SHARING IDEAS

SHARING IDEAS 2

Effecting change through staff development

change in MEDICAL EDUCATION

Edited by Angela Towle

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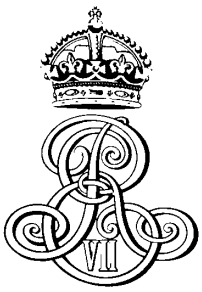

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I would like to thank various colleagues who have helped me to think through the issues raised in this report, and in particular Judith Riley from the King's Fund College who helped me with the planning of the conference.

Executive Summary

Until recently, few medical teachers were expected to undergo any educational training but fortunately the situation is rapidly changing. The current unprecedented interest in staff development in the UK has arisen partly as a result of internal and external pressures to demonstrate the quality of teaching and partly in relation to curriculum change.

British institutions of higher education, under pressure to account for the public money which they receive, now face two processes of scrutiny in relation to their procedures and practices of quality assurance and control: academic audit and quality assessment. However questionable the effectiveness of these exercises in improving the quality of teaching, it is clear that medical schools are no longer able to ignore the new emphasis on teaching and the need to introduce staff appraisal and training.

In addition, medical schools are in the process of reviewing their undergraduate curriculum in the light of recent recommendations from the General Medical Council. There is dawning recognition that changing the curriculum is unlikely to be effective without staff development to ensure that teachers are willing and able to change their teaching practice. Unless staff are provided with new skills, for example in supporting student-centred learning, and new attitudes which will motivate them to embrace the change, the curriculum which is being so carefully planned is unlikely to be successfully implemented.

However, such staff development as does occur in medical schools is still largely a series of isolated events, often undertaken by motivated individuals on their own initiative, rather than as part of a planned strategy for bringing about the kind of changes which the school requires. The true potential of staff development in acting as the link between the personal and professional development of the individual and the development of the organisation or institution has yet to be realised. Organisational development is increasingly necessary if medical schools are to plan successfully for the future at a time when all institutions of higher education are operating in the context of a changing and sometimes hostile external environment. Now, more than ever, there is a need to move towards the concept of the 'learning organisation' in order to both manage uncertainty and to make effective use of the skills of the people who are the medical schools' main resource.

The promotion of change at the organisational (medical school) rather than just the individual level calls for a statement of the purpose and goals of staff development and a planned strategy for their achievement. At the very least, as curriculum changes are being planned, someone on the curriculum committee might be given the responsibility of overseeing the staff development requirements which any new curriculum will inevitably engender and to propose a strategy for how these might be most effectively met.

Such a strategy should take cognisance of the most effective and efficient means of achieving the purposes intended. It should consider what kinds of activities are most likely to change behaviour and recognise that formal training courses of the type most people are familiar with are not the only, or even necessarily the best, way of effecting change. The report describes a variety of effective staff development activities which highlight the importance of allowing staff to identify their own needs, of reflection on practice, active participation and building upon existing expertise. The provision of good communication networks allowing both the sharing of information and informal contacts between colleagues is fundamental to effecting change through staff development.

Some academic staff still feel little need for staff development; others are willing but do not perceive it as a priority given all the other calls on their time. Teachers need to be convinced that participation in staff development will bring them benefits. Staff may be motivated in a number of ways, for example through specification in contracts, promotion and appraisal procedures, or by linking training opportunities to curriculum change. The aim is to produce a culture within the medical school which values learning and expects participation in staff development activities. It is therefore vital that these are supported by key individuals within the institution (deans, heads of departments, curriculum managers).

Practical constraints on delivering effective staff development include finding suitable times and places in which to hold events, and limited resources of time, money and expertise. Few places have an identified budget for staff development but some money is required for items such as room and equipment hire, refreshments and payment for workshop leaders. Staff development may also involve paying visits to other institutions, study tours, bringing in expert consultants, etc. Funding may be required to set up an infrastructure to support staff development, for improving communication within the institution or for the setting up of an educational database or resource centre.

