IN BRIEF

- An action research methodology using focus groups in a staged process encourages open and shared dialogue based on trust and confidentiality and is a commendable instrument to promote change.
- The change is more likely to succeed because it is: a)relevant and practice-based rather than theoretical and b) grass roots rather than hierarchical thus promoting ownership.
- The methodology is transferable but does require the commitment of time and qualitative research expertise.

A novel approach to promoting change in SHO training in a dental teaching hospital

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An action research study using a series of staged focus groups with senior house officers (SHOs) and educational supervisors (ES) was used to identify the perceptions of the strengths and challenges in the SHO training programme and to indicate areas for improvement.

The basic findings were not entirely surprising, with SHOs wanting more detailed feedback from educational supervisors and educational supervisors challenged (by time constraints and competing clinical and research responsibilities) in meeting the expectations of the SHOs. However the novel approach of using staged focus groups enhanced the educational supervisors' perception of the SHOs' view of their training and the SHOs' perception of the challenges faced by educational supervisors. Thus a culture of dialogue was created which supported change and innovation.

This process was able to directly inform and influence the development of a new induction programme for SHOs and provide valuable insight into the use of the portfolio of learning and the provision of study opportunities. These findings may only be of local interest, however the method employed can be transferred to other contexts to support a grass roots approach to change. Indeed, since this study has been completed, the method has been replicated in a medical setting.[1]

The Standing Committee on Postgraduate Medical and Dental Education's (SCOPME) investigation of the early years of postgraduate dental training in England identified that training for SHOs is changing significantly.[2] For example, there is greater emphasis on more chair-side teaching, a formal system of appraisal, and the use of new learning tools such as logbooks and portfolios. Such change has made demands of both SHOs and their consultant educational supervisors and stretched the finite resources of the training environment. The SCOPME report also identified several unresolved questions including 'whether the service demands of the hospital make it more difficult for SHOs' training needs to be met'. The experience of one of the authors (JDC) is that SHOs have an incomplete understanding of the service and other demands on their consultant educational supervisors and both parties, to a varying extent, find it difficult to assimilate the newer learning methods in the context of their day-to-day work. The management of change within the postgraduate dental training environment is, therefore, a very real and current challenge.

When the wind blows, some build walls, others build windmills.

The possible reactions to change are illustrated in a quote from Hawkins and Winter.[3] 'When the wind blows, some build walls, others build windmills.' If change is to be successful – windmills rather than walls must be built – in other words those involved need to be open to, and supportive of, the proposed change. The first challenge of managing change, then, is to establish the need for, or benefit to be gained from, the change and to involve all whom it will affect.[4] It was therefore important for SHOs and consultant educational supervisors to openly discuss the good and problematic aspects of the SHO training programme and together consider the changes which could be made to maximise the potential of available training opportunities. The aims were twofold:

- To focus on the perception of the existing SHO training including the use of the portfolio, and to share the different perceptions held by educational supervisors and SHOs.

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- To allow the groups to suggest changes to the training programme as separate groups of educational supervisors and SHOs and as a mixed group of both educational supervisors and SHOs together.

METHOD

An action research methodology was used involving the systematic collection, organization and interpretation of relevant and valid textual material derived from talk. Although still regarded with scepticism by some in the medical community it is nevertheless a systematic and reflective process, which can be contested and shared.[5]

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Each of the focus groups and feedback meetings was led by one of the authors (MT) who audio taped, transcribed, read and re-read the transcript. Her involvement was primarily to seek clarification if required and to encourage all members of the group to participate equally. This author had not been involved in the design or implementation of the SHO training programme but had previous experience of educational evaluation and had also been involved in portfolio research in a primary care setting.[6]

All the educational supervisors (n=9) and all the SHOs (n=16) were invited to take part in two rounds of focus groups. The focus groups were unstructured apart from two broad questions designed to promote discussion. The first round, which comprised five groups – three groups of SHOs and two groups of educational supervisors – took place in January and February 1999 approximately six months after the SHOs were appointed. All participants received advance notice of the two broad questions on which discussion would be based:

- What is going well?
- What are the problems in the current training programme?

