So much more than a necessary evil? Lessons from a study following the implementation of recognition of trainers

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Abstract

Background: The UK General Medical Council (GMC) now requires that trainers in specified roles be "recognised" by evidencing training (General Medical Council, 2012), with wide variation across the UK in implementation. This study aimed to understand the impact on established local educators of this mandatory requirement but also to investigate how our faculty development programme (the Clinical Educator Programme – CEP) can optimise this process for future trainers. Literature review found little published work on the Framework Standards used for this process.

Methods: From a pragmatic stance, case study methodology was used allowing for mixed methods of data collection (online survey and focus groups) and "insider research" (Unluer, 2012). Consultants holding a named role (n=875) as defined by the GMC (2012, p.15) were sampled.

Results: Of the 28% who responded, the majority (83.3%) were clinical supervisors (n=204). 77.6% were registered on the Faculty Development Programme (CEP, n=190), most stating they registered because of Recognition of Trainers (RoT) (n=107). Demonstrable differences were found between CEP participants and others and between those registered for personal developmental reasons when compared to those who gave RoT as their only reason. This included potential benefits and risks of the process. Ten themes emerged including "a necessary evil". Support for CEP contributing to a community of practice (Lave & Wenger, 1991) was found. Mandatory requirements should not detract from professionalization of medical education, yet this study found just over half of respondents were supportive of the implemented process (51.8%).

Conclusion: Further support is needed to help clinical educators understand the potential benefits of on-going educational CPD.
Keywords: clinical educators, communities of practice, Recognition of Trainers, Faculty Development

Introduction

From July 2016, the General Medical Council (GMC) demands that UK trainers in certain educational undergraduate and postgraduate roles require to be recognised by evidencing training. There is some evidence showing regulatory systems lead to doctors who perform better, but the evidence for faculty development programmes such as the Clinical Educator Programme (CEP) leading to improved teaching effectiveness is limited. Anecdotally, we had become aware that some clinicians had concerns about the requirements of the recognition of trainers’ process, suggesting that, despite aspirations for teaching excellence professionally being laudable, mandatory imposition is not well received and this study planned to investigate these attitudes further.

Background / Literature review

A literature search was performed (Medline, Web of Science, Google Scholar) using the terms "revalidation", "recognition of trainers", "faculty development", "mandatory training", "credential" and "attitudes", then widened to include the grey literature and relevant websites (General Medical Council (GMC), British Medical Association (BMA), NHS Education for Scotland (NES)).

In a review of the NHS (High Quality Care for All 2008, p.17), Darzi called for the introduction of "mandatory training and performance review”. This mirrored changes in Higher Education as a result of recommendations by Dearing (1997) and Garrick (1997).

The impact of faculty development programmes worldwide (1980 – 2002) was reviewed by Steinert et al. (2006), evaluating studies using the Kirkpatrick model (Kirkpatrick, 1994). In this review three papers evaluated outcomes at Level 4 (evaluated results of programme) and only two found statistically significant change (Stratos, Bergen, Albright, Skeff & Owens, 1997; Skeff, Stratos, Campbell, Cooke & Jones, 1986). One finding of this review (Steinert et al, 2006, p. 519) was "establishment of new and improved collegiate networks”. Some studies have shown limited evidence for impact on postgraduate trainees in the USA (Griffith, Haist & Ramsbottom-Lucier, 1997, 1998; Stern, Williams, Gill, Gruppen, Wooliscroft & Grum, 2000). No studies were found showing faculty development programmes linked to improved patient outcomes. Ten years on from their initial publication Steinert et al. (2016) undertook an updated systematic review (2002 -2012), which again found that communities of practice could be built by faculty development interventions.