Finally, the increased emphasis on staff development has highlighted the shortage of expertise available in medical schools wishing to provide such opportunities. Two types of expertise are required: 'educational experts' who can provide skills training and 'independent facilitators' who can help the sharing and development of expertise which already exists within a staff group. Schools should take steps to identify what expertise exists already within their institution, seek to build up a critical mass of staff who can raise awareness of educational issues, act as role models, run workshops, serve as resource people, consultants, etc. Some medical schools have already forged links with their university staff development/training unit or education department. There may also be an advantage if medical schools were to work collaboratively to share expertise and maximise staff development opportunities.

CHAPTER 1: Introduction

This report arises out of a conference held at the King's Fund Centre on 27 November 1992 on Effecting Change through Staff Development. The conference was the second in the 'Sharing good practice' series which is designed to identify new areas for development, and to identify constraints and problems and propose solutions.

There is currently an unprecedented interest in staff development in medical schools in the UK, stimulated in large part by internal and external pressure to demonstrate the quality of teaching. Higher education in general is required to be more accountable for the public money which is spent on it. The introduction of academic audit and quality assessment are designed to ensure that institutions have mechanisms in place for monitoring and enhancing standards in teaching. Yet staff development is too often just regarded as training teachers to improve the quality of the education they deliver rather than as a necessary and integral part of the curriculum changes which medical schools are currently pursuing. In this case the aims of staff development go beyond changing the behaviour of individuals towards changing the behaviour of the institution as a whole.

The central questions concerning staff development in medical education are, what are the purposes and how can effective and efficient staff development be delivered in an environment of scarce resources of time, money and expertise? The specific questions which the conference and this report attempt to address are:

- What do we mean by staff development and how is it related to change in individuals and organisations?
- What methods are most suited to achieve the various purposes?
- What has been the experience so far? What lessons have been learned?

Chapter 2 is designed to answer the first of these questions and considers staff development and change in medical education in the broader context of current thinking and practice in British universities, faced as they are with a changing external environment and a need to demonstrate quality.

The main bulk of the report (chapters 3 and 4) provides various examples of staff development and change which, it is hoped, may be a source of ideas, an aid to the avoidance of making mistakes, and a stimulus to reflection. Chapter 3 summarises two of the conference sessions, led by Judith Riley and Brian Jolly, who shared their expertise in teaching and staff development and involved participants in reflecting on their own experiences in order to identify what kinds of activities or experiences are really effective in changing behaviour and promoting learning. Chapter 4 comprises short contributions provided by conference participants. Some of the examples are descriptions of specific work in progress or planned; others are reflections on personal experience and lessons learned.

Chapter 5 draws on these experiences to summarise the main problems and constraints, and propose some solutions, in order to help those responsible for organising staff development or managing medical education to make informed decisions, sound choices, and effective and efficient use of limited resources.

CHAPTER 2: Effecting change through staff development

Much has been written about staff development in higher education – what it is for, who should be doing it, and how. It is not the intention of this report to provide a review of this work, but to put into context some of the initiatives which are currently underway or planned, to question in relation to medical curriculum change what staff development can and should achieve, and to examine (in Chapter 5) some problems and solutions. In particular the focus will be on staff development in relation to education rather than any of the other functions which medical academics have, such as research, clinical care or administration and management.

THE NATIONAL CONTEXT

Until recently few medical academics required any training on how to teach. It was widely believed that their professional qualifications and own experience of education were sufficient to guarantee that they would be at least adequate teachers. In addition, since medical students are amongst the brightest in the country there was the expectation that they would still be able to cope with any parts of the course that were less than satisfactorily taught.

This view is now being challenged not just in medical education but in higher education across all disciplines. Recent moves towards accountability and standard setting in the public sector are raising concerns about the cost effectiveness and quality of higher education, and hence the quality of teaching. It is highlighting the lack of incentives and opportunities for academics to develop the necessary personal skills to be not only effective teachers, but also curriculum designers. In this way staff development has been linked to the quality of teaching.

