges to change that occurred in the practical teaching of the course participants of cohort one over a period of one year. The impact on learners is also explored, as is the impact on the organization more generally.

6. The evaluation takes a qualitative, illuminative approach primarily, which is concerned with description and interpretation rather than measurement and prediction. In illuminative evaluation, a programme is studied by qualitative methods to gain an in-depth understanding of the programme and the context within which it takes place. This approach is an appropriate process of evaluation for educational programmes, particularly innovative ones.

7. **Participants reported that the course had effected a positive change in their thinking and in their own clinical practice.**

- They felt better able to articulate their own clinical thinking processes as clinicians, this is helpful both for teaching as well as in communicating with other teams and colleagues.

- The way they document their clinical decisions in the clinical setting, has improved, becoming clearer and more explicit.

8. Participants reported substantial positive changes in their individual practical teaching practice

- More teaching is taking place in the clinical setting.
- The teaching is more efficient and less time consuming
- They have a clearer idea of how the learners are progressing
- Supervision and assessment of junior staff has become more rigorous.

9. Existing processes are being used to improve, deepen and assess learning in the clinical setting more rigorously by adding a new approach called *CbD Plus* ©.

10. <u>Learners</u> in the clinical setting (postgraduate doctors) reported positively about the new approaches to their education.

- They noted a positive change in the relationship with their teachers, improving communication in the clinical setting.
- They reported a deeper understanding of their own decision-making process, prompted by the way their practice was being probed differently.
- They were motivated by the new teaching processes and willingly engaged.

11. There is evidence that colleagues not on the course are becoming curious about and interested in the educational process taking place.

- Participants are being asked to give educational advice.
- Participants were asked to present their experience to outside bodies.

12. Small system changes are being introduced into practice.

- Some departments were able to make dedicated time for teaching in the clinical setting.
- Improvements are being planned, to make the teaching in specialty departments more effective.

13. The coming together of a knowledgeable faculty of educators representing a supportive critical mass is showing the potential to introduce wider educational change into the organization.

- Nine participants chose to continue their studies for a second year. (This is a high number for this type of course).
- Participants saw the group as a catalyst for sustainable change in the organization.

Conclusion

This first year of the programme has seen very positive changes in the views and teaching practice of the course participants. Both the structure and content of their teaching practice has changed (for the better) as they came to understand teaching as a practice in its own right. Their teaching has become more holistic, encompassing the wider professional, contextual and ethical issues of what being a doctor entails. These changes began surprisingly early in the first module and have become anchored in and part of participants everyday clinical practice.

The learners' comments endorsed and validated these changes. The shift from knowledge testing to a deeper exploration of the learners' thinking processes was clearly articulated by learners, as was the change in the relationship that this new teaching approach brought about.

Course participants began to seek solutions to the conflicting tensions identified earlier in the life of the course, and seemed less daunted by the difficulties of introducing changes to the organization. Organizational changes are more difficult to define at this early stage but small shifts have most definitely occurred.

The nine participants who are continuing their studies for a second year, feel that to continue to be part of a supportive group will engender further changes. These changes will not only benefit post-graduate education but also benefit the organization and in particular patient care.

Making quality education a key value of the organization could make the Countess of Chester Hospital an even more desirable Trust for attracting doctors as trainees as well as more permanent staff. This would underpin service provision and safer patient care.

Evaluator's Key Recommendations

1. **Continue and expand the teaching programme within the Countess of Chester Hospital Trust, to build a faculty and a critical mass of advanced clinical teachers to enable the introduction of enriched teaching processes aimed at both a better educational experience for all involved as well as a sound underpinning of safer patient care.**
2. **Continue to focus postgraduate teaching in the clinical setting working from practice to theory.**
3. **Recruit course participants from other organizations but recruit sufficient candidates from any one organization to effect meaningful change.**
4. **Encourage Clinical Reflective Writing (CRW) to secure visible evidence of learning and progression of learners.**
5. **Build on and develop existing assessment structures such as *CbD Plus*©.**
6. **Share the educational and organizational experience across the world of healthcare.**

MA (EPMP) Aims		QUOTES
Module One (Oct-Dec)	**Data collected**	**Participants as Teachers views**
To base teaching on good educational values and sound educational principles To develop an advanced expertise of teaching and assessing at postgraduate level in medical practice. To gain well-founded expertise in teaching and assessment in the clinical setting, and thus establish better-focused and more rigorous supervision of doctors	**Day one: Observations** **Questionnaire** **Observations** **Assignments** **Focus group 1**	**Beginnings** (baseline of understanding) "There is no time in the clinical setting to teach I just help solve problems." "My teaching is ad hoc and short term, unplanned and informed by clinical imperatives." **Transitions** "It opened my eyes to new fronts of education" "I have been training not educating." " I make the learner work rather than lead the session myself." "My questions (during a teaching session) did not really explore what the learner's thinking processes; were and what led him to propose the course of action in his answers."
Module Two (Jan-April)		**Learners' views**
To consider the role of clinical reasoning and professional judgement in medical practice. To enable teachers and learners in the clinical setting to make explicit their own clinical thinking and decision-making. To understand and use clinical reflective writing as a develop-mental tool and an assessment process to develop clinical thinking and professional judgment in junior doctors.	**Learner interviews** **Observations**	**Transitions** "It was interesting to debate the reasons behind my thinking and I changed my mind in what I wanted this case to be, by thinking it through." "Normally in Case based discussion you would be talking about what you did, whereas we were actually discussing what was going on in my head." "I think it was also more in depth and there was more basis to my thinking because I had written the initial draft."
Module Three (May-July)		**Participants as Teachers views**
To learn about the design and development of the formal curriculum on paper and become adept at maximising the learning potential inherent in the settings in which they teach. To learn to harness multi-professional collaboration for the support of medical education in a Health Care Trust.	**Focus group 2** **Observations** **Assignments**	**Endings and new Beginnings** " It has made a huge difference in the way I talk and think and deal with the learner." " Accepting that you can actually teach the ordinary is a big thing." "It makes it more holistic, not just teaching the clinical but also other aspects of the Invisibles. Making your teaching more 3D." "Every clinical situation is a teaching opportunity".

Perceived challenges to change		
Module Two (Jan-April)	**Data collected**	**Participants as Teachers' views**
Learning doctors spend only a short time with each supervisor, causing a lack of continuity	**Focus group 1**	*"Placements are too short, there is too much rotation, lots of exposure but less depth. Keeping in touch is difficult. "*
Time pressures of clinical practice leave limited space for in depth teaching.	**Assignment 1**	*Current medical education is heavily reliant on training, it is quick, with readily achieved goals which are easily assessed ... This produces doctors who can only perform basic, predictable tasks.*
Senior doctors have a sense of powerlessness in the face of organizational demands	**Focus group 1**	*"I can improve my teaching as an individual but I don't see as a hospital or department that we can make it better generally..."*
Senior doctors perceive that the organization places a low value on post graduate medical education		*" Doctors in training are seen as workhorses, they are there to improve the flow of patients through and payment by results"*
		" I can tell you I have been clinical director of xxx for 3 years and in any single management meeting in the xxxx division I cannot remember any discussion about education of trainees featured at all."
Perceived opportunities for change		
Module Three (May-July)		**Participants as Teachers' views 3 months later**
In time senior doctors began to see the possibilities of change.	**Focus group 3**	*What we have to do is to keep this cost neutral and you incorporate it into your greater practice for education actually to be seen as a seamless part of your practice."*
Systems could be used to advantage	**Observations**	*" I am excited that X has got management on side and we can actually get a hospital wide structure that is good and different and innovative and challenges young Doctors coming through. It it will make people come to Chester".*
These potential changes were seen to be able to make a difference	**Assignment**	*"Being part of something innovative, taking things forward with a good group..."*
The critical mass of the group is seen as supportive in introducing change		*"To go out and start new things there are times when it is not going to work and if you are still in this kind of circle it helps to keep going."*

Chapter 1 Introduction

1 Introduction

The MA in Education for Postgraduate Medical Practice (MA EPMP)is a three year master's programme focusing for the first two years on educational practice development at the Countess of Chester NHS Foundation Trust. The first module began in September 2010.

