How do Departmental Lead Educators Review the Quality of Postgraduate Medical Education and Training Provided within Their departments?

Fatima El Bakri and Mark Rickenbach

Abstract

Introduction: Good quality postgraduate medical education and training is linked to good quality patient care. Departmental Lead Educators (DLEs) are identifiable in Hospitals/Trusts and a useful resource to review and develop quality of education and training at the local level. There is little published data on how they undertake this role. In this qualitative study we investigated the tools/approaches used by DLEs to review education and training quality.

Methods: We interviewed 12 DLEs about their role and analysed the scripts by using a standard content analysis approach.

Results: Thematic analysis of the responses revealed that the tools used by DLEs could be categorised under informal communications, formal meetings and surveys. The sources of information were mainly the trainees but DLEs also reported relying on fellow Trainers, Deanery feedback and GMC national annual survey. All the DLEs we interviewed used multiple tools to source feedback.

Conclusions: DLEs are a useful resource in the education and training quality review cycle. Their role should be formally recognised, included in job plans and supported by Deaneries and employing organisations. A synergistic local feedback system can be developed with local feedback led by the DLES and co-ordinated information on quality metrics by the Deanery.

Practice points

1. DLEs are a useful resource for local reviews of the quality of junior doctors education and training
2. The DLE role deserves formal recognition and support
3. DLEs use multiple tools to monitor the quality of education and training with a focus on trainees’ feedback and informal approaches
4. A synergistic feedback system can be developed with local DLE tools and Deanery feedback

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Article

Introduction

Monitoring the quality of postgraduate medical training and education has the potential to be a formative activity for Educators, and also for organisations. It contributes to organisational development and patient care (Francis 2013). Feedback helps Educators identify good practice as well as address any shortfalls in a timely manner before they impact adversely on the education and training of trainees and the quality of patient care.

Monitoring the quality of Postgraduate medical education and training locally is part of creating a supportive and effective learning environment. This can be done within the Department (one speciality in a Trust/Hospital) and usually requires an Educator to take an organisational Lead. These Educators are often the speciality college clinical tutor, but their roles outside the organisation do not always link to their role within a Department. The term “Departmental Lead Educator” or DLE has therefore been used in this study and one Deanery to describe this position. This study sets out to identify Departmental Lead Educators, ask them about their role and how they review the quality of education and training.

Monitoring the quality of education and training can be a difficult task for Educators due to time pressures, the nature of the working relationships and the perceived/actual hierarchical structures in clinical settings in the UK.

Educators can rely on the national General Medical Council (GMC) quality assurance system, and the annual trainees’ survey (GMC 2013). Trainees fill in a confidential electronic survey once a year to provide feedback on their training to the GMC. Website based reports on all responses are available to the postgraduate medical Deaneries, Trusts and Departments in the UK. Postgraduate Medical Deaneries usually summarise these reports for Educators and when shortfalls are detected, these are usually investigated and remedial action taken. However, this feedback takes time to filter down to DLEs and up until recently did not provide cumulative reports for Departments with less than three trainees, with the intention to protect confidentiality. It can also be difficult to interpret and relate the GMC national trainees’ survey feedback to specific aspects of training. These limitations create the need for local adjuvant systems for seeking feedback from trainees and Trainers.

There is little published qualitative research on how DLEs, training Programme Directors (TPDs), Directors of Medical Education (DMEs) or educational supervisors quality control postgraduate medical education and training in clinical settings. It is possible that such literature is scarce because this is a complex issue that is difficult to quantify and present in a way that is acceptable to the “orthodox” scientific culture of medical practice.

Seeking trainee feedback by the Lead Educators can improve quality of education and training and helps create an environment that values and nurtures trainees. It can promote trust and support enhanced learning opportunities for all involved (de Cossart and Fish 2005). The Academy of Medical Educators (2010) recommended this as one of the seven key activities that educational supervisors should undertake in order to establish and maintain an environment for learning. An excellent supervisor is expected to proactively seek the views of trainees on their experience and to establish a learning community within their Department.

In this study our aim was to gain an insight into the role of a Departmental Lead Educator and approaches they use to assess the quality of education and training within their Departments.

Methodology

This is a qualitative study with an interpretive methodological approach, seeking to understand and describe opinions and actions of Departmental Lead Educators that influence quality improvement for education and training. The qualitative approach is better suited to the nature of this enquiry than the quantitative approach because it allows for the complex bases of the opinions and actions to be explored and understood.
**Methods**

We choose individual telephone interviews as the research method for collecting data. As Siedman (1991) stated, an interview allows for opinions to be explored and clarified unlike questionnaires, surveys or observations. Telephone interviews allowed the busy clinicians involved to be more flexible over the arranging a mutually suitable time. It was felt that the loss of non-verbal clues was unlikely to negatively affect the quality of the data.