There is some evidence showing that regulatory systems lead to doctors who perform better (Kawasumi et al, 2011; Inglehart & Baron, 2012). Although this intervention (RoT) is designed to enhance and protect the status of training rather than improve teaching practice, it has been suggested that mandatory requirements have brought about greater patient safety and improvements in patient care, namely licensure (McMahon & Talia, 2010), certification (Steiner et al, 2003) and accreditation in speciality certification (Chen, Rathore, Wang, Radford & Krumholz, 2006; Norcini et al, 2010; Pham, Schrag, Hargraves & Bach, 2005; Prystowsky, Bordage & Feinglass, 2002; Silber et al, 2002) but the evidence does not prove a causal relationship and little is known about how skills may change over time, so how often doctors should recertify or revalidate is unclear.

In March 2009, the Department of Health commissioned the Academy of Medical Educators (AoME) to lead on a project that aimed to define training requirements for educational supervisors in secondary care and to explore
options for their future accreditation and performance review. A professional development framework for postgraduate medical supervisors in secondary care was piloted and studied within the London Deanery (Swanwick, McKimm & Clarke, 2009. This pilot study identified a number of considerations, constraints and challenges in use of this framework, which is almost identical to that used by the GMC for Recognition of Trainers. They found: a lack of clarity on supervisory roles and responsibilities; a desire for this process to be aligned with other accreditation processes such as revalidation; postgraduate medical education not being prioritized by trusts; service pressures and clinical accountability causing problems with engagement and motivation, especially for more experienced consultants; the process being viewed as unnecessary and bureaucratic; and identified the potential costs involved.

A guidance document: *A Framework for the Professional Development of Postgraduate Medical Supervisors* (Academy of Medical Educators, 2010) was released, which applied to all UK doctors with a designated supervisory role (both educational and clinical supervisors). At this time the GMC's *Generic Standards for Training* (GMC, 2009) provided the regulatory benchmark. This document states that "[t]rainers with additional educational roles must be selected and demonstrate ability as effective trainers" (GMC 2009, p.16), but the GMC wanted a specific set of standards to cover all trainers (undergraduate, postgraduate, primary and secondary care) as previous legislation only applied to those in primary care. The GMC used and built upon the AoME study, publishing their own framework in December 2012 leading to formal recognition of trainers in secondary care. Worldwide, there have been other similar initiatives, for example medical education in Germany (Lammerding-Koeppel et al., 2016) and across all higher education in Sweden (Lindberg-Sand & Sonesson, 2008).

**Methodology**

Underpinned by a pragmatic philosophical stance, this study sought both qualitative and quantitative data responses. The total target population was the number of local consultants identified as holding a "named" role by NHS Education for Scotland (n=875). A flowchart of the process is included (Figure 1). Questionnaire design was informed by the background reading. Items concentrated on attributes, behaviour and attitudes and were laid out in different sections: About Your Educational Role, What Recognition of Trainers Means to Me, How Much I Know About Recognition of Trainers, Benefits and Risks of Recognition of Trainers to Medical Education, Process of Collecting Data for Recognition of Trainers and Attitudes to Recognition of Trainers. A combination of closed, forced choice (Likert (1932) style and ranking formats and checklists) and open questions was used. Free text responses were analysed qualitatively using thematic analysis along with the focus group transcripts (n=3) where a semi-structured topic schedule was employed. Recruitment to focus groups was by self-selection with invites sent to those who indicated willingness during completion of the questionnaire survey, dependent on availability on chosen dates and times.
This study does not constitute "research" as described by NHS HRA guidelines but was designed taking the Ethical Guidelines for Educational Research (British Educational Research Association, 2011) into account. Ethical approval was obtained through the University of Dundee research and ethics committee and local approval gained from the clinical governance committee (reference number UREC 16071). Participation was entirely voluntary with withdrawal from the study possible until survey submission. Software allowed for anonymization using an
individually, a token system (Cohen, Mannion & Morrison, 2011, p.91) unless respondents elected to include their contact details.