British universities are currently under considerable pressure to demonstrate to the outside world that they are providing 'quality'. They face two processes of scrutiny in relation to their procedures and practices of quality assurance and control, namely audit and assessment. Audit was introduced when the Committee of Vice-Chancellors and Principals (CVCP) decided that the structures and mechanisms for the assurance of the quality of provision of programmes of study and the maintenance and enhancement of academic standards in British universities should be examined by a body owned and managed by the universities as a whole. Consequently the Academic Audit Unit (AAU) was formed in October 1990. The AAU has now formally become Quality Audit, a division of the Higher Education Quality Council, but it is still owned, managed and funded by the institutions of higher education. By contrast, the process of quality assessment stemmed from proposals in the White Paper, *Higher Education: a New Framework* (DES, 1991) which were subsequently enacted by legislation in Spring 1992. The methods of working of the government's quality assesment procedures have yet to be clarified but many concerns have been raised that the process will be used as a stick rather than as a developmental and supportive means of enhancing university teaching. Refer to Knight (1993) for a collection of papers on these issues. None of these processes will by themselves lead to an enhancement of quality which, in view of the lack of professional training of university teachers, is most readily achieved by the provision of staff development and training (Elton, *pers. comm.*). In fact there are fewer resources for the latter than for audit and assessment and there is a danger that resources are

likely to be further diverted into quality assessment by removing a sizable proportion of the best academic teachers from teaching, curriculum design and staff development.

Whereas in the past university funding has been allocated on the basis of research ratings, the Higher Education Funding Council will in the future be taking into account the quality of teaching when it allocates money. In this case, quality, as rather crudely defined by 'excellent', 'satisfactory' or 'unsatisfactory', will be used as the basis for allocation of student numbers, and hence amount of funding. The criteria for determining the quality of teaching have yet to be defined conclusively, although useful work has already been done in this direction (the paper by Elton and Partington, 1991, is important reading). Although it is questionable how effective this mechanism will be in actually improving the quality of teaching, it is at least alerting medical schools to the change in climate and raising the profile of teaching generally. As the status of teaching increases, and medical schools have to provide answers to auditors' and assessors' questions, so they will have more incentive to introduce staff appraisal and training.

The main impact of the trends described above will be on individuals within institutions of higher education (see below). In relation to curriculum change, the impetus has come from the Enterprise in Higher Education (EHE) initiative which is nationally the most important, if not the only instance of planned curricular development in UK higher education. In a useful review of the aims and impact of EHE, Wright (1992) highlights how institutions which wish to take part in EHE initiatives have found themselves involved in the process of strategic curricular devlopment, previously all-but unknown in higher education. Although not all medical schools are part of institutions receiving EHE funding, in those that are, Enterprise initiatives in the curriculum have been accompanied by staff development (see Case Studies 4, 5, 8 and 9). Brown and Sommerlad (1992) suggest that EHE has also covertly introduced the need for an organisational development approach in which a more integrated, comprehensive and strategic approach to staff development is necessary.

EFFECTING CHANGE

Effecting change through staff development can be thought of as a spectrum: at one end is the individual (medical teacher) and at the other the organisation (medical school). In relation to the individual, staff development can be used to improve the skills of inexperienced or poor teachers, to continue to improve the performance of good teachers, or to provide new skills in order to facilitate new ways of teaching. This latter is most frequently done in relation to the introduction of innovation, so that the emphasis in the spectrum moves from changing the behaviour of the individual teacher to changing the behaviour of groups in order to implement curriculum change, where teachers require different skills or attitudes in order to teach differently. Such efforts may, through incremental change, lead to cultural change within the institution and a reorientation of the entire faculty. On the other hand, organisational change on this scale may require a more radical approach, such as the development of a learning organisation (see below).

I have thus chosen to consider change and staff development in relation to the individual, the curriculum and the institution (medical school), although it must be realised that these three approaches do not operate in isolation, and that there will be interaction between them. For example, on the one hand institutions are comprised of individuals, so individual changes may potentially have an impact, planned or unplanned, on the whole organisation. On the other hand the behaviour of individuals is influenced by the culture of the organisation in which they work, and this may enhance or undermine individual change.

Hatton and Bullimore in Case Study 6 provide a useful model which depicts staff development as an evolving process with four stages: *a random stage* where there is no recognition of staff development as a necessary function at either the individual or organisational level; *a fragmented stage* where staff development does exist but is related to individual needs only, not to organisational goals; *a formalised stage* where individual needs are met in a systematic way through individual performance review/appraisal, linked to departmental and ultimately university aims and needs; *a strategic stage* where each individual has a personal development plan, linking their development needs with those of their department and the university.