The Kvale and Brinkman (2009) seven stages for undertaking interview-based research were followed. The seven stages are: thematising, designing, interviewing, transcribing, analysing, verifying and reporting.

The Directors of Medical Education (DMEs) in Wessex were asked to provide contact details for DLEs in their Hospital or Community Trusts. There were different options available for stratification and selection for interview including speciality type, Trust size and number of trainees. The number of trainees was chosen because small specialities are often not captured by GMC surveys and also because there would be more issues surrounding confidentiality and quality of feedback. The influence of the number of trainees in a Department is likely to be greater than that of speciality type or Trust size, but the qualitative nature of the enquiry also allowed for this to be investigated.

The sample subgroups were Departments with less than three trainees, 3-5, 5-10, 10-15 and more than 15 trainees. Two to three DLEs were identified in each group and a total of 12 DLEs were interviewed by telephone and recorded. Each interview lasted between 17 and 26 minutes.

**Data analysis** was carried out using a standard thematic content analysis approach described by Gibson and Brown (2009) and Priest, Roberts and Woods (2002) as well as a standard visual word cloud analysis based on word frequencies. The themes were independently identified by the two authors and were similar, providing validation through triangulation. An additional validation approach through a review of published literature was used.

The participants’ informed consent was sought from the outset and the purpose of the enquiry and intended use of the data were explained to the participants beforehand. The Data gathered was anonymised before the analysis phase.

A formal ethical approval was not undertaken as this study was agreed as part of the process of enhancing quality improvement of the Wessex Deanery and it was part of the educational role of the researchers.

**Results**

All DMEs were able to identify DLEs in their Trusts and twelve of these DLEs were interviewed. There was a range in the number of trainees placed in their Departments varying from one to 22 trainees.

The role: The DLEs perceived their role as: being responsible for the day to day delivery of education and training, acting as a link between Departments, being Lead Educators within their organisations, acting as a Lead person for links with the Deanery and the Royal Colleges, and ensuring good quality education and training is provided. Examples from the responses include: “I’m the person to coordinate it all”, “setting up their rotations”, “I organise the on call rotas”. “responsible for the training that we give”, “responsible for a looking after role of the trainees, and making sure they have the best possible training experience that they can have”. “Making sure that we’re able to sign them off at the end, and that they’re able to complete their final period of training to a degree where they are well able to take up higher training or the next opportunity”, “Coordinate all the SHO weekly training programme, responsible for that making sure it ties in with the core curriculum”, “responsible for allocating an educational supervisor to all of them”,
As a **link**, DLEs work with trainees, educational supervisors, DMEs, and the medical education committee. Examples from the responses to support that include: “Dealing with any pastoral issues”, “to try to identify problem areas and deal with them basically”, “Me and the DME work very flexibly so there’s a lot of informality”; “I sit on the Education Committee”, “the GMC or the intra Hospital reports, or the ARCP feedback”.

With regard to **Deanery** activities, DLEs participate in Speciality Training Committee and annual review of trainee progression meetings, recruitment interviews, and annual Deanery report.

Examples from the responses to support these themes were: "I liaise both at Deanery level from an FT training point of view, and also with the GP scheme”, “I’ve been involved in interviewing for recruitment of FY docs for replacements”, “I have to go to the Foundation Programme Steering Group Meeting”, “I submit a report every year. We report back to the Deanery”, “I attend all the various speciality training committee meetings”, “We have the three ARCP’s a year”, “I see the junior doctors at the appropriate times for ARCP paperwork, and attend ARCP interviews”.

DLEs mentioned **feedback** as part of their role. Examples from responses are: “I listen to their feedback, I’m really interested in the feedback they give me around the clinical supervision they receive”, “trying to get feedback”, “I ensure that good quality training is provided locally. We get good feedback from GMC survey”; “making sure we get the feedback about what the post was like for the trainees”.

Some DLEs said that getting feedback is done by GMC and the TPD and they then get it and act on any shortfalls e.g. “assessing the quality of training in speciality training is done through TPD and he feeds back and we work on any problems identified”.

**Assessment of quality**: ensuring good quality of training and education is integral to all the activities mentioned by the DLEs we interviewed hence the reference to the role as a whole above. However, DLEs reported using multiple approaches to specifically seek feedback from trainees and Trainers on the quality of training and education with reliance on opportunities for direct contact with both.

The thematic analysis of the responses is summarised in (Table 1) under three major themes: **Informal, Meetings and Surveys**. All the DLEs we interviewed reported using multiple tools/approaches and none relied on a single system or approach. The informal communication approach with trainees and Trainers was the strongest theme followed by meetings and education forums. Mock ARCPs and Log book reviews were reported as a helpful gauge of the quality of supervision and documentation.

Analysis of the **sources of information** based on the DLE responses highlighted reliance on direct feedback from the trainees, and feedback collected around the Annual Review of Competence Progression (ARCP) meetings. These were usually in the form of a questionnaire or direct questions at the end of the ARCP review. Feedback from Fellow Trainers was also mentioned.