Following the first round, themes were identified (Appendix 1) using an editorial style, which makes observations in the margins of texts. These are organized into categories or codes, which are then re-read for further interpretation.[7] The categories that emerged from the texts were returned to the focus groups and the hospital dental services tutor (JDC) for comment. Ambiguities were clarified and improvements suggested. As a final stage in the process all the data was re-interrogated for inconsistencies and tensions. This triangulation process of both data and investigator is required to ensure that the information collected is of the highest quality.[8] This process informed the development of a questionnaire, based on the themes identified, which was administered to all participants at the beginning of the second round of focus groups. As a device it served no statistically useful purpose due to the small sample size. However, the questionnaire did:

- integrate the themes developed by each focus group, thus making them available in an easy, summarised format to each participant.
- act as an interactive way for busy educational supervisors and SHOs who had not read the circulated summaries of the focus groups to update themselves on focus group data, and thus be prepared for the next stage of the discussion.
- act as a trigger to the development of new ideas and avoid repetition of the original themes.

"I don't think that people tell you enough when you are doing something right. When you do something badly it really sticks"

- serve as a mechanism to indicate trends in the relative importance of issues as perceived by educational supervisors and SHOs.

This second round of focus groups took place in April and May. They comprised three groups – one of SHOs, one of educational supervisors and one mixed group. All groups received advance notice of the two broad questions, which would be discussed in the focus group:

- What changes can be made to the SHO training programme?
- What educational opportunities could be developed?

The discussion in these focus groups was recorded and analysed in the same way as described for the first round and a feedback meeting was arranged with the educational supervisors and the hospital dental services tutor (JDC) one month later to agree and plan changes.

RESULTS

One educational supervisor and one SHO were unable to take part because of other commitments at the time the focus groups were scheduled, leaving 8 educational supervisors and 15 SHOs.

The first round comprised two groups of educational supervisors (n=5 and n=3) and three groups of SHOs (n= 7, n=5 and n=3). Two members of the original groups were unable to take part in this second stage and therefore the second round comprised, one mixed group (n=10) of five SHOs and five educational supervisors, an SHO group (n=10) and an educational supervisors group (n=3).

1 First round – 'What is going well? '

1.1 SHOs' views

SHOs appreciated the opportunities that their posts afforded to acquire new, and enhance existing skills ie '*getting the opportunity to do things that hadn't been done as an undergraduate, for example doing special bridge work …*'

All posts were felt to give experience and support that would not be available in general practice– '*Out on your own in general practice you are more rushed and there is more standard work.*'

Time for examination preparation and opportunities to gain experience in areas of interest were also seen as important.

1.2 Educational supervisors' views

SHO training was perceived to have improved dramatically over recent years. The SHOs were seen as '*stimulating*' and '*stretching*' to work with. However the frustration for educational supervisors was that they could see how much better the training could be if they had more time to devote to SHO training.

2 First round –'What are the problems in current training? '

2.1 SHOs' views

The availability of clinical experience was seen by some to be restricted. '*At times you do get the feeling that you are being used as a dog's body...we are palmed off with the slightly less exotic things.*' There was disappointment that a more structured learning contract had not been made. *'I thought that I'd say "I haven't done many bridges and I could do some more" and I thought they would have sat down and said "By the end of the*

contract you will have done four"...and then they would chart it...but that hasn't happened.'

