A qualitative evaluation of senior house officers’ teaching and learning: towards sharing good practice

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SUMMARY The evaluation explored junior doctors’/senior house officers’ (SHOs’) teaching and learning experiences and identified examples of consultants’ good teaching practices. The qualitative study is based on semi-structured interviews conducted towards the end of a six-month rotation. Data analysis revealed that in spite of the heavy workloads of both consultants and SHOs there were many positive examples of consultants’ creative approaches to teaching and learning, as well as provision of personal and professional support and, for some, ongoing feedback from both consultants and the healthcare team. There was room for improvement, particularly concerning learning experiences in some clinical settings, the development of clinical skills and a need for two-way feedback. However, all the participants would recommend their experience to future SHOs and colleagues.

Introduction

There is now national recognition of the need to reform the Senior House Officer (SHO) grade (Donaldson, 2002). Yet, currently these junior doctors do not have a formal structure of training (Drury, 2000) and are still regarded by many as the ‘lost tribe’ in both employment and education terms (BMA, 2001). There is recognition of the minimum education standards for SHOs in all specialties (Davies et al., 2000), and of the value of service-based learning (for example Gale & Marsden, 1983), but the ethos is service first, education second (BMA, 2001). The SHOs’ situation is enhanced by “those trusts that accept responsibilities to educate and train their SHOs and other junior doctors”, and compounded by “those trusts which view juniors as simply a resource from which every drop of service can be squeezed” (BMA, 1998).

The status quo

In-house teaching can be seen as an acute and difficult problem. The majority of SHOs have heavy workloads. Their consultants have increasing commitments of patient care targets, administration, keeping academically current and delivering training—often without suitable increases in resources (BMA, 1998). In a climate of increasing workloads based on greater service provision, and greater professional demands and accountability, medical service work has been combined with educational requirements in work-based learning (Stanley, 1998). As a consequence, consultants now need to take on the roles of tutors, mentors, and coaches (Irby, 1994).

SHOs define their most useful attachments as those in which their consultant had the time and inclination to teach them (BMA, 1998). Yet, past surveys of postgraduate training have identified that many SHOs are critical in particular of the lack of priority and time given to their training by seniors (though the pressure of clinical workloads is recognized) and the little feedback given on progress in training (the feedback provided tends to be sparse, haphazard, implicit, indirect) (Hargreaves et al., 1997).

These factors were explored within a qualitative evaluation of SHOs’ teaching and learning experience in an acute NHS Trust in the South East of England. The focus of the study was to:

- explore SHOs’ perceptions of their teaching and learning experience in different hospital departments;
- identify examples of good practice;
- inform future educational planning, to support shared learning, improved teaching and better outcomes for junior doctors.

Methods

The 10-day study examined data through semi-structured interviews conducted with 29 SHOs. With limited time and resources, the purposeful sample should be large enough to be credible given the purpose of the evaluation, but small enough to permit adequate depth and detail (Patton, 1987). The approach, illuminative evaluation, has been mostly used in the field of education to interpret practices and participants’ experiences, and is undertaken and interpreted within a paradigm which is different from the natural science experimental paradigm (Ovretveit, 1998, p. 131).

The SHOs who participated in the study had been working for five months or longer in the following departments: Accident & Emergency, Anaesthetics, Department of Medicine for the Elderly, Ear, Nose & Throat, General Medicine, Obstetrics & Gynaecology, Ophthalmology, Paediatrics.

The interview proforma (Figure 1) was devised from discussion with the Postgraduate Clinical Tutor and from the literature, which encompassed general educational principles so that adult learners should:

- be involved in all aspects of the learning;
- base their learning on previous experiences;
- set their own learning objectives;
- relate learning to real-life experiences;

*The study was undertaken at Worthing & Southlands NHS Trust on behalf of the Kent, Surrey and Sussex Deanery, 7 Bermondsey Street, London SE1 2DD.