Brown and Sommerlad (1992) cite research on management in private industry which identifies three main approaches to staff development: *the fragmented approach* where training is perceived as a cost not an investment, a luxury, not linked to organisational goals, based in a training department and is primarily knowledge-based courses; *the formalised approach* where training is part of career development, linked to human resources needs, linked to appraisal and individual needs, knowledge-based courses plus a focus on skills, and is carried out by trainers and line managers; *the focused approach* where training is a continuous learning process, essential for organisational survival, linked to organisational strategy and individual goals, on-the-job plus specialist courses, the line manager's responsibility and is 'tolerant'. The focused approach, favoured by progressive industry, carries with it a vision of the 'learning organisation' in which learning is linked both to organisational strategy and to individual goals. This demands a shift to a learner-centred approach, the cultivation of a culture which supports risk-taking and is tolerant of mistakes, and one that 'fundamentally promotes learning as a cherished value'. In relating these concepts to the situation in higher education, Brown and Sommerlad note that the dominant staff development approach until recently has conformed to the fragmented model, but with a discernable shift towards the formalised approach and, in some institutions, a tentative movement towards the focused model, particularly in those that have received EHE funding.

CHANGE AND THE INDIVIDUAL

The kind of staff development with which most people are familiar is that designed for the individual teacher where the purpose is mainly to improve the quality of teaching rather than as part of a wider strategy for curriculum change. Staff development is therefore frequently thought of as 'courses on how to teach', for example for new staff who have had relatively little teaching experience, or as remedial treatment for staff who have poor ratings in student evaluations of teaching. Although such courses may be intended to improve the teaching of the inexperienced or unsatisfactory, in practice they have been more frequently attended by those who are interested in teaching and possibly already highly skilled. In part this has been because the requirement for training has not been part of the culture of medical schools, although this is now being redressed with several medical schools specifying some basic educational training in contracts for new staff. The demands of academic audit and the introduction of staff appraisal are likely to reinforce this trend. If the demand for training opportunities increases, it is likely to highlight what has been apparent for some time: that training has not been widely available because there are few staff within medical schools who have the expertise and/or time to provide teaching courses.

Methods for effecting change at the individual level are various. For inexperienced (or poor) teachers basic training programmes are required. These may follow the model of traditional courses or workshops, possibly supplemented by self-study materials, but there should always be some provision for follow-up. All too often isolated training events may raise awareness and introduce new skills, but on-going support is crucial and frequently neglected. Good teachers, on the other hand, have learnt by reflection on their teaching (Schon, 1983):

they do not necessarily require training courses but rather institutional support and opportunities for self-improvement and, ideally, recognition for teaching excellence (for example, through career advancement on this basis). Opportunities for self and peer assessment, and educational 'support' groups, equivalent perhaps to journal clubs for research, may be appropriate methods here.

CHANGE AND THE CURRICULUM

It is becoming increasingly apparent that changing the medical curriculum has had limited success (General Medical Council, 1991; Association of American Medical Colleges, 1992) for a variety of reasons. As Coles (1977) pointed out, most teachers see innovation as a design problem rather than an implementation one and it is this perception that has resulted in a failure to consider appropriate strategies for adoption. Since the adoption of an educational innovation frequently requires fundamental changes on the part of teachers, in order for curriculum change to be implemented there may well be a need for staff (and students) to develop new skills and, even more significantly, new attitudes, assumptions and values. It is thus the role of staff development not only to develop new skills (for example, to help staff to change roles from didactic teacher to a tutor who facilitates active, student-led learning) but to promote new attitudes which will motivate and support staff to do things differently. In addition, new curriculum developments must be owned and adopted by all those who teach, otherwise the curriculum that is planned is likely to differ considerably from that which is actually taught, which is likely to resemble closely the model of past teaching with which staff feel comfortable. Again, staff development has a role in promoting this sense of ownership, commitment and participation, through debates on the need for change, explanations of the type of changes envisaged, allowing proposals to be formulated and modified, and problems to be aired, addressed and resolved. Thus, staff development is a necessary and integral part of any strategy for implementing curriculum change.

Some of the cases in Chapter 4 describe methods of achieving curriculum change through staff development, especially Case Studies 1 to 5. Ideas could include: workshops, awaydays, visits to other institutions and visiting consultants (for example, from other medical schools) to work with staff.