This report seeks to evaluate the impact of the first year of the course on participants and the organisation. To support the evaluation, evidence was gathered at three time stages: the start of the course, half way through, and at the end of the first year.

Ten senior medical staff at the Countess of Chester NHS Foundation Trust, and one senior nurse, whose role include the education of junior medical staff, were enrolled on the programme. They were drawn from the departments of Anaesthetics, Surgery, Emergency Medicine, Pathology and Maxillo-facial surgery.

Chapter 1 considers the background and context of the development of the MA in Education for Postgraduate Medical Practice

Chapter 2 looks at purpose and methodology of the evaluation project. The approach to this evaluation is formative and illuminative drawing on a number of different data sets to present different perspectives**.**

Chapters 3-5 set out and discuss the data collected throughout the year, through observations, questionnaires, interviews and assignments. The analysis and discussion is divided into three different sections, each dealing with one of the three time stages when data was collected. Chapter 3 deals with '**Beginnings**,' Chapter 4 addresses '**Transitions**' and Chapter 5 explores '**Endings and New Beginnings'.**

Chapter 6 concludes the evaluation and considers the strengths and limitations of the study and recommendations

The words **Participants** and **Teaching Doctors** in this report defines those senior clinicians who took part in the MA course.

The word **Learners** applies to all those doctors who work in the clinical areas as part of a postgraduate programme

1.1 The Background and Context

This innovative three year Masters in Education for Postgraduate Medical Practice is run jointly between the Medical Education Department of the Countess of Chester NHS Foundation Trust and the University of Chester which has validated the course. Set up by the Director of Medical Education at the Countess the course is unique in a number of ways.

The course design was a result of collaboration between a medical practitioner and an educationalist. This is an unusual combination of two professional practices collaborating to meet the educational demands of postgraduate medicine. The development of the ideas about what is needed in post-graduate medical education and consequently the design of the course is the result of a number of

years of joint research into medical education by these two peolpe.(de Cossart and Fish 2005; Fish and de Cossart 2007).

The Postgraduate Certificate (PGCert: year one of three in the Masters Programme) is taught face to face over a period of one year with several weeks between sessions. It consists of three modules of each of five days. The gaps between each day allows for the course material to be practised in the clinical setting. The course is aimed at senior clinicians, mainly consultants who are responsible for the postgraduate education of doctors in the Foundation Years and in their specialty development beyond this stage.

The course has drawn all participants from the same employing organisation: The Countess of Chester Hospital NHS Foundation Trust. Usually courses of this kind recruit from different locations when participants do not have the opportunity to return to practice and meet a group of colleagues who have undergone the same educational experience. This is important in terms of the impact the course may have on practice. (Condignly et al 2005; Hughes 2005).

Course participants, although not necessarily known to each other, at the start of the course share a common experience of the organisation. Several participants work in the same specialty. Recruitment through interview has meant that the group is well balanced in terms of experience and expertise with many senior and a few less-experienced doctors in the group, all of whom are either Consultants, Associate Specialists or Specialty Doctors.

The teaching practice of every participant was observed in the clinical setting by one educator three times during the first half of the year. The first observation took place before the beginning of the course, laying a foundation for progress and learning and aiming to capture evidence of where participants had started Teaching observations allow for immediate comment as well as written follow-up on teaching practice. The third observation was a summative of assessment and provided evidence of participants' actual teaching development.

The course focuses on medical education **in the clinical setting.** As learners' contact time with their teachers and supervisors in practice has been reduced it is imperative that medical educators gain a deeper understanding of educational values and principles to maximise the teaching and assessment opportunities that are part of the clinical setting. This will ease the burden of teachers in the clinical setting and will shape better teaching. For further details of the flavour of this course see Fish 2012.

The course philosophy (Figure I below) clearly sets out what the teaching team hoped to achieve.

For course aims please refer to Appendix 1

For course rationale refer to Appendix 2

Figure I Course Philosophy (from course documents, Module One 2010)

Right from the start we want to situate this course clearly at the cutting edge of **NEW Medical Education**. As an educational enterprise the course will start with your current practice and introduce into it **new ways of thinking and of being**, that will enable us all to challenge the status quo of what we call 'old medical education' (which sees teaching as 'telling', assessment as measurement and which is based on 'tips for teachers').

We believe that we can bring you new educational understandings that will help you develop – and where appropriate to change **the ways in which you work with your learners.** We believe that this will be more powerful given that you all work in the same institution.

We hope we can all work together to make the Countess of Chester NHS Foundation Trust a recognised centre of excellence in NEW medial education, to match the recognition it as been accorded in other areas.

Chapter 2 Methodology

2 Methodology

This evaluation takes a qualitative, illuminative approach, focusing on description and interpretation rather than measurement and predictions (Parlett and Hamilton 1967).

In illuminative evaluation, a programme is studied by qualitative methods to gain an in-depth understanding of its educational content and context. Parlett and Hamilton term this context the 'learning milieu'. It is the social-psychological and material environment in which students and teachers work together. They add that acknowledging the diversity and complexity of the learning milieu is essential for the serious study of educational programmes.

Illuminative evaluation takes a general research strategy and is both adaptable and eclectic. Parlett and Hamilton describe the three stages to illuminative evaluation:

- Observation
- Further inquiry
- Explanation and interpretation

Beginning with an extensive database the researcher systematically reduces the breadth of their enquiry to give more concentrated attention to the emerging issues. This progressive focusing permits unique and unpredicted phenomena to be given due weight.

2.1 Evaluation outline

This evaluation aims to trace the changes that occur in the teaching practice of the participants, and to note the challenges to change.

Evidence has been gathered through observations, informal discussions, questionnaires and interviews with course participants and their learners in clinical practice. A sample of the assignments produced by the participants, as well as the work done by their learners, has also been analysed. (See Appendix 3 for a few examples)

Data gathering started in September 2010 at the beginning of the course and continued throughout the year. (see Figure 1.1).

The evaluation set out to focus on three main areas: the participating teachers, their learners and the organisation. These areas are further detailed below.

2.1.1 Changes in individual participants' teaching practice

The aim was to explore changes in individual participants' teaching practice by:

1. Tracing the change or resistance to change in how teaching and learning in the clinical setting is viewed by the participants.

2. Observing and recording the changes (or not) in how [their] teaching in the clinical setting is conducted.

3. Exploring how assessment was viewed by the participants and how their views altered as the course progressed?

2.1.2 Learners' perceptions / other stakeholders' perceptions

Changes in teaching and learning in the clinical setting by those involved were explored keeping the following questions in mind:

- Do learners working with the participants perceive there to be any changes in the way educational activities are approached?
- How do learners view these changes?