The annual GMC survey was a source of information for some DLEs while others reported perceiving it as not specific enough for their own Departments. Some stated it was more useful for DMEs and organisations above their Department because it can provide an overview. DLEs were concerned about the quality of the feedback from the GMC survey when there small numbers were involved or if there is low return rate. Some DLEs preferred their own questionnaires/surveys, in both electronic and paper formats. Overall a local questionnaire was reported as more useful than the GMC survey.

Three DLEs mentioned the success rate of their trainees when interviewed for subsequent posts as one of their quality assessment tools. Others mentioned success in getting a post when they leave e.g. “we record and are aware of where our trainees go when they finish”, “it’s competitive to get to our Hospital which means the training is good”, “I think sometimes the trainees do vote with their feet”.
Challenges reported by DLEs: The DLEs we interviewed mentioned some challenges they faced in relation to their roles in general and also when seeking feedback from trainees. Examples of challenges relating to feedback include: “Getting reliable feedback when the number of trainees that go through the Department is small”, “The Trainers do not have a consensus opinion on what should constitute good training”, “Making things too formal sometimes doesn’t work”, “Trainees may feel a bit inhibited when feeding back to DLE about other supervisors”, “Interviews or asking about quality can be seen as an invitation to complain”, “Can involve more form filling in, more reports that people have no time to look at”, “GMC quality reports are unreliable when the numbers are so small yet they make big statistical statements”, “the GMC Survey is not very specific sometimes, so it can be difficult to hone in on what the problem might be”, “Low response to feedback questionnaire/surveys and confidentiality issues”, “There is no clear mechanism for collecting reliable feedback locally”.

Other challenges mentioned by the DLEs relate to the role itself e.g. “Most of these extracurricular jobs are almost being done on goodwill”, “It is a challenge trying to keep the educational supervisor workforce keen because of time pressures and lack of recognition”, “There isn’t a standard for local educational programmes, which is what makes it extremely difficult to quantify or qualify even the kind of training and education that trainees have received”.

Discussion

The roles of Educational and named Clinical supervisors are being formally recognised in the UK by the GMC (GMC 2012), however, a Departmental Lead Educator (DLE) role has not been included. Whatever title is applied to this role these Lead Educators were identifiable in each Department we studied. They do undertake a valuable role in co-ordinating educational and training activities within their Departments and sometimes undertake multiple educational roles as supervisors and college tutors. Their role needs recognition especially in relation to quality control with their Departments. If strengthened further their role could help ensure a nurturing learning environment for trainees and Trainers alike. It is likely that Departments with an absence of organisational structure and no clear Lead Educator are more likely to have quality issues with education and training which are not being addressed. This is an area for future research.

The data collection in this study was helped by the committed engagement of the Educators allowing the enquiry to reach saturation in response. The selection of Educators for interview was not randomised and it is possible that the respondents were biased and more enthusiastic. However the aim was to generate options rather than measure the frequency of each approach, so the study methods met the objectives set.

This study provides an insight into how DLEs undertake local quality control processes and the challenges they face. DLEs use multiple tools to gather feedback, which include both informal and formal processes. There was some variation in the preferred methods but, most were comfortable with a local informal approach being backed up by formal surveys and visits.

There was a reliance on trainee feedback which opens up opportunities for strengthening this approach further. Educators could encourage an environment that allows for honest and productive feedback that leads to continuous improvements and development. There is potential for further dissemination and sharing of experience between Educators and Departments with different approaches.

Engaging the trainees in feedback not only helps make them feel valued and respected, it also allows them to recognise the complexities involved in quality matters. As Pring (2000) said “the first step in students struggle to make sense is to become aware that their views are not as straightforward as they think”.

DLEs do use more informal methods during regular work contact. Reticence and inhibition as well as confidentiality pose challenges to getting effective feedback that relates to the actual issues. For DLEs,
external review, such as visits and national surveys can be helpful in overcoming potential reluctance of the trainees to engage in feedback.

Conclusions:

There is a dedicated group of Lead Educators who support education and training in their Departments and can provide a useful resource for quality monitoring at the local level. Departmental Lead Educators is the term that has been applied to this role, which could be more clearly defined and supported both at local and national levels. This study provided an insight into how DLEs assess education and training quality by using multiple tools, including informal, formal meetings and surveys.

There is a need for a wider dialogue and guidance on collating feedback on the quality of education and training at the level of the Department in each hospital/community Trust.
Notes on Contributors:

- **Dr Fatima El Bakri**: is a Consultant Microbiologist and the Infection training programme Director at Wessex Deanery
- **Professor Mark Rickenbach**: is the Associate Postgraduate Dean for Quality at Wessex Deanery. Visiting Professor at Winchester University and a General Practice Appraiser and Trainer

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Declaration of Interest: The authors are involved in the quality review of education in this Deanery
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