Descriptive objective quantitative data were required in terms of demographics of trainers locally and how and why they access our programme. Responses were analysed for the whole sample, then by different groups: CEP registration status and reasons for CEP registration. This latter categorisation was subjective and made by developmental reasons for registration (Group A): to improve myself as a clinical educator, for educational CPD, to become an Associate Fellow of the Higher Education Academy, to become a member of the Academy of Medical Educators; and Group B: those who gave recognition of trainers as their main reason along with a few who gave other reasons (eg because CEP is free).

There has been much debate in medical education literature about whether ordinal data (such as generated by Likert scales), converted to numbers, can be treated as interval data (Carifio & Perla, 2008) to allow parametric statistics to be used in data analysis. Analysis here was informed by Norman’s review (2010) and his assertion that parametric tests can be used when analysing Likert scale responses. In this part of the analysis unpaired t-tests were used. Chi-squared tests (2 x 2 contingency tables) were carried out when comparing group proportions and responses.

Results Questionnaire Data - Quantitative Analysis

245 out of 846 questionnaires were completed online (28%), representing 51 clinical specialities from all major hospital sites.

Table 1. Roles and Status of Respondents of the Faculty Development Programme

| Are you a named ...       | Yes        | No         | Don't know |
|---------------------------|------------|------------|------------|
| Clinical Supervisor (CS)  | 204 (83.3%)| 34 (13.9%) | 7 (2.9%)   |
| Educational Supervisor (ES)| 165 (27.3%)| 73 (29.8%) | 7 (2.9%)   |
| Undergraduate Role        | 38 (15.5%) | 164 (66.9%)| 43 (17.6%) |
| Are you registered with CEP| 190 (77.6%)| 43 (17.6%) | 12 (4.9%)  |

The ranking responses of the potential benefits of recognition of Trainers are shown in Table 2.

Table 2 Perceived benefits of Recognition of Trainers (* p<0.05)

|                         | All     | CEP     | Non CEP | P *    | Group A          | Group B          | P *    |
|-------------------------|---------|---------|---------|--------|------------------|------------------|--------|
|                         | Mean    | SD      | Mean    | SD     | SEM Mean         | SEM Mean         | Mean   | SD    | SEM Mean | SD    | SEM   | <0.05 |
| Improved patient safety| 5.75    | 2.46    | 5.61    | 2.45   | 0.2  6.26  2.4   | 0.35  NS  5.07  2.32 | 0.28   | 5.99  2.48 | 0.24  | <0.05 |
Results - Perceived Risks of the Process

Table 3 Perceived Risks of Recognition of Trainers (* p<0.05)

| Potential Risks of RoT                                      | All   | CEP   | Non CEP | P *   | Group A | Group B | P *  |
|------------------------------------------------------------|-------|-------|---------|-------|---------|---------|------|
|                                                            | Mean  | SD    | Mean    | SD    | SEM     | Mean    | SD   | SEM  | Mean  | SD    | SEM  | Mean  | SD   | SEM  |
| Lack of educational supervisors                           | 2.75  | 1.83  | 2.87    | 1.88  | 0.14    | 2.37    | 1.58 | 0.22 | NS    | 2.87  | 1.91  | 0.23  | 5.98 | 2.46  | 0.17 |
| Decreased motivation to train juniors                     | 3.34  | 1.81  | 3.53    | 1.86  | 0.14    | 2.73    | 1.51 | 0.21 | <0.01 | 3.08  | 1.76  | 0.22  | 3.39 | 1.89  | 0.18 |
| Lack of clinical supervisors                               | 3.21  | 1.52  | 3.22    | 1.52  | 0.12    | 3.19    | 1.52 | 0.21 | NS    | 3.17  | 1.54  | 0.19  | 3.20 | 1.54  | 0.15 |
| Reduced time for patient care                              | 3.9   | 1.87  | 3.83    | 1.9   | 0.15    | 4.15    | 1.75 | 0.26 | NS    | 3.69  | 1.95  | 0.25  | 3.91 | 1.85  | 0.18 |
| Training status being withdrawn from departments           | 4.02  | 1.63  | 3.88    | 1.66  | 0.13    | 4.47    | 1.43 | 0.20 | <0.05 | 4.05  | 1.54  | 0.19  | 3.87 | 1.69  | 0.17 |
| Decreased motivation to teach medical undergraduates       | 4.07  | 1.72  | 4.12    | 1.73  | 0.13    | 3.92    | 1.65 | 0.23 | NS    | 4.45  | 1.85  | 0.23  | 3.89 | 1.60  | 0.15 |
Attitude statements