2.1.3 System changes

System changes in how participants engaged in clinical teaching were explored with the following questions in mind:

- Does this group of professionals make use of the developing community of practice that might or might not emerge from participating in this course?
- Will systems within the organisation be improved or deteriorate as a result of the course?

2.2 Process of data collection

Data was gathered in a number of different ways:

1. Non-participant (the evaluator) observations of the group cohort during module days. These include informal discussion with the students and observations in the classroom setting.
2. A questionnaire offered to participants at the end of module one. This was separate from the routine evaluations carried out by the teaching team.
3. Focus group Interviews with the participants:
   Focus group One took place midway through the course.
   Focus group Two took place at the end of the year
4. Interviews with postgraduate learners in the clinical setting took place during and after module two.
5. Written material that might offer an insight into the learning process of the participants was explored. (Permission was requested an given for both of these processes)
6. Sampling of participants' assignments,
7. The writings of the learners in clinical practice (rainbow drafts).

Data was collected over a period of one year.
See Fig 1.1 for note the timeline of data collection.

Figure 1.1 Evaluation Timeline and Sampling strategy year one 2010 – 2011

	Module One				Module Two			Module Three			
	Introduction to post graduate medical education				How doctors think; teaching and assessing clinical reasoning			Medical curricula on paper and in action			
	Sep	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**
Observations	v v v	v v v				v v v				v v v	
Questionnaire				v v v							
Assignment one				v v v							
Focus group one						v v v					
Learners' interviews							v v v	v v v			
Assignment two								v v v			
Learners' *rainbow drafts*								v v v			
Focus group two										v v v	

Detail of evidence collected

Written evidence	• A sample of participants assignments 1 & 2 and their Clinical Reflective Writing (Rainbow drafts)
Formal Evaluation	• Interviews with learners; teaching staff; medical director. • Questionnaire to participants • Focus group for participants
Informal comments	• Observations in class • Informal discussions at break-time

2.4 The Evaluator's context

My background is as an educationalist. I have worked in health care education for twenty years and have been involved, in a teaching capacity, with a somewhat similar course to the one taking place in Chester. This affords me an understanding of the course its content and intentions.
My familiarity with the course might be seen as a bias to report in its favour. On the other hand, it has enabled me to focus on the participants, rather than be distracted by the content of the course. My role as an outside observer has helped me to retain an impartial viewpoint. The multiple perspectives of data collection, taped and written, allows for further independent scrutiny if necessary.

My interpretations of the data have been reviewed by participants at the draft stage, and they have been encouraged to make comments which have been incorporated into the report. The framework of the evaluation lies in collaboration and openness and hence asks for a qualitative, naturalistic approach rather than one based on numbers and measurements.

The aims of the course and intentions are clearly stated in the course outline. The evaluation has been carried out in the light of these aims and intentions, together with discussions and observations throughout the course. (See Appendix 1 for aims of the course)

2.5 Data Analysis

Observational and conversational Data was collected in diary form. This data was analysed in the light of the other data gathered during the project. Written data, questionnaires and interview data were analysed and categorised considering the questions and thematic framework set out at the beginning of the project. Data was gathered over a period of 11 months. The summary of the data presented here is divided into three main time sections.

1. Beginnings
2. Transitions
3. Endings and new Beginnings

Beginnings (Module One): this section captures the views on teaching and learning as expressed by the course participants at the beginning of the course. Data consisted of non-participant evaluator observation on day one and informal discussion with the group participants.

Transitions (Modules One and Two): this section presents evidence from data collected over the first seven months of the course September 2010 to March 2011. The data consisted of a focus interview with the participant group, a questionnaire to all individuals in the group, and evidence from assignment two which required participants to teach a learner in the clinical setting. Learners in the clinical setting were also interviewed and their perspective is included at this point.

Endings and New Beginnings (Module 3): this section presents evidence from the second part of the course - April 2011 to June 2011. Evidence was gathered through observations and informal discussion, a second focus group interview of all participants, and evidence from assignment three which asked for an analysis of a teaching session linked to the relevant curriculum.

Chapter 3 Beginnings

3 Beginnings

This section outlines briefly the views and understanding of teaching as expressed by the participants at the beginning of the course.

Data is drawn from:

- Observation and informal discussion (OS)
- Assignment One (A1)

3.1 Doctors/ Participants as Teachers

This section gives a views of teaching in the clinical setting at the beginning of the course providing a baseline snapshot of where participants started from, in terms of their understanding and practice of teaching in the clinical setting, as they began the course.

All participants had years of experience of clinical teaching. Some held specific educational positions in the organization such as college tutors and educational supervisors. All were responsible for teaching and supervising young doctors. Although enthusiastic and committed to teaching, their understanding of what teaching entailed was limited. Teaching was mostly viewed as training in skills and problem solving. It tended to be ad-hoc and, if prepared, focused on the teacher's presentation rather than developing the learner's understanding.

Participants' reasons for joining the course varied. For some it was a career choice informed by their interest in teaching, others felt dissatisfied with their teaching and wanted to improve how they carried out this part of their role. Some felt that eventually a formal qualification would be required to remain involved in teaching. This course would supply that, as well as maintaining and refreshing their interest in teaching. All were committed and interested in teaching and saw it as part their professional work.

Typical comments from the participants were:

> "*I teach 'skills' how to do it and then sign them off."*
>
> *"There is no time in the clinical setting to teach, I just help to solve problems."*
>
> *"My teaching is ad hoc and short term, minutes, really unplanned and informed by clinical imperatives."*

The following quotes from the participants' assignment One reinforce these views, albeit in a more reflective voice.

> *"I have never really thought about what makes a teacher, good or bad. There are many reasons for this lack of thought, not least that I have focused upon becoming a clinician." [A1]*

"Previously I was preoccupied with ensuring that handouts were clearly presented or that my PowerPoint animations worked seamlessly. I was wholly consumed by the presumption that quality of performance correlated directly with quality of teaching."

3.2 Summary

The views held by these participants are not unusual and reflect, in general, the views of many medical teachers. Doctors' understanding of teaching tends to be anchored in the traditional ideas of transmitting, and possibly testing, the knowledge of their postgraduate learners. Teaching is often seen as needing formal time and sometimes as separate from the clinical setting. Being firstly clinicians who teach, few had really explored the practice of teaching or thought about teaching as a discipline in its own right,

Chapter 4 Transitions

4 Transitions

The following section summarises data collected over the first seven months of the course, from September 2010 to March 2011.

The data was gathered from:

- A questionnaire to all individuals. [Q]
- A focus group Interview. [FG1]
- Evidence from the second module assignment [which required participants to teach a learner in the clinical setting]. [A2]
- Interviews with 6 learners who participated in the teaching session required for the assignment in module two. [LI] [A2]

Each set of data was analyzed separately and then amalgamated for the purposes of this report.

4.1 Doctors as Teachers

4.1.1 Individual changes: From training to education

All participants found that the course opened up for them, a new and different way of seeing teaching. All three sets of data, the questionnaire, the focus group interview and the reflections on the experience of teaching in the first two terms, revealed that participants had changed their understanding of teaching and learning at this point in the course. Attending the course was an illuminating experience and the teaching they consequently engaged in was both different and more challenging for them as teachers.