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SHOs’ teaching and learning in clinical practice

1. What type of teaching and learning experiences did you anticipate when you first came to the directorate?
2. Who/what has had the most impact on your learning?
3. Who has supervised you & how have you been supervised?
4. What teaching methods/approaches have you found most useful? Did you set your own learning objectives?
5. Can you recall a consultant from whom you learned a lot? What was it about that person’s approach that was so valuable?
6. How have you benefited from consultants’ teaching (in clinics, theatre, ward rounds, seminars etc.)?
7. What have been the most significant learning experiences for you?
8. How have generic skills been learnt?
9. Can you give me some examples of good teaching practice/facilitation of learning?
10. Have there been any difficulties with teaching and learning in the department? For example…
11. Do you still have any significant knowledge gaps? If so how will these be addressed?
12. Have you had sufficient feedback on your work? How was this given?
13. Are you happy with how your competence has been assessed? What examples can you give?
14. From your observations/experience—what has contributed to a good learning environment within the department?
15. What factors have hindered teaching, supervision, feedback, assessment?
16. What improvements would you suggest for the future?
17. To what extent have political issues within the Trust impacted on your teaching/learning experiences?
18. Overall have your professional practice development needs been met? What have you valued most about your time in the department?
19. Is there anything else you would like to say?

most interviews lasted between 30 and 60 minutes and were undertaken either in the Postgraduate Centre or in a vacant room within the SHO’s department. The interviewer was unknown to the participants and had no vested interest in the outcome of the study. To preserve anonymity of participants only the speciality in which they worked was placed on each interview transcript.

A thematic analysis of the transcribed interviews was undertaken, as recommended for professions such as education and medicine (Boyatzis, 1998). The eight themes that emerged were: workload; word of mouth; teaching and learning environment; teaching approaches; making time and providing support; room for improvement; positive conclusions; consultants’ good teaching practice. The themes distinguish between different aspects of teaching and learning, yet, in reality, these overlap significantly. The process and outcomes of the evaluation were presented at a seminar for consultants, junior doctors and senior non-medical staff, which helped to both validate the findings and disseminate the outcomes of the study.

**Findings**

Exploring SHOs’ teaching and learning experiences enabled them to identify good teaching in clinical settings and also provided them with the opportunity to identify factors that contributed to their learning as well as highlighting areas for improvement. Key findings from the themes are presented in the participants’ own words, which should demonstrate both authenticity and richness of the data.

**SHOs’ perceptions of their teaching & learning experience**

The SHOs reflected on both teaching in their clinical setting and the structured education programme provided. The multi-professional team’s contribution to their learning was
acknowledged. The importance of receiving feedback on their work was explored as well as acknowledging that feedback should be a two-way process. Gaps in knowledge were related to specific clinical skills. A significant outcome was that they would all recommend their department to future SHOs and colleagues. However, the pressure of work and the learning process is sometimes difficult to reconcile:

There’s a lot of pressure put on you but you do learn a lot so that’s good. But it gets to the point that it’s so busy that you’re tired every day when you’re on call, you’re so stressed you’re not really learning very much.

Overall quite good teaching and learning except for our on call at the moment which is horrendous. … We’ve got five wards to cover plus patients on the other wards … and you have between fifteen and twenty admissions on your own … it has reduced a few of us to tears a few times which is not really a good way of working or learning.

Whilst there is recognition that the SHO grade is traditionally the ‘workhorse’ grade of the National Health Service, the participants also acknowledged the workload of their consultants and the extent to which it impacted on their education:

Dr … is an excellent teacher but unfortunately he’s just the busiest man in the world and it’s all extremely quick … you don’t get a chance. He’s fantastic but unfortunately a lot of the time he’s got to be somewhere else which is a shame because I’ve had some really good teaching off him…

They take on the supervisor role on top of their normal duties. … Some consultants you just feel are always tired or busy, just really busy.

Finding time for appraisal is difficult. I haven’t been able to see my supervisor for the last couple of months because he’s so busy. I saw him in the corridor last week … it’s just been a bit hectic.

**Teaching in clinical settings**

Teaching in clinical settings was the most talked about and valued learning process, whether this occurred on-the-job or as a teaching round in protected teaching time.

The informal on-the-job teaching is really important. The best way of learning is to go round the patients with a consultant who points out and explains your mistakes, it’s the best way to learn.

The patient is the best teaching aid … need a combination of teaching ward rounds and structured teaching in practice rather than just classroom teaching.

Where teaching in clinical settings did not happen or had decreased, it was missed:

No teaching ward round now, we had one. No ward teaching at all. We’d really like that, I think they know.

One of the consultants said I know I’m giving you too much theory, I think I need to start teaching you on the ward rounds, so they know. They need to motivate themselves to do it.

I think the simple statement would be that we don’t get bedside teaching and that’s very important … I don’t think you ever learn quite as much as being shown a case and then talking about it and discussing it afterwards.

