Managing the Quality of Ward Based Training in Surgery in UK- A Critical Review

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Executive Summary

Junior doctors alerted the Director of Medical Education (D.M.E.) to a lack of training by senior colleagues on ward rounds in surgery. At the same time surgical training was rated poorly on the General Medical Council (G.M.C.) Trainees Survey. The West Midlands Deanery threatened to withdraw posts recommending that at least 40% of trainee time be dedicated to training. Trainers reported a lack of time to train and poor engagement by trainees. This review examines the merits of different quality improvement initiatives to patient care through programmed ward round training.

Context of the Problem

Poor feedback from trainees within the trust at the ‘Junior Doctors Forum (J.D.F.)’ had suggested a lack of ward based training opportunities due to unstructured ward rounds poorly led by the senior doctors within surgery. The Medical Director (M.D.) tasked the Royal College of Surgeons Tutor for the trust with changing the learning environment on ward rounds to improve care and training.

Project Objectives

To identify factors within the educational and management literature that would enable training within the workplace. To consider the values, mind-sets and barriers to managing changes to training within varied clinical environments. To consider the quality improvement strategy that would enable doctors to develop and maintain robust reproducible training on the surgical ward round.

Background Literature

Clinical

There is a growing recognition that the quality of ward round care following surgery accounts for half the adverse outcomes for patients [1] and that this should be led by senior doctors and nurses daily [2]. Clinical skill acquisition by junior doctors are declining because of a lack of time spent training these proficiencies [3]. Trainees spend only 15-30% of their time honing their skills which will then enable them to provide better care [4,5]. Trainers are expected to balance safe effective care with training opportunities with 35-55% of trainee’s time anticipated to be in training [6].

Students and trainees recognise the learning opportunity presented by the ward round [7] but find barriers to learning due to a lack of dedicated time for training especially for clinical and ward round skills [8,9]. Models to facilitate bedside training are available for clinical settings to ensure these opportunities are captured effectively [10]. Modifying work patterns to allow more time with each patient and dividing the workload between several consultants improves care and training opportunities [11]. There is an ‘institutionalized medical understanding of management’ which creates a barrier to clinical engagement [12]. It has long been recognized that doctors have a central role in the success of any quality management initiative in healthcare settings [13].

Opportunistic situated learning [14] stimulates postgraduate trainees to learn through ‘participation’ as well as knowledge ‘acquisition’ [15]. This requires specific, constructive, challenging and timely feedback, traditionally sort from more experienced clinicians [16]. However, it remains difficult to provide and receive feedback that is perceived as ‘negative’ [17,18]. Responding to ‘challenge’ professionally and ‘resiliently’ enables clinicians to value diverse opinions from colleagues and the wider multi-professional team [19,20]. This facilitates teamwork improving safety for patients [21,2].

To ensure that the feedback has ‘value’ for the learner it has to be in context, measured and supported by the wider organization rather than an individual’s opinion [23,24]. Recognizing the values of the recipient [25] helps to create the learning environment that nurtures feedback and development [26].

Feedback in clinical practice benefits from educators well-trained in providing feedback and directly observing tasks. Com-
Feedback remains important for both learners and those aiming to educate [50] and still appears difficult to provide especially when determining a paper’s impact [42]. However, checklists do have more distinguishing ability when evaluating the underlying concepts underpinning a paper and the results of a study [41]. The Evaluation Tool for Qualitative Studies (ETQS 2015) was used to evaluate the first paper of two papers looking at the evidence directing practice for ‘in situ’ feedback and the Quality Assessment Tool for Quantitative Studies (NCCMT 2008) for the second.

The DME had been interested in ‘foundation doctor’s reactions to challenge from the multi-professional team’. This proved too focused an area for study, broader search terms were used looking at ‘feedback in medical education’ to capture more value based papers. Care was required to choose the correct search tools, databases and terms to ensure relevance, inclusivity and ensuring that intuitive relationships were not missed for the field of study [43]. The final terms used in the search on the MEDLINE database and Education Research included ‘doctors and feedback in the workplace’.

Debriefing in simulation settings had initially been excluded as this represented research in relation to a controlled environment [64]. However, educators own valuable skills in delivery and learners in receiving feedback whilst in the simulator transferability is improved by ‘in situ simulation’ [45] (See Table Below).