" It opened my mind to new fronts in education". [Q]

" I have been training in the past not educating". [Q]

" The course gave me a good deal more to think about than I anticipated". [OBS]

" I have realised that teaching is not about pure transmission of knowledge which is the way it usually is viewed but that there is more to it". [OBS]

The changes in teaching practice were numerous and interesting. Most participants talked about doing more preparation and follow up in their teaching.

"I now get the learner to do some pre-learning". [OBS]

" I make the learner work rather than lead the session myself (or am trying to)".

"... more learner involvement and responsibility". [OBS]

" I focus on learner's aims (not mine)." [ASS]

Some talked about personal insights in relation to their teaching practice and mentioned the idea of reflection-on their teaching.

" I am aware I like to give more help than is needed". [Q]

" I engage the learner more and reflect on my own teaching". [Q]

In the assignment participants were invited to reflect on their teaching and to critique their observed teaching. The insights again demonstrate a shift in the way they now viewed and carried out their teaching.

"My questions [during a teaching session] did not really explore what his thinking processes were and what had led him to propose the course of actions in his answers." [A1]

"I have also widened my thinking of slightly abstract topics, such as organisational or professional issues, helping develop the learner with all aspects of their education and development." [A1]

Some participants took the opportunity to extend their thinking to reflect on the system of medical education more generally and considering what they had learnt on the course. Others broadened out the content of what they were teaching to widen the education they offered the learners.

"Current medical education is very heavily reliant on training as it is quick, with readily achieved, clear goals which are easily assessed. This approach is desirable for Trusts and the government as it is measurable and therefore easily evidenced, whilst also being reproducible and cheap. These benefits are very short-sighted and produce doctors who can only perform basic, predictable, uncomplicated tasks, however when faced with something unexpected they do not have the capacity to reflect-in-action". [A2]

The changes highlighted here happened relatively quickly in the life of the course and were evident after the first module. These insights are very positive but do need to be sustained to become meaningful and embedded. During the focus group interview participants voiced a number of concerns. Foremost in their thoughts were the challenges that would threaten the implementation into practice of the understanding they had gained on the course.

4.1.2 Challenges to individual change: Time and the exigencies of clinical practice

All the participants agreed that they had altered their individual teaching practice. They had managed to implement, some, at least of the ideas that they had learnt. However, there was some doubt whether it would be possible to sustain these changes or to bring them to the organisation as a whole. The systems in place seemed, to the participants, to make the kind of meaningful teaching advocated on the course very difficult to do in real practice. Continuity and follow up, a keystone of good education, were hard to maintain due to the fragmentation of short-term placements. Learners spent less time in the clinical area and shift patterns made it difficult to meet with learners in a regular and consistent way.

"*I feel I could do things as an individual I feel on my lists I can do my best within the constraints of the system I work in. I can improve my teaching but I just don't see as a hospital or a department that we can make it better generally". [FG1]*

Some wondered whether the changes they made were sustainable beyond the demands of the course.

"*For me at the moment it seems very theoretical it seems like a big leap to actually implement what I am getting at is are we just doing it for the purposes of the course at the moment". [FG1]*

Even at an individual level some felt that it had become increasingly difficult to teach meaningfully as learners were only in the clinical area for short periods of time. This made the continuity and follow up, essential to learning, difficult.

"*More effort is required to keep in touch with learners and often you do not see the outcomes of your teaching, this means that there is less satisfaction in doing it and less motivation to do it. Meeting each student anew and having to sort out what they know, or do not know, is difficult and so time consuming". [FG1]*

"Placements are too short, there is too much rotation, lots of exposure but less depth." [FG1]

Participants at this stage of the course seemed to have altered their understanding of what teaching and learning was about and had brought these to their teaching practice. At the same time many felt that, even on an individual level, implementing these changes was difficult due to the challenges and external influences on their own practice, in the clinical setting.

4.2 The Organization

This section aims to offer the thoughts of participants about medical education at the Countess of Chester Hospital.

4.2.1 Potential Challenges to change: 'They do not value education'

Participants felt that the ability to make time for education was impeded by the service imperatives of the Trust. There was a strong sense that the Trust did not value postgraduate medical education and considered the trainees mainly as a workforce with little time for anything else.

"My concern would be that the organisation would have to support this and I don't think that it lies at the heart of this organisation that postgraduate medical education is as important as we are going away from these meetings consider it to be". [FG1]

"It is the service line managers they want more and more productivity they don't have any interest at all in teaching they don't care what the quality of the doctors is, all they care about is productivity". [FG1]

"Doctors in Training are seen as workhorses they are there to improve the flow of patients through and payment by results". [FG1]

Participants felt that the Trust placed low value on postgraduate education. Education rarely appeared on the meeting agendas for the Trust. Cost imperatives seemed to the participants to override other less pressing concerns such as education.

"*I can tell you I have been clinical director of xxx for 3 years now and in any single management meeting in the xxx division I cannot remember any discussion about education of trainees featured at all." [FG1]*

"*....the Trust relies on the income for a half day list is £ xxxx so it is a lot of lost income so they would say if you want to go teaching we want you to do a list at a different time. However much lip service is paid, the most important thing is the book balancing and after that achieving so called quality targets reducing waiting times. The fact that actually good education will help a lot of that is lost." [FG1]*

The participants did not seem to see themselves as part of the force that might bring education to the centre of concerns, however, some were beginning to formulate ideas about how things might be changed.

"The problem is dissemination.... is potentially a problem because I see that a culture where teaching or every opportunity in the clinical setting is a teaching opportunity has got to spread into the trust." [FG1]

Bringing postgraduate medical education to the meeting agendas of the Trust and discussing it in a different way was one suggestion. Pointing out the cost implications of not having students or making education the feature of attraction for doctors to apply to this Trust as a centre of excellence was another.

"*What we have to do is to keep this cost neutral and you incorporate it into your greater practice and for education actually to be seen as a seamless part of your practice. Not seen as something separate that can be hived off as a cost saving venture in order to increase productivity." [FG1]*

"....we can function without the other Drs we have on board here. (But) while they come primarily for educational purposes they also do fulfill an important function in the running of the hospital." [FG1]

4.3 Early Transitions

At this stage of the course, there were some definite changes in the understanding of teaching and learning. Individual practice had altered for most participants. However, some felt this was not yet fully anchored either in their minds or in their everyday practice. There were many challenges to implement these changes. These challenges were perceived to come from external forces and the participants felt they had little power to alter things.

These challenges included the tension between education time and service imperatives, and a system that participants felt neither understood nor valued postgraduate medical education focusing rather on performance, throughput and monetary targets.

However, there was a sense that some of these issues could be addressed by bringing education more to the forefront of strategic concerns, and to ally educational practice closely to clinical practice so that it was seen as an essential part of the fabric of quality care in the Trust rather than a luxury. These ideas were tentative and not clearly formulated at this stage.

4.4 Learners experiences

This section outlines the perspective of learners who took part in a Case based Discussion (CbD), which formed part of an assignment for the course participants. Module two of the course involves the course participants in learning and teaching a different way of approaching a Case based Discussion (CbD), termed ***CbD Plus©*** (www.ED4MEDPRAC.co.uk).

Participants learn to explore a case of their own using the eight different elements that form the 'Invisibles' of practice (Fish and de Cossart, 2007). As part of their assignment, they are then required to teach a learner at least two aspects of this way of exploring a clinical case. Learners have to produce a written account of this process called 'the rainbow draft [because different colours are used to highlight different elements explored in the case].