**Educational supervisor**

The role of the educational supervisor (ES) was significant in the identification, implementation and evaluation of learning objectives. Most SHOs had three meetings over six months with their ES, but not everyone had a second midway meeting to explore progression and practice development.

We have different consultants as educational supervisors. I was initially asked what I wanted to get out of the six months, what I’d done before, what I thought my weak areas were and how was I going to meet the requirements, what I’d like to concentrate on, what career aspirations I had and what could I could do in the six months to help reach them.

We set our own learning objectives, but mostly verbalized not written down. It was very individual.

I’m happy with mine but he wouldn’t have a clue because he’s hardly seen me in action.

**Collaborative teaching and learning**

Besides the consultants the participants acknowledged teaching and learning from colleagues and other healthcare professionals:

Quite often registrars are very important as they’ve got more time to give you one to one, and they’re on call with you … I’ve actually learnt more from them.

We learn a lot from the nurses, for example, minor injuries, dressings, management of patients.

You learn a lot in the first couple of months then you get to do it on your own and suddenly realize how much you’ve learnt! The ODAs [Operating Department Assistants] contribute to our learning and get us out of difficulties.

**Nature and quality of feedback**

Feedback is an extremely important part of the education process. According to the participants, some consultants provided very good feedback. However, SHOs also commented that the only direct feedback they received was from their patients.

Feedback given by reassurance. In the past in other jobs I’ve thought please tell me something, am I doing anything well, but here they don’t have an
aura about themselves or be stand-offish and if you don’t agree with something you can tell them. They give you good feedback and a lot of the time even if it’s bad feedback it comes back in a good way. It never gets you down and they’re amazingly approachable. It’s a really good department and I’d recommend it to anyone.

Feedback is pretty good. The Educational Supervisor doesn’t pull punches, you know where you stand and you’re told when things are going well. This is the first time that I’ve met a consultant who acknowledges that things are running smoothly on the ward.

The last time I had positive feedback from a consultant was this morning. It happens quite a lot. They’re quite informal here.

Areas where SHOs believe there could be improved feedback include:

I have had a really bad night on call then you get to the handover meeting and then it’s picking over little bits you didn’t do. If someone said you did really well, you did a good job, but it doesn’t happen very often.

I often want to know on the ward round did I do something correctly. Often the answer is yes you did but it would be good to have a couple of minutes say just after the ward round to collect my thoughts and have the chance to ask some specific questions.

Members of the multi-professional team contributed to SHO assessment and feedback. This was seen as a most useful approach:

Recovery staff give us good feedback on how the patient woke up.

The nurses say that patient actually said you explained their problem very well.

He [educational supervisor] does get feedback on me from the nursing staff and other doctors.

Structured teaching

The participants reflected on their structured teaching sessions. The benefits included shared learning and review of recent patients. However, the SHOs identified lack of feedback regarding personal input, and the need to evaluate the structure, process and outcome of the teaching session.

Friday afternoon presentations we learn from each other but we don’t really get feedback on our presentation.

A lot of the sessions are really useful if you haven’t done the job. … The content of the teaching was good and we could go through cases that we’d seen that week and that could be helpful.

Our three hours of teaching is valuable time but it is too long to sit in a room all the time, unimaginative use. It’s valuable time but we’re never asked for feedback on how the teaching is structured, never once.

The teaching sessions on Friday afternoons, you’re not told anything until Thursday. Thursday night they’ll say can you prepare this for tomorrow which is really annoying but I think we’ve got used to that now.

There hasn’t been very good organization of teaching. A lot of consultants promise they’d teach on a Wednesday but … there’s a journal club which is quite fun but also that fell through.

Two-way feedback process

For consultants to recognize and acknowledge that learning can be a two-way process is a positive feedback approach that demonstrates valuing and empowerment of junior doctors. Whilst there is evidence that consultants do learn from their juniors, this was acknowledged to only two of the SHOs:

The consultants acknowledge when I’ve told them something they didn’t know.

Sometimes they admit they have learned something new from you and that’s tremendous.

Knowledge gaps

Specific gaps in knowledge identified were mainly clinical skills:

The department is pretty busy, it’s very frustrating because I want to learn but no one’s got time. I need some help with chest drains.

Experience has been quite good. I’d appreciate the opportunity to develop skills say in lumbar puncture, you wait for it to come along really.

Would have liked to have learnt more skills like suturing, but the nurses do it all.