CHANGE AND THE INSTITUTION

In their stimulating paper, Brown and Sommerlad (1992) argue that institutions of higher education are now in a changed political and financial climate leading to uncertainty and instability; that this situation is making unprecedented demands on the quality of institutional management and direction, requiring of the institution at all levels a capacity to manage in a much more self conscious way; that it is important for all staff to have a shared view of what their institution stands for (its mission) and to develop a sense of organisational allegiance alongside collegiate loyalties; and that staff development can play a key role in the ensuing processes of organisational change and development. They see staff development as providing a crucial link between the individual and the organisation by, on the one hand, satisfying the development needs of individuals who are the institution's key human resource; and, on the other, through using staff development strategically to increase the capacity of the institution itself to engage with, adapt to, and indeed to be proactive in new circumstances. They argue that institutions of higher education need to become 'learning organisations', a well known concept in organisational management, in order both to manage uncertainty and to make effective use of the people skills which are their main resource.

By common agreement, the kind of organisational climate that is conducive to the learning organisation is one which: encourages experimentation; is open and provides feedback; is

tolerant of mistakes and sees them as opportunities for learning; respects the individual and encourages the questioning of the status quo; gives individuals the maximum possible autonomy and which, while providing a supportive setting does not shirk from confrontation and facing up to major issues when necessary.

If staff development is to be an integral part of organisational development, the institution will first need to specify more clearly its organisational goals and means of achieving them. Staff development can be used as a way of involving staff members in a discussion about these issues. Secondly, staff development needs to be seen as an on-going process at all levels of the organisation (not just for the academic staff). Thirdly, staff development should be seen less as a series of events but as having an integrative function – encouraging networking and forging links across traditional boundaries, providing for a mutual exchange and learning, creating a culture and ethos which supports reflection and learning. Fourthly, if staff development is conceived as part of an organisational change process, the responsible persons need to have sufficient seniority and credibility within the organisation to be taken seriously and to have access to the appropriate formal and informal channels of power and influence.

CONCLUSION

The tradition of staff development in the past has been one of concern for individual professional development without reference to curriculum, departmental or institutional priorities and needs. Organisationally it has been largely disjointed and *ad hoc*, lacking any integration with regular management functions. The common pattern has been for financial support to be given to individuals to attend conferences or courses, usually on their own initiative. Many institutions of higher education are now moving towards a more strategic, integrated and comprehensive approach to staff development, but medical schools still have a long way to go in recognising its potential for effecting change. Some schools are beginning to place more emphasis than hitherto on individual training and personal development, but moving beyond this stage to developing a staff development strategy which links in with desired curriculum or, ultimately, institutional change is still an unrecognised opportunity to be grasped.

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CHAPTER 3: Summary of conference sessions

THE PROCESS OF DEVELOPING AS AN EDUCATOR

JUDITH RILEY, KING'S FUND COLLEGE

USING OUR OWN EXPERIENCE

When I began to think about how to respond to Angela Towle's invitation to contribute to this workshop, I found that I moved through a series of stages. Later I realised that these stages which I passed through over a few days had many parallels to the stages I could see in my own development as an educator. This chapter describes these stages as a model of development and describes the way we learned together at the workshop.

We began the workshop with a 'graffiti board' exercise. I set up two flip charts on opposite sides of the room, headed with the start of contrasting sentences: "When we were students, what really helped us was:" "When we were students, what really hindered us was:".

The participants were asked to find a partner and agree an ending to one of the sentences and write it up on the appropriate flip-chart. As soon as they had done this, they were encouraged to find new partners and look for an agreed ending to the opposite sentence. This process continued until everyone had worked with at least half a dozen different partners and the flip charts were full.

This form of brainstorming is an active way of starting an event. The particular sentences were chosen to encourage participants to focus on their own experience as students; not that these high-powered academic staff's experience of some years ago was a perfect model for their own students' current world. The point was to remind them that their experience had some relevance and to involve them actively in the workshop. I also hoped that this exercise would help the different professions present (educators, medical academics, staff developers) to see that they had a lot in common and make them comfortable in working together as far as possible. To this end I had encouraged them to take as partners for the exercise those they knew least well.

Here is what they wrote on the first flip chart.