As part of the evaluation, some of the learners were asked for their views on how they experienced this process. Five out of a total of eleven learners who took part in this experience were interviewed. Sampling was largely pragmatic as many of the learners had left the Trust for other jobs, and others were not available at time of interviews. The learner's clinical reflective writing as part of this way of teaching ***CbD Plus©*** was also scrutinized and emerging ideas are described below.

From the information gathered during interview the following themes emerged:

- New versus old: the experience of the new ***CbD Plus©***
- The relationship (between teacher and learner): more of an equal discussion
- S/he knows what I did and now wants to know what I think.
- Writing time
- Usually if you ask a question you get an answer/Changes in teaching approaches

4.4.1 New versus old: The experience of the new *CbD Plus©*

All those learners interviewed found this new way of approaching CbD interesting and useful. Comments capturing their views included:

> *"It was really good we do **CbD Plus©** but I have never done it in that fashion before." [LI]*

> "*CbD varies depending on who you do them with I did one with him before but this was different. The first one focused on procedural issues, went through the background, history and management plan. This time we looked more on the thinking pathway which was good it got you thinking about why did I do that?" [LI]*

> *"It was interesting to debate the reasons behind that and I sort of changed my mind in what I wanted his case to be, by thinking it through and exploring it,...was really helpful." [LI]*

They felt it allowed for a much more in depth examination of the case. It dealt with the usual clinical issues, but also opened up aspects of the case that many had not previously considered but that were important to the case and its management.

> "*She sort of broke it down into different aspects different ways of looking at it. In hospital we tend to look at one thing and focus on mainly the clinical side of things and the other things tend to be forgotten about" [LI*]

"I think it was also more in depth and there was more basis to my thinking because had written the initial draft ..." [LI)

"It was interesting and you realise how you take it for granted a lot we do it is just subconscious and you don't talk about it [more senior Clinician/learner]." [LI]

Most noted that the focus of the case was less on 'what I did' but more on 'what my thinking and decision making' was. They realised that the supervisor was probing the 'why' of their action not just asking for the description of the actions taken.

"He looked more at the way I came to my decisions." [LI]

"*Normally in a Case based Discussion you would be talking about what you did whereas we were actually discussing what was going on in my head..."[LI]*

These perceptive comments made by learners point to and validate the participants' comments that they had made changes in the way they teach. The learners, possibly more than the teachers, realised and identified the differences in approach and were quick to point out where the different learning took place. They noted the usefulness of preparation and follow up as part of the teaching process. Learners seemed to have enjoyed the process and many used the writing that resulted from it in their appraisal and e portfolio as evidence of learning.

4.4.2 The relationship : More of an equal discussion

Learners noted that this way of being taught had altered the relationship between them and their supervisor. They felt more comfortable in what they described as a more open relationship. They noticed that they were generating some of the questions relating to the case whereas before the questions tended to be the premise of the supervisor. This more 'equal debate' allowed for an interactive relationship with the supervisor which extended to the ward environment where learners felt more able to question and enquire than they had before.

"We still had the basic discussion of the history and examination but we definitely explored the more ethical wider issues than we had done previously."

"...Previously more of a question and answer situation whereas now it was more of a discussion with more of an equal debate going on."

"And it wasn't just xxxxx asking questions it was ME bringing up questions!"

4.4.3 S/he knows what I did and now wants to know what I think.

Case based Discussion is a recorded assessment in the clinical setting, and thus an important marker as to the ability of the learner. It is a requirement that the learner chooses a case the supervisor is aware of and has in sight of the notes. In practice, it does not always work out quite like this.

The fact that the cases discussed on this occasion were cases which both learner and supervisor had worked on together was noted, by the learners, as an advantage. Some learners even suggested that, when the learner alone choose a case the supervisor is not fully familiar with, it allows the learner to avoid difficult issues! When both have been involved, learners noted that the probing was deeper. In the words of one learner:

" Whereas we were actually discussing what was going on in my head when I made this decision or that decision. I think it was actually he was more interested in what was underlying my decisions rather than what the decision was."

The more senior learners also felt that this deeper probing helped them to take their thinking further, forcing them to verbalise their decision making more clearly. It made them aware of what they did not know and what they may be asked to know in a future more senior role.

"He is trying to get into my head to see what am I thinking .... how would you manage this patient what would you do?? That is an important question I need to ask even in my position." [soon to be a consultant] otherwise I will just be providing a service."

4.4.4 Writing time to reflect

Most learners found the writing they were asked to do time consuming. Some felt skeptical initially and could not see how this would support their learning. Once they had completed it, however, they came to see the benefit and found it helped to consolidate and clarify their thinking. One learner who repeated the process twice found the writing became easier as she became more practiced at it. Some learners also felt that they had better recall of what they had learnt.

"It took a longer than I was expecting time to write about two and a half hours worth of writing but by having to do it I think I picked up a lot more points than I would have doing it off pat."

Some felt the reflective writing should be done more regularly and that the structure of the 'Invisibles' was helpful. They all felt that they could use the written part in their portfolio as evidence of what they had learnt.

"It is important that it is done regularly [the writing] If you do it once in 6 months maybe it will not be much good but if you do it once a month and talk about this case with the consultant I think it would be more useful. "

4.4.5 Changes in the teaching approach

Some learners, who had worked with the supervisor for only a very short time, were not able to comment on the changes in teaching approach. However, they did compare the experience to previous CbD with other supervisors. All felt that those teachers involved in this event were good teachers as they were interested and keen to teach. Those who knew the teachers noted changes, such as the way the supervisor asked questions and the purpose of the questions which moved away from the doing and description of the case to probing the thinking of the learner.

"Usually if you ask a question you get an answer, this time he made me do the thinking, and only then helped me."

4.5 Learners' *Clinical Reflective Writing* (rainbow drafts)

All eleven learners completed the rainbow drafts. This in itself is interesting as most teachers initially felt that learners would not engage or take part in the writing process.

All learners handed in several drafts as requested and some wrote additional pieces as they became interested in the process. Some learners were more engaged than others and the quality and quantity of the writing varies.

The evidence gained from the learners' reflective writing of the case [the rainbow draft] was useful in eliciting what the process of teaching yielded. This is found in the appendices of the module two assignment.

4.5.1 Complex decisions

All writing demonstrated the complexity of the decision making that junior doctors face in the clinical areas. The teaching and writing process, used on this course, allowed these decision-making processes to be made explicit. This helped learners to explore what the rationale for their decisions was and how they come to make them. Those learners interviewed commented favorably on this learning process.

4.5.2 Ethical dilemmas

The writing also highlighted the ethical dilemmas that many of the cases discussed raised for the young doctors. The ability to discuss these wider issues and not focus entirely on the clinical was a feature of the writing.

> *"Strangely quite interesting to actually write what was going on rather than just state medical facts!" [LI]*

4.5.3 The context of the patient case

The pressures of context not usually discussed in CbD were highlighted in the writing. The impact of context on the care of patients was illuminating for both learners and teachers. In the words of one teacher:

> "*It is the context of the case which justifies all subsequent decisions. Some things which are easy at midday on a Monday appear to be insurmountable problems at midnight on a Sunday."[A2]*

4.5.4 Evaluators comments

The importance of clinical reflection was an important element in the writing. Learners worked out in the writing some of the dilemmas they had faced in caring for patients. Reflection supported by additional learning helped them to stay rational about choices made in an often pressured and rapidly changing situation.