### Table: Eligibility Criteria for Study Inclusion

| Inclusion Criteria                                                                 | Exclusion Criteria                                                                 |
|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| Empirical study e.g., randomized study, observational, case note analysis, interview or survey. | Studies without educational content.                                                |
| Involvement of trainee doctors or doctors in general                              | Experiences within a simulator.                                                     |
| Experiences in hospital or any clinical setting.                                  | Out-of-hospital care.                                                               |
| The main focus of the article related to feedback, learning or teaching effectiveness and behaviors. | Review of literature or commentary (although reference lists were checked).         |
| Values based commentary                                                           | No reflection against values based practice filters                                 |

### Results of Critical Appraisal

Feedback delivered in clinical settings was explored by qualitative analysis of data obtained in focus groups from nineteen residents in four different specialties from three different teaching institutions in the United States [46]. This study clearly states the area of qualitative research [47] and was selected as it had identified similar key themes and barriers influencing feedback noted earlier.

Four authors recruiting participants electronically by email from teaching hospitals with differing community and urban placements and affiliations to larger teaching institutions [46]. Values are not ‘normally distributed’ so recruiting diverse and ‘rich’ views from clinician’s is difficult [48].

Two focus groups did not achieve the target size aimed for by the authors of eight to ten participants containing four, seven and eight participants respectively [46]. There was no description as to where or when the groups were held which can facilitate participation, things may have been made worst by having multiple sites spread apart geographically [49]. However, involving different institutions improves the generalizability of a study’s findings.

### For Future Research

Feedback remains important for both learners and those aiming to educate [50] and still appears difficult to provide especial-
ly when the content is challenging and the relationship between learner and educator not established [17]. The selected papers both looked at feedback using different methodology and proposed that practice can be improved by improving training design, leadership style, aligning personal attributes and values [46,51]. Some attributes like a person’s linguistic skills and cultural background are difficult to change but still impact on the value they place on clinical placements and faculty support received [35]. Others like the confusion learners and teachers still have over feedback for summative and formative assessment and its educational value can be improved with training [52]. A recent review identified thirty variables affecting feedback worthy of further research in clinical settings [53]. Educators and learners value feedback from patients as it helps improve care [4].

Learner participation and involvement in the workplace is a social process [54]. Triangulation with other studies involving patients [55] and other multidisciplinary team members [29] would better determine how to change feedback in the context of clinical practice. The Teunissen and co-authors paper (2009) showed us what variables interest psychologists and what obstetric residents think in relation to feedback on night shifts. It does not show how it would work in the middle of the day or when you are trying to encourage colleagues to teach on ward rounds or in busy clinics or accident and emergency departments [11].

Trainee characteristics like motivation and self efficacy influences responses to questionnaires and feedback but this can be influenced by the organisations and teachers support and values and the strength of influence of leadership style and goal alignment for that learner [51]. Introducing a similar survey to facilitate changes in my organisation though would be a useful first step as a baseline to measure against in order to enact change [46].

For My Clinical Education Practice

Although the design of critical appraisal tools may not have been validated or reliability tested [56] they did facilitate a structured review in both papers and would be useful in any detailed future paper review. While all the strengths and weaknesses of both papers could not be discussed to the level outlined by the critical appraisal tools the structure provided has enabled me to consider how reliable the evidence is, what circumstances it may be useful in and how practical it would be to introduce within my practice.

At a fundamental level the studies approach influences the data captured [32] and up until recently I have concentrated on quantitative data to evaluate preferences whereas a qualitative approach may help me understand what are the barriers to feedback in the context of my institution [46]. It is interesting to consider why as a learner, educator and occasional researcher I thought that there might be a ready-made tools, algorithms or guidance available from previous researchers for immediate use [57,58].

Feedback is social and contextual [54] and to improve it we should adopt multiple approaches to suit the learning styles and values of different learners [59]. The studies have made me reconsider how I view evidence and how I should balance opinion. Weighing evidence is not always analytical or critical and we favor certain researchers for assessment, like we value certain opinions which may be pre-programmed and resist change to our practice [60]. A participative approach involving patients in decisions about their care [61] and learners in their education [62] would be the best way of introducing changes to challenging feedback within clinical environments.

This review confirms that learner’s value feedback based on observation [63]. It also shows that the approach would have to vary depending on which learners we were being targeted [64]. The focus group study is eminently reproducible in my institution to help me understand local issues between learners and educators [65,66] and in-depth interviews focusing on one area may help educators further understand how to improve feedback [67,68].

A strategy that focuses on the needs of each group of learners designed in conjunction with the participants would facilitate a change in the ‘culture of practice’ within my trust and other trusts.

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