When we were students, what really helped was:

Enthusiastic teachers
A friend on the course
Support from other students
Relevance
Enthusiasm

Enthusiasm
Our ideas seen as worth listening to
Telling me what I should be doing
Explaining things at my level
A moderately stable sexual relationship
Organised lectures which made clear what was expected of students
Nothing
A teacher who knew how to manage people
Previous learning experience
Being treated like an adult
A really excellent library
Approachable teachers
Relationship with one particular tutor
Independence
Good small group teaching
Asking questions/discussing
Enthusiastic teacher
Positive feedback
Extra-curricular society (group skills, meeting/political skills)
Co-operative enthusiasm in a task with others
Visualising and handling then working through
Group participative events
Getting encouraging remarks on written work
Getting high marks
Experiential learning, e.g., fieldwork
Interactive teaching methods
Reading round interested me
Relevance – relevant level

On the second flip chart they wrote the following:

When we were students, what really hindered us was:

Lack of confidence
Feeling we didn't belong
Lectures – dull delivery
Lack of clarity re objectives
Following recipes (biochemistry practicals!)
University structure
Volume overload
Humiliation
Social distractions
Seminars where students reluctant to participate
Not understanding the context for one's learning
Poor lecturing
Left hand not knowing what the right hand was doing
Uncommitted teachers
Excessive factual material
Huge numbers of students
Distractions such as sport
Boredom
Group I was assigned to

Smarmy consultants
Lecturers who couldn't lecture or teach any other way
Too much structured teaching (>35 hours)
Worrying we might not be good enough
Too much to do
Not knowing what is required for assessment
Restrictions, tramlines
Being picked on
Poor facilities
Disorganised teachers
Best friend bonking my favourite woman
Staying with the same group of students through the years
Being ignored
Falling in love
Discovering that the lecturer's 'original' work was plagiarised

You will have found your own points of interest in this. I was pleased to see recognition of several factors that I believe important:

- Students are helped by being involved and given responsibility for their own learning, with the challenge and risk that that ownership implies; while passive learning from didactic teaching presents difficulties.
- Students are whole people while learning and strongly affected by their emotional and social lives; while teachers often behave, unhelpfully, as if this were not true.
- Good teaching is well organised with good communication between the lecturers providing the separate components. The disorganised creative genius imposes a cost on students, even though such a lecturer is probably far preferable to the bored uncommitted teacher.

Having got off to an active start, I then spoke of my own development as an educator. In preparing for this workshop, I had begun by being absorbed in my worries about whether I could perform well enough for the occasion, reinforced by the knowledge that I would be an outsider with my lack of medical training. My mind automatically jumped to running through all that I knew about staff development.

Without consciously realising what I was doing, I had then turned to showing off by designing jolly exercises that the participants would enjoy. My aim was not only survival, I wanted approval too.

As a third stage, I had begun to think more about the participants' needs. I wanted to make a diagnosis and a treatment plan. Without having met these people I was deciding what they most needed was to be moved from a state of being focused on the content of their teaching to being focused on how to plan a process of development.

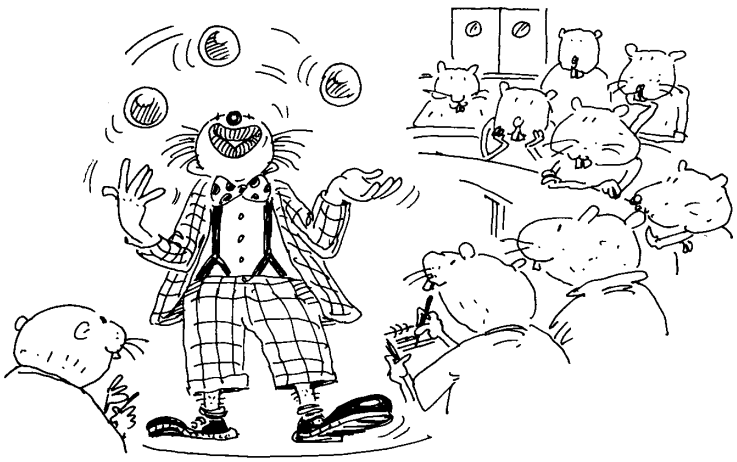
Gradually it dawned on me that there was something wrong with all this and I began to feel uncomfortable. I knew that this approach was wrong but for a while I just felt depressed by its inadequacies. Then I saw what a primitive model of development I was using in designing the workshop session. It was as though I had regressed, when faced with the challenge of working with a group of eminent strangers. Then I was able to set the following model and to use it appropriately to plan the session.