4.5 Summary

The learners' interviews seem to validate the changes what the participants themselves had voiced. What the learners also picked up and articulated was the change in focus about what was being asked and what was being learnt. Those learners who were interviewed were unanimously positive about this particular teaching session and saw it as beneficial.

It may be that their general endorsement was due to them not wanting to do their teacher a disservice. However, the nature of their comments and the insights into teaching they expressed remain valid evidence of the change in the teachers. Those who had not worked

with these teachers before were quick to note that the format of teaching was different from most of what they normally experienced in CbD. A most significant indicator that the learners engaged in the process came from the quality of Clinical Reflective Writing that they offered. Its depth and breadth of knowledge and understanding was a surprise to their teachers.

Chapter 5 Endings and New Beginnings

5 Endings and New Beginnings

This section explores the time span between April and July the last few months of the course. Data collected comes from a second Focus Group [FG2] that took place in June, Observations continued to the end of the course in July.

5.1 Doctors/Participants as Teachers

5.1.1 Like a light has been switched on

Surprisingly some participants reported that their own clinical practice had changed for the better as a result of the course. All participants acknowledged that the way they viewed and undertook teaching had changed irrevocably. Their teaching had moved from teacher presentation and clinical problem solving to a more considered educational practice that included preparation and follow up. They used every day events in clinical practice as a teaching opportunities and explored the reasoning behind their learners' decision making. They did reiterate some of the views they expressed earlier in the year relating to the difficulties of time pressures and the fragmentation of placements. However the new ways of teaching seemed much more part of their normal everyday practice. They had moved on to work in a different way as teachers in the clinical area. They now felt that they were 'Thinking like teachers' as well as 'thinking like clinicians'.

> *"Yes, enormous it has made an enormous difference I feel that there are times that the teaching I did before is still relevant but you feel so much more self conscious about it." [FG2]*

> *" Almost like a light has been switched on." [FG2]*

> *"It is a huge difference in the way I talk and think and deal with the learner." FG2]*

> *" I have gone from 'what are you doing'? To 'Why, Why, Why????" [FG2]*

5.1.2 Teaching the ordinary

Teaching the ordinary, the simple everyday things that normally were taken for granted had become a part of this new teaching approach. Teaching did not only take place when there was an interesting case to discuss. The every day practice presented many opportunities for teaching and extending the thinking of the learners.

> *"I think accepting that you can actually teach the ordinary is a big thing." [FG2]*

> *"Yes yes that ... Culturally it is when something big happens that you think about teaching but now I think about what to talk about what to do even if it is something simple. It is things that are simple and straight forward that have not been taught before." [FG2]*

> *"It makes you more holistic now you are not just teaching something clinical but also the other aspect of it like the Invisibles. Making your teaching a bit more 3 D." [FG2]*

The realization that ordinary practice, the taken for granted, also warrants thinking and reflection represents a change in the value given to teaching. It is also a step towards making teaching an integral

part of the daily clinical practice. This attitude to teaching allows for a broader spectrum of teaching in the clinical area and a more holistic approach that no longer focuses on the purely clinical aspects of care.

5.1.3 Using the System to support teaching

Many mentioned the change in the way they approach the teaching session, the preparation before, and the reflection required from the learner afterwards making the learner do the work. Others noted that they had incorporated teaching as an important element in their practice and used time differently.

> *"The system hasn't changed but I have worked out how to manipulate the system to make it a better teaching experience." [FG2]*

They made use of existing assessment systems to serve the teaching rather than the other way around.

> *" I also think making the CbD fit into what we are doing rather than the other way around. You have a teaching event and as a consequence you fill in a CbD rather than just being the focus for the teaching." [FG2]*

Overall participants were confident in the changes they had made to their teaching practice as a result of the course. These changes appeared to have become an integral part of their work pattern. There seemed to be less of the concern that these individual changes were not sustainable in practice and would disappear once the course assignments were completed which was a fear expressed some months earlier.

5.2 The Organization

5.2.1 Changes in the attitude of others and in the organization

Several reported the change of attitude of colleagues in their team. Initially cynical and dismissive, they were now becoming interested and curious about the changes they saw introduced.

> "*They are quite curious and want to know what you are doing." [FG2]*

Some participants were being asked for advice on teaching and some were requested to talk to outside visitors about their experience. Other big changes were mentioned, for example the discussion about appointing an education fellow in one of the departments. A discussion they felt would not have happened a year ago.

One clinical area where a number of participants had been on the course had negotiated an agreement for senior clinicians to spend an hour of non-clinical time with one of the junior staff doing an extended case based discussion. This negotiated change involving six senior clinicians was seen as a good starting point to put teaching at the heart of clinical practice. They were still cautious of success, however.

> *" This is a small change and we will need to see how it goes." [FG2]*

One participant made an important system change in being able to have a registrar released for an hour every week for a fixed teaching session. The motivation for this change seems to have been scrutiny from college about training issues.

Learners seemed more than willing and keen to participate in this new way of being taught, notably some who had not had the opportunity to take part in the rainbow draft had asked why they had not been 'chosen.' However one participant found colleagues were supportive but the learners were less willing to take on the changes and did not engage as well as was hoped.

There were few negative comments about what might be possible in terms of putting education at the heart of clinical practice. There remained quite a dose of skepticism regarding how possible all this might be given time and resource pressures in the NHS today.

Nevertheless, the support of the group and the community created by the group was seen as an important element in sustaining the move to change. This was also a motivator to progress to year two of the diploma.

> "*To go out and start new things and there are times when it is not going to work and you are still in this kind of circle.. I think if we all just stopped now we would just give up and be back where were." [FG2]*

5.2.2 Diploma days supporting change

All but three participants will be joining the diploma year. The motivations for this were diverse. Making use of what had been learnt and really embedding it in practice was a common reason for continuing with the course. Some felt that to be able to be part of a group of people with innovative ideas and taking these ideas forward together was an exciting prospect for the next year. Some saw the group as the support system to get things moving in practice needing like minded people to make changes and to be there when the going got difficult.

> *..."making use of this, it would be a waste of time doing this year and not using it." [FG2]*

> "*Being part of something innovative and modern taking things forward with a good group I think I would feel a bit sad to jump ship." [FG2]*

> *"...To go out and start new things and there are times when it is not going to work and if you are still in this kind of circle.. I think if we all just stopped now we would just give up and be back where we started from." [FG2]*

Others noted the changes in the organization and felt that this was a time where change may be possible. The way postgraduate education of doctors was viewed in the organization might make a difference to the wider reputation of the hospital and might support better recruitment and retention of staff. The fact that the Director of Medical Education had been able to gain the support of management was seen as a very positive move in this direction.

> *" I am excited that X has got management on side and we can actually get a hospital wide structure that is good and different and innovative and challenges young doctors coming through it will make people come to Chester. " [FG2]*

"....if we actually set up our training programs to the right sort of standard we will get more trainees and that is really important and that will make our rotas more sustainable and there is a lot of good will." [FG2]

Others agreeing with this view also appreciated the creation of a knowledgeable faculty and saw themselves a potential future educational leaders in their organization as well as nationally.