When analysing the responses to the attitude statements responses in the strongly agree and agree, as well as the disagree and strongly disagree, categories were summed and the neutral responses not included. Chi-squared test used as below. All results are tabulated (Table 4).

Table 4. Attitude statement responses with comparisons between groups

| Number | Description                                                                 | Group A Mean | Group A SD | Group B Mean | Group B SD | P *  |
|--------|------------------------------------------------------------------------------|--------------|------------|--------------|------------|------|
| 18.1   | I do not agree with the GMC's decision to recognise trainers in secondary care | 3.44         | 1.17       | 3.09         | 1.08       | <0.05|
| 18.2   | Recognition of Trainers has helped me improve as a clinical educator        | 2.96         | 1.23       | 3.73         | 1.2        | <0.001|
| 18.3   | Recognition of Trainers will have no impact on the quality of undergraduate medical education | 3.24         | 0.97       | 3.07         | 0.98       | <0.01|
| 18.4   | The Recognition of Trainers process has helped me reflect more on my teaching | 2.6          | 1.22       | 2.79         | 1.21       | <0.05|
| 18.5   | Recognition of Trainers will have a positive impact on the quality of postgraduate medical education | 2.7          | 1.1        | 2.94         | 1.14       | <0.001|
| 18.6   | The Recognition of Trainers process has involved too much paperwork for myself | 2.44         | 1.06       | 2.28         | 1.01       | <0.05|
| 18.7   | My involvement in the Recognition of Trainers process has decreased my isolation as a clinical educator | 3.31         | 1.05       | 3.54         | 1.01       | <0.001|
| 18.8   | Recognition of Trainers has made me feel under too much scrutiny             | 3.33         | 1.02       | 3.19         | 1.02       | <0.05|
| 18.9   | While working through Recognition of Trainers paperwork I have been able to address problems in my own teaching | 3.27         | 0.94       | 3.43         | 0.91       | <0.01|
| Question                                                                 | Mean | SD  | 95% CI | t    | df   | p     | Mean 2 | SD 2 | 95% CI 2 | t     | df   | p     |
|------------------------------------------------------------------------|------|-----|--------|------|------|-------|--------|-----|----------|------|------|-------|
| 18.10 Implementation of Recognition of Trainers will improve patient outcomes | 3.42 | 1.1 | 3.8    | 1.03 | <0.05 | 3.01  | 1.1    | 3.72 | 1.01     | <0.0001 | 3.01  | 1.1    | 3.72  | 1.01 | <0.0001 |
| 18.11 I find the process of Recognition of Trainers threatening         | 3.7  | 1.02| 3.39   | 0.89 | <0.05 | 3.76  | 0.99   | 3.66 | 1.04     | NS    | 3.76  | 0.99   | 3.66  | 1.04 | NS      |
| 18.12 I am happy with the communications I have received from NES regarding Recognition of Trainers | 2.87 | 1.04| 3.52   | 1.11 | <0.0001 | 2.95  | 0.99   | 2.83 | 1.09     | NS    | 2.95  | 0.99   | 2.83  | 1.09 | NS      |
| 18.13 I received useful advice regarding the process of Recognition of Trainers from the GMC | 3.24 | 1.05| 3.82   | 1.01 | <0.0001 | 3.15  | 1.09   | 3.31 | 1.03     | NS    | 3.15  | 1.09   | 3.31  | 1.03 | NS      |
| 18.14 The implementation of Recognition of Trainers by the GMC has been supportive | 3.27 | 0.97| 3.84   | 0.8  | <0.0001 | 3.18  | 0.93   | 3.34 | 1        | NS    | 3.18  | 0.93   | 3.34  | 1    | NS      |
| 18.15 Clinicians can learn to teach by completing online modules rather than engaging in face to face training | 3.22 | 1.07| 3.2    | 1.18 | NS    | 3.23  | 1.12   | 3.21 | 1.03     | NS    | 3.23  | 1.12   | 3.21  | 1.03 | NS      |
| 18.16 Not all doctors should teach                                      | 2.59 | 1.23| 2.45   | 1.22 | NS    | 2.62  | 1.32   | 2.56 | 1.17     | NS    | 2.62  | 1.32   | 2.56  | 1.17 | NS      |
| 18.17 Educational supervision is not all about teaching                 | 3.01 | 1.13| 2.91   | 1.07 | NS    | 3.09  | 1.1    | 2.95 | 1.14     | NS    | 3.09  | 1.1    | 2.95  | 1.14 | NS      |
| 18.18 Recognition of Trainers will ensure accountability of trainers    | 2.85 | 1.03| 3.07   | 1.01 | NS    | 2.58  | 0.9    | 3.05 | 1.08     | <0.01  | 2.58  | 0.9    | 3.05  | 1.08 | <0.01   |
| 18.19 Not all doctors can teach                                        | 2.25 | 0.98| 2.2    | 1.09 | NS    | 2.23  | 1.05   | 2.26 | 0.93     | NS    | 2.23  | 1.05   | 2.26  | 0.93 | NS      |