A need for more constructive feedback from some educational supervisors was expressed. In the absence of feedback, doubts were raised about personal competence. *'I would have appreciated more feedback from the people that you are working with on how you are doing...I don't think that people tell you enough when you are doing something right. When you do something badly it really sticks and you think "Oh no I am really bad." '*

There was a feeling that the SHOs could not influence the frequency with which their educational supervisor saw them for formal appraisals (this contrasts with the educational supervisors' perception that some SHOs were difficult to meet!). Limited clinical supervision was considered to compromise both the learning opportunities available and the quality of patient care. It was also felt that some educational supervisors were not aware of the learning needs that could be met in the clinic.

Some SHOs did not see the logbook/portfolio (in which they were encouraged to record and reflect on their practice and plan further learning, weekly for the first three months and monthly thereafter) as useful other than when the post was new. It was felt that unless the diaries were formally recognised they might not be of interest to other hospitals or dental schools when applying for jobs. *'Different people learn in different ways. Nobody has wanted to see it (the diary). Nobody wants to know where it is and it just got put away.'*

SHOs saw preparation for Membership of the Faculty of Dental Surgery (MFDS) examination as important and were motivated to study but expressed the need to have leisure time as well. They felt that the introduction of MFDS, with its three parts, had put increasing pressure on their time and their finances. They were also concerned that there will be many more people with MFDS than there are Specialist Registrar (SpR) posts available.

2.2 Educational supervisors' views

The educational supervisors felt the SHOs were on a steep learning curve. For some the learning curve was steepest in the first two weeks, for others it continued steeply over the first six months. *'They don't know when they are doing quite well because they are so critical of what they are doing or they feel so much responsibility but are still making the right decisions. They may carry that feeling for a long time.'*

The most challenging SHOs, however, were the few who did not realise that they were making mistakes and thought they were '*the bee's knees*'.

'One-to-one' supervision of clinical sessions by the educational supervisor (in Dundee the majority are academics) was seen as important but not always possible, because of their administrative and academic duties. As a result the SHOs were *'sometimes thrown in a little earlier than you would like them to be'* and *'...do procedures before they are really confident and competent with the basics'*. More consultants and sub-consultant specialist staff would allow better supervision and service delivery, but would require additional funding.

"They don't know when they are doing quite well because they are so critical of what they are doing"

The logistics and practicalities of rotations are challenging and the ideal is not always possible. For example, the introduction of the General Professional Training Scheme[9] resulted in some SHOs working in a discipline they would perhaps have preferred not to. This could reduce their initial confidence but, the educational supervisors thought, would benefit them in the long term.

The educational supervisors thought that it was sometimes difficult through constraints on time to get feedback from other members of staff, such as lecturers and career grade NHS staff involved in the supervision of the SHOs. This, they felt, compromised the appraisal of the SHOs' progress.

Educational supervisors recognised that for SHOs there is a potential conflict between clinical practice and the need to develop skills such as critical reading and knowledge in the basic sciences.

A logbook/portfolio diary was perceived as useful, in spite of the possibility that it could be completed retrospectively and fictionally. However, it was thought that while some found it useful, others did not. *'Twenty per cent really take to it, 60% come to see its value and 20% will never find it of value.'*

The educational supervisors were concerned that many SHOs with MFDS would not be successful in obtaining the few SpR posts available and that there would be increasing pressure on them to obtain additional qualifications and/or publications. There are, however, few posts available for them while they do this.

3 Second round: identification of key areas where change was needed

Interestingly the mixed group of SHOs and educational supervisors spent most time continuing their discussion about the successes and challenges of the SHO training programme before considering the changes that could be made to the programme. The other two groups shared in more detail their perceptions of the written feedback from the previous focus groups prior to discussion about changes that might be made.

In response to the feedback from the first round of focus groups, the educational supervisors tended not to be surprised by the SHOs' comments. They acknowledged that the SHOs had high expectations of the training programme but felt that some were unrealistic. However, they were keen to avoid cynicism and to take advantage of the enthusiasm behind these high expectations.

For the SHO group, one comment made by the educational supervisors (in the focus group feedback) regarding some SHOs who *'thought they were the bee's knees'*, triggered a lengthy debate about the importance of relevant, and therefore effective feedback.