Three participants who did not wish to continue with the diploma and gave their reasons for this. One felt that, although they had gained a great deal personally from the course and had altered their teaching approach, the last module in particular had not helped them. They saw their specialty as not suffering from some of the issues that others experienced and brought them to the decision to leave now.

The others had taken on other management responsibilities that would leave them no time to continue studies at this level. They did however feel that, in their management role, they may be able to support educational changes.

Overall the feelings at the end of year one were positive and hopeful. The despondency voiced earlier in the course seemed to have diminished and both views and teaching practices had altered.

5.3 Summary

There has been a definite change in the way that participants approach and understand their teaching practice. The doubts and concerns raised earlier in the year seemed to have lessened and overall feelings were positive. Eight participants (joined by one other consultant) chose to pursue their studies for an additional year to diploma level. The motivation to continue was much informed by the hope that change could be brought about through the support and development of a knowledgeable faculty within the Countess of Chester Hospital.

Chapter 6 Conclusion

6. Conclusion

The aims of the course curriculum were to enhance the understanding of the course participants with respect to their practice of teaching. These have, at least in the short term, been achieved. Participants certainly altered their views and practice of teaching in the clinical setting. They have also started to integrate these new ways of thinking and teaching into their daily clinical practice.

Those learners interviewed expressed positive views on the new ways of teaching and learning they had been offered. They engaged willingly in the writing and found it helpful and were able to included it in their portfolio speciality. Their comments about the depth of probing, the focus on decision-making and the changes in the teacher-learner relationships confirm that changes in teaching style have taken place.

Organizationally it is too early to define lasting changes. The enthusiasm and energy created by the group of participants seems to have driven a number of small changes in teaching practice. The fact that participants were able to draw on support from each other has no doubt accelerated these small yet meaningful changes. It also appears that the agenda of education has risen in the Trust's priorities and the commitment of the Director of Medical Education has been instrumental in this shift of emphasis.

6.1 Strengths and Limitations of the study

This course is unusual (even unique) in that all the participants are located in the same organization. It is not possible to say whether similar results would have been achieved with participants from a number of different organizations.

This study is small scale and does not aim to prove cause and effect but rather aims to offer evidence drawn from the various data sets of changes in views and practice. The study has drawn on a number of different data sources and has been conducted over a twelve month period. It offers a number of snapshots which illustrate clear changes taking place over time.

The organizational changes are not yet embedded in practice and it is difficult to validate organizational changes from different perspectives, such as the teams in which the participants work. Equally longer term changes in the reputation of the Countess of Chester Hospital as an institution offering quality education for post graduate doctors will take some time to establish. The impact of a committed and creative DME cannot be underestimated in the changes occurring within the organization.

The evaluation will continue into the second year, and this further and longer-term review of the impact of the course may offer stronger and more lasting evidence to the changes achieved. It would be interesting to explore the changes identified here over a number of years and measure these against the survey evidence of learners and recruitment ease of post graduate doctors.

6.2 Evaluator's Key Recommendations

1. Continue and expand the teaching programme within the Countess of Chester Hospital Trust, to build a faculty and a critical mass of advanced clinical teachers to enable the introduction of enriched teaching processes aimed at both a better educational experience for all involved as well as a sound underpinning of safer patient care.

2. Continue to focus post-graduate teaching in the clinical setting working from practice to theory.

3. Recruit course participants from other organizations, but recruit sufficient candidates from any one organization to effect meaningful change.

4. Encourage Clinical Reflective Writing (CRW) to secure visible evidence of learning and progression of learners.

5. Build on and develop existing assessment structures such as ***CbD Plus©.***

6. Share the educational and organizational experience across the world of healthcare.

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Univeristy of Chester (2010-2011) MA in Education for Postgraduate Medical Practice: Programme Handbook.

www.ED4MEDPRAC.co.uk

Appendix 1

Course Rationale

There is increasing emphasis upon quality teaching in postgraduate Medicine. Although there is a long tradition of and requirement that consultants should supervise, teach and assess their juniors throughout their medical careers until they too reach consultant level, there has been little serious support and preparation, for this. However, now, Postgraduate Medical Education (PGME) in the United Kingdom has reached a defining moment in terms of the quality of its educational ideas and processes. Modernising Medical Careers (MMC), the government's project to reshape the medical profession in terms of education and career structure, was called for by the Chief Medical Officer in 2002 (DoH, 2002), heralded in a policy statement in 2003 (DoH, 2003) and piloted and revised between 2004 and 2006. Although MMC is now defunct, the regulations are still the basis for PGME for all doctors in England, Wales and Scotland. It places firmly in the clinical setting, the teaching and assessment of postgraduate doctors and requires the detailed recording of their progress (DoH, 2004; Academy of Medical Colleges, 2004; revised 2005). The General Medical Council (GMC) makes very clear demands that all doctors must possess formal qualifications in respect of teaching and assessment. (GMC 2006).

The programme has been designed by a combination of senior medical and surgical consultants (from primary and secondary care) together with senior educationists with specialisations in pedagogy for and curriculum development within, medical education. It has been developed to fit the needs of Medical and Surgical Consultants, senior Registrars and senior healthcare professionals who are mandated as part of their current posts to teach and assess junior doctors within Primary and Secondary care, as well as to the Trust Quality Agenda requirements.

The programme is based on the premise that those who teach need to develop a better understanding of their own clinical practice and values as well as an advanced understanding of education and their practice as teachers. In addition the course seeks to support the development of their role as educators by stimulating rigorous research into their practice as teachers using an appropriate range of evidence and clearly articulated educational principles.

The main focus of this programme is on teaching in the clinical setting, to maximise educational opportunities in the context of reduced working hours. It thus takes a new approach to medical education in that it enables course members to work at the cutting edge of educational development for postgraduate doctors and to understand the need to enrich the national medical curricula, rather than simply to work within them. It will thus enhance the university's reputation as a provider of innovative and forward thinking education. And in particular it will act as an important basis for the new developments in medical education that the university is currently putting in place.

University of Chester, 2010.

Appendix 2

AIMS AND STRUCTURE OF THE MA PROGRAMME
University of Chester (2010- 2011) MA in Education for Postgraduate Medical Practice.
Programme Hand book

The aims of the course are to promote a deep understanding of educational issues, principles and values and through this to enable doctors to become better teachers in the clinical setting by supporting them to:

- Develop an advanced expertise of teaching and assessing at postgraduate level in medical practice.
- Gain well-founded expertise in teaching and assessment at postgraduate level in medicine/surgery in the clinical setting, and thus establish better-focused and more rigorous supervision of doctors (whether as educational or clinical supervisors or in other key educational roles).
- Recognise the crucial role of language in education (talking/listening/reading and writing) and understand how the clinical teacher can utilise these to make the most of every learning opportunity for their juniors.
- Learn about the design and development of the formal curriculum on paper and become adept at maximising the learning potential inherent in the settings in which they teach.
- Recognise, make explicit and understand the tacit processes of clinical reasoning and professional judgement in medicine in their own practice, in order to share this and support the exploration by learners in their own practice.
- Develop their own reflective processes and the ability to produce clinical reflective writing, know how to teach this to others, and how to respond to it and use it educationally and in assessment.
- Learn to harness multi-professional collaboration for the support of medical education in a Health Care Trust.
- Develop the ability to research and thus continue to improve their practice as educators.