**Qualitative Analysis - Free text comments and Focus Group transcripts**

On interrogating the data CEP participants were more likely to talk about issues coded as "value or identity as a clinical educator" (37 versus 21), "community of practice" (18 versus 3), "enjoyment" (20 versus 5) and "motivation" (55 versus 32) than those not registered on the programme.

Using a multiple reading thematic analysis approach while coding the transcripts and free text comments, it was apparent that there was a high level of emotion elicited in the responses. There was a real sense of the impact that the process had had on individuals and many comments made related to the CEP. Support or lack of it (time, IT, feedback, financial reward) all featured strongly throughout. The themes that emerged when talking about Recognition of Trainers are: something's got to change; a necessary evil; I'm not good enough; lack of clinical ability so become an educationalist; it's a cultural thing; it's made me think; one size does not fit all; doesn't experience count?; the standard is only as good as the … process; and the generation game. Quotes are attributed here as CEP/ non CEP, Focus Group (FG), Educational Supervisor (ES) and Clinical Supervisor (CS).

There was an acceptance that society as a whole is demanding more accountability from all professions including...
medicine "something's got to change" and there may be a positive side to this in that the process may root out bad trainers and reward good ones by job planning. Achievement of these goals involved a 'necessary evil. Concerns were however raised about how fit for purpose all levels in the process from appraisal and job planning to RoT are:

... that it's entirely reasonable that people ... who do training should be trained in training and ... should be good at training but there's very little from having been through the process to suggest that [if] I am a crap trainer I will be stopped from training ... that if I'm a you know a good trainer I will be rewarded for that.FG2,CEP,ES&CS)

"The standard is only as good as the accreditation process" (FG3, CEP, ES&CS) with a real sense that it is not fit for purpose.

Comments were made that were coded as value or identity as an educator with real anxieties about "being good enough" and a sense of divisions developing between clinicians and clinical educators. The possibility of only becoming an educator if you weren't any good clinically was part of these anxieties.