I don’t think I’ve had enough experience of practical procedures. Things like central lines, chest drains … cardiac arrest experience…

The majority of participants were satisfied with their level of knowledge, for example:

I don’t have any glaring gaps, you’ll never see everything. I came into the job knowing that I needed to do family planning and to do another exam specifically. The job itself is about learning as you go along.

Gaps in knowledge? I hope not. This has given me the grounding I need to go on.

Identifying good teaching practice

This section provides examples of good teaching practice and insight into what SHOs value in consultants whom they consider to be good teachers. There are also some perceived areas for improvement. The SHOs also describe how much they value the consultants who make time for them and provide ongoing support. Initial support to promote self-confidence included:

Just after we started we had to pick an afternoon and a consultant would shadow us. If we were doing anything wrong or taking too long, it was very
helpful. At first I thought oh god what’s it going to be like but they’re terribly relaxed, it’s a relaxed department.

The consultants shadowed us, ‘being there’, it gives you a bit more confidence . . . we had an OSCE as well. It’s a whole morning and it’s really useful. It was everything, a range of everything you could get, even telephone calls, people phoning up for advice, it was good.

They take a random set of ten of our patients’ notes and then they’ve got certain criteria that they mark it on. They tell us exactly what they’re looking out for and that’s very useful but you don’t actually get to see the ones you fell down on which would be equally useful.

Every single patient you saw in her clinic, whether it was a new referral or follow-up she would ask you about. Not because she thought you were stupid but because every time she wanted to teach you something. I would see a number of patients and sometimes run over time but she always stayed behind. I learnt how to begin and finish consultations, she was really good.

Breaking bad news is formally taught and followed up in practice. We will sit down with the patient’s relatives and the patient, the consultant and I together, he starts and I follow his lead.

Many of the participants were able to identify the characteristics of consultants whom they considered good teachers. They spoke of enthusiastic consultants who made learning exciting, acting as a role model, and teaching that was relevant to practice. The consultants also needed to ‘know their stuff’, not be too intimidating but challenge them to see the ones you fell down on which would be equally useful.

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One of our consultants here in the department is really excellent at teaching. She does put people on the spot but not in a way when you think I’m going to look stupid if I can’t answer the question. She makes it very light-hearted and good fun. I think people learn a lot from her because she’s got really good people skills and she’s really involved . . . she’s not frightening so you don’t clamp up, she laughs and jokes about things.

On ward rounds he will spend time going through patients, explaining stuff. He’ll ask you questions or make you go and do something, read up or give you something to read and he’ll remember it for the next ward round.

She’s approachable, sympathetic and she seems to simplify things, she doesn’t use a whole load of medical jargon if there’s something complicated you’re trying to get your head round she’ll say well, look, just go back to basics. I think it’s because she’s really positive about everybody as well that makes people feel confident, she values us . . .

Consultants who take time to explain things. Enthusiastic, reassures you that what you’re doing is fine . . . to know that you’re valued is important and from that you give a bit more and want to learn more.

People who are animated about what they’re teaching. Those who push you to work, to make you think about something, to lead you through it in a logical way so you get the answer in the end rather than than telling you.

You feel it’s easy to converse with them, they’re approachable, you don’t feel they’re way above you . . . They’ve got to want to get the best out of you and be really enthusiastic with it. Obviously they know their stuff and in that respect they gain respect, but they’ve got to come down to our level as well.

Dr . . . talks out loud about what he thinks is happening to a patient then puts the X-ray up and talks through it and then might ask a question or two. It gets you thinking, you’ve learnt something without realizing it. There always is something to learn. He talks about the problems he had when he tried to learn about it. When we can’t understand, when we get stuck at certain points, he reiterates it and says did you understand it because I know it’s difficult. He seems to know exactly when to stop and say did you understand?

Exploring the characteristics of good teaching and different consultants also engendered the following response:

But you do learn a lot from consultants who are not so approachable, more didactic, but then you sometimes come away from them not quite knowing what they mean, but you wouldn’t ask them because you wouldn’t feel able to.

Differences in practice

Difficulties arise when consultants’ practices differs. If such differences could be explored in depth this would provide an additional dimension to learning.

They all do things so differently but when they watch you they say that’s okay but I would have done it like this . . . You can be with someone all day doing it one way and then go with someone the next day who does it differently . . . (laughter)

Each consultant has obviously got their own plan about how things should be managed and that may differ which can be a bit confusing . . .