Course Structure

The programme will be offered on a modular basis. It is designed to meet the NHS Knowledge & Skills Framework (DH 2004) where applicable to the health and social care sector.

The programme contains six taught modules (20 credits per module). Students may exit with a post-graduate certificate following completion of three modules, a post-graduate diploma with the completion of 120 credits, with an option to achieve a further 60 credits through a dissertation module to complete the Masters' degree.

This MA will consist of 7 modules of study; with the exception of the dissertation which is worth 60 credits each module is worth 20 credits at master's level, amounting to 180 Masters level credits on completion of the programme. All modules have internal integrity and are linked together to form a coherent programme of learning.

The educational philosophy of the programme is that those who teach qualified doctors are both members of the medical profession and associate members of the teaching profession. Further, and central to this, is that they carry out these particular duties in the clinical setting.

The course is designed to fit the needs of practising medical and surgical consultants, senior registrars and senior healthcare professionals who teach in the clinical setting.

Course Modules

Postgraduate Certificate **Year 1**	**Module 1** Introduction to postgraduate medical education	**Module 2** How doctors think; teaching and assessing clinical reasoning.	**Module 3** Medical Curricula on paper and in action
Postgraduate Diploma **Year 2**	**Module 4** Practice development in postgraduate medical education	**Module 5** Language and literature for learning and teaching in clinical settings	**Module 6** Teacher as researcher in Postgraduate Medical Education
MA in Education **Year 3**	**Dissertation**		

Appendix 3

Extracts from course participants' assignment at the end of module One

Example 1 (course participants comments on his teaching prior to the course)

I thought I knew what they wanted to know and so selected something, which I can now see was unquestionably isolated from what they had learnt the day before and undoubtedly not followed-up at any stage after the session. My overall aims and intentions were short-sighted and did not reflect the needs of the learner. Then, having made little preparation, I socked it to them, the then preferred approach. By the end, through repetition, I had inculcated him into my way of thinking.

Overall - One component of good teaching I believe I have always held and will continue to throughout my journey through educational practice is that of being a good person. As Carr (2003) and Palmer Parker (1998) argue, being a good teacher is not about staging a polished performance, but more about being morally aware, with the utmost integrity and that is why it is important to address ontological issues such as who we are as people and as teachers.

My personal, short-term intention is to enhance my approach to stage 3: follow-up. On reflection of my second observation the main issue was the lack of specific follow-up tasks which I set (or did not set) for the learner. This is an equally important stage in the process as it allows the learner to take away the newly challenged and extended aspects of their learning, to consolidate, re-fashion and find meaning in it, and then reflect upon it to gain insight for future learning.

Example 2

At the beginning of the course I was observed as I taught in the clinical setting by a professional educationalist who made written, contemporaneous notes of the activity. This activity lasted 45 minutes and was followed by 60 minutes of discussion, feedback and reflection face to face with the educationalist.

This exercise was repeated at the end of the first module. Not only was the observed teaching an interesting, novel and enjoyable experience for me but the 2 episodes help to set a baseline and reference point that allowed me to track my progress in developing my new educational strategy.

When I compare the 2 observed teaching scenarios that I was involved with, they are certainly different and there is clear development in my approach. The first episode involved teaching a CT1 doctor at the bedside on the high dependency unit (HDU). I had selected the case – a patient who had fallen and sustain some significant chest wall injuries. I had 'set-up' the teaching session to impart what I considered important knowledge to my learner and chosen the case on that basis because I thought that the case illustrated some important points in the management of chest wall injuries. I suspect what had influenced me to set it up in this way was my own experience as a medical student and doctor in training. This was 'traditional' bed side teaching and I have used it unquestioningly. Looking at the written commentary of the observation I was pleased with some aspects. In particular, my observer commented that I had demonstrated the importance of listening skills when taking the handover from my nursing colleague and I hoped that my learner recognized this. Comparing the 2 teaching observations I can see that the first one lacked any preparation and follow-up. In addition it was primarily a monologue where, I as the teacher dominated the discussion. The style was very much me trying to impart gems of knowledge to the learner described by Brigley et al (2004) as Magpie learning.

Example 3

This became painfully apparent to me during the second observation in particular (appendix 1, p.33). I was happy to 'teach' on the hoof with whatever subject matter the learner brought with him, with no real preparation other than my greater experience. As a consequence I had not considered the educational intensions of the session or indeed his needs as a learner. When I consider the three essential elements of a true education event (preparation, dialogue and follow-up) I had failed on all accounts

If being observed has taught me anything at all, it has taught me that I need to be less self-centred. My obsession with promoting my specialty, something which I consider to be at the very heart of all intelligent medical practice, has only served to build barriers between learners and that knowledge which I hold in such high regard. I need to step back. I need to curb my sometimes unhelpful enthusiasm. I need to listen. Only then can I hope to reveal actual learning needs and prepare educational events to address those needs.

Learners' *Clinical Reflective Writing*

These short extracts show how getting a learner to write about context (see web site) deepens what they say about involvement in a case. The writing in black is what they first offered and the blue is after teaching about CRW.

Example 1

Five minutes after administering the diamorphine he was moved to the resuscitation room, however at that moment he had a cardiopulmonary arrest and CPR was commenced. I pulled the emergency buzzer, moved the bed into the CPR position and shouted for help. Help arrived within seconds in the form of my experienced colleague and ST3 registrar, another A+E sister plus a healthcare assistant.

At this point I felt personally responsible for his cardiac arrest, due to my administration of diamorphine, and as the arrest algorithm was commenced by my colleagues, I immediately sought naloxone reversal of the diamorphine. A cardiac arrest call was placed, requesting anaesthetic and senior medical support.

The first round of CPR consisted of chest compressions, attachment to monitoring, insertion of a wider bore cannula and ventilation via a bag valve mask. The cardiac monitoring showed pulseless electrical activity, therefore adrenaline was given intravenously. By the second round of CPR the anaesthetic middle grade had arrived, with the medical registrar and an SHO. I handed over the case to the anaesthetic registrar, giving details of all medications given, investigations performed and the patient's premorbid state.

Example 2

The CT scan of the brain showed a massive intracerebral bleed. The radiologist commented on the extensive nature of this bleed inside the brain. The images clearly showed a catastrophic event and we were quite sure that the outcome was likely to be poor [propositional knowledge].

In line with our standard practice [procedural knowledge] we arranged for the CT images to be electronically transmitted to our regional neurosurgical centre. [The decision to send the CT brain

images to Liverpool was a professional judgement]. This allowed us to obtain a specialist neurosurgical opinion within a short space of time.

I asked the locum 1st on-call anaesthetist to discuss the patient with the neurosurgical centre. The expert advice was unsurprising. The neurosurgeons were absolutely sure that the patient could not benefit from any sort of neurosurgical intervention and they recommended that patient should be managed conservatively in our hospital. They confirmed that the prognosis was likely to be extremely poor.

I already knew that there was no bed available in the ITU here. Based on this I decided to transfer the patient to the theatre recovery area where the life support treatments could be continued, pending a more definitive solution [Action based on professional judgement].

At this stage I thought that management would be straight forwards. In view of the devastating bleed inside the brain combined with deep coma my experience told [experiential knowledge] me that this was likely to be fatal and that palliative care would be appropriate. The initial discussion was with a senior specialist registrar in neurosurgery. As I have been involved with many such discussions I knew that learner doctors tend to be appropriately more cautious.

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