One underlying subtheme here is that many of the trainers who responded felt that they were not teachers. The quantitative showed 40% agreeing or strongly agreeing with the statement "educational supervision is not about teaching". There was however an expectation that teaching is part of the job "it's a cultural thing", so these feelings seem somewhat incongruous. No matter what clinicians felt about the process, it did make them think; they thought about their teaching – reflecting on delivery; their time and workload but also giving up being a trainer. The diversity in supervisors, specialities, students and trainees led to the theme 'one size does not fit all' with some seeing benefits in this but others having a less favourable opinion.

It could encourage a narrow faculty of inflexible trainers who were no longer representative of the wide range of doctors with diverse personalities and abilities, who work in many different medical roles. (CEP, ES & CS)

Not only was there a call for the varying needs of specialities and grades but a call for recognising experience (a so called grandfather or grandmother clause) came out strongly. This theme "doesn't experience count?", while closely related to "the generation game", contained separate issues.

'I think the old boys rate themselves as being awesome even though their teaching may be rubbish and they see RoT as an affront to their egos' (EQ)

Within this was also an acceptance that to younger consultants reflective practice and evidencing competencies are the norm and that with time attitudes to the process may change as older generations of clinical educators retire.

Discussion

A high level of emotional responses was found, mirroring similar findings by Ross et al (2014) around the introduction of revalidation. There is support for "something's got to change" even if it is a "necessary evil" and that there may be benefits from the process implementation, with 51.8% in agreement with the GMC decision.
When considering risks or how RoT may impact on practice, many stated that they had considered relinquishing their role and some have done so, but this number cannot be accurately verified.

When asked about isolation as a clinical educator, a clear difference was found between CEP and non-CEP groups and subgroups (those who chose to engage for their own development rather than for the requirements of RoT). We argue that this supports this programme functioning as a "community of practice". Participants felt they belonged to our community, they spoke the same language when referring to learning experiences and they could see the value of participating. This is in keeping with findings from Sethi, Ajjawi, McAleer & Schofield (2017) who found that their postgraduate medical education programme instilled a sense of belonging. Those engaged with CEP were more likely to feel that they had improved as a clinical educator, that the process had helped them reflect more on their teaching and that they had been able to address problems in their own teaching, all in keeping with Steinert & Walsh (2006) and Steinert et al, (2016). We argue that this positive engagement accounts for individuals who felt less threatened by the process, were much more likely to support the notion that postgraduate medical education and patient outcomes would be improved. They believe that they can make things better despite the lack of evidence to support this.

Questionnaire data revealed uncertainty regarding named trainer roles six weeks before recognition became mandatory. Attitudes towards communication and advice from the GMC were relatively ambivalent, with those from NHS Education for Scotland slightly more positive despite the negativity in free text comments. Concerns were voiced about the process and the appraisal system, so these need to be addressed.

There was agreement between all groups with the statement "not all doctors should teach" and "not all doctors can teach" – these are interesting attitudes but were not pursued further but are in keeping with findings from previous work (Finucane, Allery & Hayes, 1994).

Those surveyed saw RoT as a way of being rewarded in contractual terms and a desire for more feedback on their teaching (from students, trainees and peers) as a means of feeling more valued in this role was expressed.

Our longitudinal programme covers both undergraduate and postgraduate sectors. This lends weight to the theme "one size does not fit all" and is in keeping with the findings of McLean, Cilliers & Van Wyk (2008) and Fellow-Smith et al. (2013). Most NHS clinicians included in this study will have contact with both undergraduates and trainees so this needs to be addressed in the design and delivery of faculty development programmes.

Time (or lack of it) came out strongly as an issue both in the questionnaire answers and in focus group sessions in keeping with previous published work (Schofield, et al, 2009; Sethi, Ajjawi, McAleer & Schofield, 2017) and with the GMC Trainers survey (2016). During appraisal submission, all trainers have to indicate that their job plans contain adequate time for their supervisory role(s). It has to be accepted that while affirming this during the process this sample of clinicians still feel overwhelmed by the demands on their time from competing interests. This suggests that clinical educators are comfortable voicing concerns about this in an anonymous study but are unable to do so during an appraisal process, which is linked to career progression with job planning, which has financial implications.