There was one particular occasion I remember where a patient was being dealt with by one consultant and the other felt it was inappropriate. They basically rounded on each other in a teaching session. I’d presented the case and it got a bit ugly . . .

Making time and providing support

The theme making time and providing support deals with the extent to which consultants are able to find time to teach and support their juniors. The SHOs provide many positive
examples of consultants who make time in their increasingly busy work schedule to support them.

At my initial interview with my educational supervisor he said that if you need anything, or you're worried about anything there's always people to ask, either himself, one of the other consultants or registrar, or if you want to go and talk to any consultant in any speciality then you should feel confident in doing that. He implied that if a consultant wasn't approachable then it was their failure rather than my failure. We have been well supported particularly at the start, which was incredible. Someone was always there to keep a close eye on you. I think the first couple of weeks every time you saw a patient you actually had to go back and discuss it with one of the seniors, to go through what your management was.

They're all so easy to approach, you'd never be afraid to ask them anything. When you're on call I would call any of them if I had any problems without any hesitation. In the formal teaching sessions that we have the consultants always have time after a session to go through any queries we want to raise.

The SHOs distinguished between support for clinical and personal professional problems:

If it's a clinical problem there's always someone to talk to, that's not really a problem at all.
I agree and a lot of them are very approachable and as friendly as they can be but sometimes, when it's a different type of problem, they're just not there.

However, they were there for one SHO who felt able to share a critical problem. His narrative (Figure 2) shows that expressing a problem, though difficult, can lead to very useful outcomes. It also reflects the system of career counselling and mentoring which is extremely effective when properly employed. Some departments have made further provision:

We have a confidential counsellor in the hospital for pastoral care, which is very important. Then you have another supervisor, another one of the consultants who you can approach about anything, then you have a confidential supervisor outside the department.

The future

SHOs’ views on good teaching practice by consultants have been explored, and are identified in Figure 3. Sharing this information within and across departments should enable consultants and junior doctors to:

- recognize and value good teaching practices;
- reflect on areas for potential improvement;
- consider new ways of teaching and facilitating learning;
- seek support in developing and advancing postgraduate education in practice.

Whilst the future delivery and organization of SHO education in the UK is being considered (Donaldson, 2002), for those who participated in the evaluation their overall experience was mainly positive and enjoyable. This is a significant outcome for the departments that participated in the evaluation. Equally significant is the high value that SHOs place on teaching in clinical contexts, in spite of the pressing demands of service provision. Intra- and inter-professional provision of good quality education within clinical contexts is required. For consultants, feedback from junior staff, as well as personal reflection on teaching in practice, can be both an enlightening and rewarding experience.
Practice points

- Qualitative evaluation, even on a small scale, can highlight evidence of good practice.
- SHOs, despite their heavy workload, described positive teaching and learning experiences and where they perceived room for improvement.
- The findings provided consultants and junior doctors with current knowledge of teaching and learning in their locality, and have contributed to future planning of postgraduate education.

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Consultant good teaching practice

- Makes time to teach, particularly in clinical setting
- Is enthusiastic about speciality and has up-to-date knowledge
- Demonstrates respect for and is interested in what individual juniors have to say
- Values learning as a two-way process
- Provides continuous positive and negative feedback in appropriate ways
- Is approachable, and available at agreed times
- Acts as a role model in practice
- Demonstrates the art of caring
- Acknowledges different teaching and learning styles
- Values intra- and inter-professional contributions to teaching and assessment
- Provides both challenge and support
- Demonstrates effective inter-personal skills
- Presents information in different ways and uses creative teaching/learning approaches in practice
- Consults with juniors regarding the planning, implementation and evaluation of their structured teaching programme
- Questions in a non-threatening way
- Reinforces learning by checking for understanding, providing further reading
- Supervises peer teaching/case study presentations
- Embraces counselling and career mentoring roles
- Is sensitive to juniors’ non-verbal lack of understanding
- Starts from basic principles when explaining complex information
- Teaches at the juniors’ pace
- Enables juniors to reach answers to questions rather than just telling them
- Asks juniors for feedback on teaching methods and skills

Figure 3. SHOs’ views on good teaching practice by consultants.

Notes on contributor

LORETTA BELLMAN is currently the healthcare researcher in an independent, not-for-profit research institute, and an honorary member of staff, Guy’s, King’s & St Thomas’ School of Medicine. She undertakes research, including action research, in education and clinical practice.

References