3.1 SHOs' views

The SHOs identified the need for more effective feedback on their clinical performance.

They were keen that feedback was immediate, genuine, tactful, *'not flowery'*, direct, confidential and honest. *'Some people say it is brilliant all the time and then go behind your back and then possibly say it is not.'*

The SHOs also described the manner in which feedback was most effective. *'Some people can do it, they can come in, take things out of your hands and say this is dreadful while others can say "Well I think if you maybe just did..., that might improve it." It's definitely a technique that I think some people have and some people don't.'*

The opportunity to watch others in action was seen as a valuable contribution to learning. *'Even with a crown prep you can watch somebody do it who is absolutely brilliant and say "Oh he's done it like that, I'll do that next time."'* This not only included the opportunity to observe technical procedures, however, but also how to approach sensitive issues, such as explaining to a patient that they have cancer. The SHOs recognised, however, the logistical difficulties of arranging time to benefit from such opportunities.

Some SHOs expressed a need for both clinical and 'phantom head' training in advanced techniques.

SHOs sometimes felt pressurised, when their consultant was unavailable, to proceed outside their area of competence when faced with a patient requiring treatment beyond their skills. *'Sometimes you feel...not inadequate but you need a second opinion. You need confirmation of the treatment plan and you come away from the patient feeling "Have I made things worse?" '*

There were a variety of opinions about the usefulness of the logbook/portfolio and a suggestion that it should be revised to better meet the needs of dental SHOs who are *'not like doctors for whom the psychosocial aspects of a reflective journal are relevant.'*

"It's no good for them to have everything handed on a plate...They need to learn to think and do things for themselves"

It was thought that information from SHOs currently in post would be useful to assist new SHOs in their induction process. This could be text- or audio-based and would include *'things I found useful when I began this post'.*

3.2 Educational supervisors' views

Educational supervisors felt it would be ideal, but not practical, for all of them to be involved in the selection of SHOs. *'It would be interesting to see at interview what their expectations are, why are they applying for these posts and how it is going to fit in with what they've done previously.'*

The first meeting between the educational supervisor and the SHO was seen as important in order to clarify the SHO's expectations. Making better use of this meeting and developing its value to the SHO, may overcome some of the problems expressed by the SHOs. The educational supervisors also felt that the potential value of appraisal meetings was not realised but had no immediate suggestions as to how this experience could be improved. *'I don't know that we are quite getting it right in selling it to them, that it (appraisal) is for them...I think there is a fear that it is an assessment rather than an appraisal meeting.'*

In addition to clarifying expectations of the programme, the SHOs needed to be helped in their transition from trainer-directed to self-directed learning. The educational supervisors thought that SHOs perhaps misunderstood the concept of supervision. *'It's no good for them to have everything handed on a plate...They need to learn to think and do things for themselves and accept some measure of responsibility.'* The educational supervisors did not think they should be 'chasing' SHOs, rather, they should use a gap in their knowledge as a trigger to new learning.

The value of learning around both routine and advanced clinical procedures was thought to be important. *'I think there is a place for routine procedures where they are going out of their comfort zone a bit and where they need a bit more supervision.'*

Concern was expressed that the driving force for learning was, the acquisition of the MFDS and that *'learning was driven by exams, rather than learning for learning's sake'.* However, it was acknowledged that this was the result of the SHOs 'playing safe', allowing them to have a flexible career pathway.

It was recognised that SHOs coming from vocational training would have experienced one-to-one teaching, which it was felt the dental hospital and school could not provide. As a result, some SHOs still perceived learning as trainer rather than learner driven. This seemed a key challenge.

There is a need to explain the objectives of the training to the SHOs in terms of how they might direct their learning to achieve them. It was suggested that this could best be achieved at an 'educational induction' meeting, attended by trainers and trainees, at which the appraisal system and learning opportunities would be presented in an interactive format.