Negative feelings about the process obtained here are in keeping with findings of previous work looking at appraisal and revalidation (Middlemass & Siriwardena 2003; Dale, Potter, Owen & Leach, 2016; Williams, Holmes & Laugharne, 2016; The Uk Medical Revalidation Evaluation CoLLAboration (UMbRELLA), 2016).

Comments made about change are in keeping with preliminary results of the UMbRELLA group looking at revalidation in the UK who found that "older, more senior doctors may be the least likely to make changes" and
from Dale et al (2016) who found older GPs more likely to cite appraisal and revalidation for a decision to retire from practice. Motivation is affected by many variables including age and gender (Kusukar, ten Cate, van Asperen & Croiset, 2011). Other comments made in keeping with the themes "doesn't experience count?" and "the generation game" are in keeping with findings from Finucane, Allery & Hayes (1994) that many clinicians feel that they do not require formal training in teaching.

Support for current content of CEP as a result of this study comes from the finding that face to face training was valued above online modules. When considering what courses would be of benefit, a desire for "bespoke" training for experienced supervisors was voiced along with "Managing the Trainee in Difficulty" (as in Schofield et al, 2009).

Limitations of the study

Data analysis suggested the possibility of distinct participant groups dependant on age or experience as a trainer. This cannot be confirmed due to the lack of demographic data requested. Findings from this study are not generalizable but will be of interest to other medical educators.

Take Home Messages

The study has found that the mandatory introduction of Recognition of Trainers by the GMC has been met with a variety of responses. Many appear to resent the process and feel that it is unnecessary. Some reported feeling demoralised and demotivated. Even among those who can see benefits arising it is still "a necessary evil".

This case study of NHS Lothian Consultants who are clinical educators found that the introduction of RoT has made them think about their teaching. For some it has made them decide whether they wish to continue in a named supervisory role, resulting in some clinicians having to take on the responsibility of supervising additional trainees. This appears to be a risk of the process.

The process itself appears to have had variable impact on their practice. Some have approached educational CPD in a more structured and perhaps more strategic way "to tick the boxes". There is acceptance that something had to be implemented but perhaps this has less support from more experienced clinicians. Benefits of the process are raising the importance of medical education for all involved, not just for the clinicians but also for their trainees, students and patients.

No consensus was reached on how educational training should be approached: some supported college run speciality courses, while others felt multidisciplinary workshops helped share ideas and created a sense of identity. Some wanted online training although the majority supported face to face interactive workshops.

Messages for the GMC and NHS Education for Scotland from this work are that doctors do not like change, especially if it is imposed on them, even if they perceive benefits from it. Although the majority of clinicians appeared to understand the requirements of the process, some did not and on-going communications need to be clear and supportive. Messages for CEP highlight it as a positive motivating choice for some.

Future work suggested by this study would involve a repeat of some of this work, after the first cycle of 're-recognition' has taken place, to investigate whether the initial resentment has died down and clinicians have become more accepting of the process. Ideally this would include demographic data.

In the words of Thomas Paine (1776, p.67), "[s]ociety in every state is a blessing, but government, even in its best
state is but a necessary evil; in its worst state an intolerable one". We should be striving to make this process better than tolerable.

Notes On Contributors

Fiona Crichton is a retired Obstetrician and Gynaecologist. At the time of undertaking this study she was employed as the deputy director of a faculty development programme (the Clinical Educator Programme), based in the University of Edinburgh.

Linda Jones is a Senior Lecturer in the University of Dundee and was the supervisor of the dissertation which has resulted in this article.

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Appendices

Declaration of Interest

The author has declared that there are no conflicts of interest.