3.3 Areas for change

The following were identified as the main changes which should be made to the SHO training programme:

- the introduction of more effective feedback mechanisms for SHOs.
- negotiation of a structured learning plan between SHO and educational supervisor, clarifying the expectations of both parties.
- increased help for SHOs with the transition from trainer-driven to self-directed learning.
- increased opportunities to observe experienced clinicians and for training in advanced techniques.
- design of a more flexible and relevant logbook/ portfolio.
- development of an educational induction programme using information from previous SHOs' experiences.
- communication of the aims of the SHO training programme to all hospital staff.
- strengthen the links between learning from clinical experience and study for the MFDS.

4 The next stage

Having identified areas for change, the next stage was to agree strategies for their implementation and this is where the methodology demonstrates its value. Educational change may often be made as a result of external demands such as statutory bodies, specific interests of dental educators or competing demands on educational supervisors or SHOs. In this case change emanated from the groups upon whom the change would have most impact. Having been derived through a grass roots approach it is therefore more likely that the implementation and adoption of change will be more successful.

DISCUSSION

The results of this qualitative study (in terms of the problems perceived by educational supervisors and SHOs and the strategies they suggested to effect change) are context specific and not generalisable to other dental hospitals. However it is the methodology that is transferable and we believe has the potential to significantly influence the quality of SHO training in other settings. Using focus groups in educational research is not a new approach, however the use of staged focus groups with consistent membership as a method for identifying and implementing change has not been reported previously.

This model has the following significant benefits:

- open and shared dialogue between educational supervisors and SHOs based on trust and confidentiality.
- relevant and practice-based rather than based on theoretical content.
- a grass roots rather than hierarchical approach to change, which promotes ownership.

Feedback was open and the ideas expressed were clarified and shared. Both groups, (SHOs and educational supervisors) were pragmatic and creative when given the opportunity to share their thoughts about how SHO training could be developed. Had the ideas for change been based on the opinion of just one of these groups, for example educational supervisors alone or SHOs alone, or even based on questionnaire responses it is unlikely that the data would have been as rich and hence the information as relevant

The SHOs were happy to be involved in spite of being aware that they would not necessarily benefit directly from the changes made. They were particularly keen for this process not to be merely an evaluative process but one which would result in change for their successors. The process gave ownership to the educational supervisors and an impetus to implement

the changes despite the pressures of their teaching, research and clinical work.

There is much to be gained from using the methodology described. Qualitative research expertise and facilitation skills are required. However such an investment supports the view that worthwhile change is not a 'quick fix' but a process that requires the commitment of time and resources and the view of change as a long-term process. Such is the paradox in our current climate of change.

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Appendix 1 The themes on which the questionnaire was based (developed from the first round of focus groups)

1. The consistency of posts, staff and educational opportunity
- the awareness of all the staff of the aims of the SHO programme.
- provision of appropriate patient experience.
- balancing supervision and training when senior staff numbers are limited.
- balancing the needs of undergraduates, SHOs and specialist registrars.

2. The learning situation

Matching supervision with learning needs relating to:
- development of clinical responsibility.
- development of clinical decision-making skills.
- development as a member of a team.
- enhancing interpersonal skills.
- development of psychosocial skills.
- developing treatment planning skills.
- making use of the maturity that the GPT scheme allows to develop.
- creating a learning environments where it is appropriate to ask any question.
- providing constructive feedback to SHOs, in situations of varying competence .
- balancing learning needs and service provision.
- training in technique, using phantom heads.

3. Academic development
- promoting critical reading.
- balancing breadth and depth in the training programme.
- providing equity of study time.
- enhancing study facilities including books, CD Roms and a room for SHOs and other trainees.

4. Assessment
- preparation for MFDS.
- the appropriate use of the log book/ portfolios in identifying training needs and informative assessment.
- encouraging learning that is not only exam driven.