STAGES IN THE DEVELOPMENT OF AN EDUCATOR: THE FOUR 'E'S MODEL

Stage 1: The expert

As a new lecturer, I felt as though I had no right to my university post. I knew I had to fill my allocation of lecturing hours and I was determined to 'cover the ground'. Did I know enough to look clever? I was concerned to impress my new colleagues, the students were the least of my worries! I was focused on myself and my own needs. As I began to draft out my lectures I found that my problem was that I had too much material; in order to feel safe I had to include everything I knew. It was as though I was trying to pack too many things into a box of fixed size.

Stage 2: The entertainer



After my first year I began to feel more confident now. I had time to learn about teaching methods and enjoyed trying out every new technique. I became hooked on innovative methods. It was as though my students were my experimental guinea-pigs, and I was their clown, showing off, controlling them and at the same time desperately wanting them to be entertained.

Stage 3: The engineer

After a few more years passed, I became more caring for my students. Perhaps I grew up a little or perhaps I just got bored with structured exercises. I began to think about my teaching objectives and what my students needed to learn in order to perform well in the assessment that I set. My focus was on devising routes through my material, dividing it up into steps, sequencing them and providing opportunities to pause and practise what had been learned. It was as though I were designing a railway track through difficult terrain for my little trains, the students, to negotiate their ways from A to B.

Stage 4: The equal

It was not until I moved to the King's Fund College that I could see that I wanted to move into a fourth stage. My new colleagues taught me to try to operate as an equal with my students. I try to aid the exchange of experiences, to make things safe enough and challenging enough for adult professionals to learn from each other. I can offer the resources of experts either face-to-face, or in books, or videos. I try to listen well and can sometimes ask a question that provokes insight. I am now a facilitator of independent and individual learners, each discovering and pursuing their own objectives. Being an educator now feels like a relationship between equals, where I have real respect, at last, for my 'students' and where I must not, and no longer need to, hide my own inadequacies.

Whether there will be a further stage, I do not know for sure, but I suspect there will be!

When we discussed this model at the workshop, most of the participants could place themselves and their colleagues in my stages. (We could also see some parallels between this process of development and changes in the doctor/patient relationship.) Several of the participants found that they too were liable to regress to earlier stages when under stress as teachers.

We debated whether these were desirable stages in development or whether it was more that each approach was appropriate in different circumstances. My own view is that in general the later stages seem in some way more ethical and certainly more powerfully effective for student learning. Yet circumstances will often make an earlier stage the most appropriate approach: you probably cannot avoid stage one when young and new to lecturing; stage three may offer more appropriate approaches than stage four for large groups or for young inexperienced students.

HOW CAN ONE ORGANISE POWERFULLY DEVELOPMENTAL EXPERIENCES?

We then turned to small group working to allow each person more time to explore their own views on what makes for development in students. We began in threes, sharing some examples of experiences that had been developmental for us as individuals. Then I asked the threes to double up to form groups of six and suggested they focus on the question, "How can you organise similar developmental experiences for others?". Each group produced a brief note of the main points that they discussed, which I have summarised as follows. You will notice that most of the points applied both to medical students and to clinical lecturers.

There was a realisation that we have to give recognition of talent and achievement and to allow others to take responsibility and to develop through this. This would help our students to mature, build their confidence, encourage self-help and their career development. Similarly we need to arrange for staff to experiment, experience risk and to become dissatisfied with their teaching or they will not change. Some discussed deliberately creating stressful situations. Several groups recognised that encouraging risks meant that students and staff need role models and support in a culture that did not blame when mistakes were made, and where ignorance could be openly acknowledged.

Both students and staff need to surround themselves with like-minded people who share a similar vision. There needs to be protection for those who take risks and key people, such as deans, need to encourage those who take responsibility. People need to feel wanted and staff may need to be helped to find appropriate roles. People should be encouraged to follow their own inner motivations.

Students need help to break the learning into manageable steps and to integrate learning across courses. Both students and staff need frequent feedback and a constructive atmosphere in which to discuss it. They need to share experience with their peers.

These points seem to me to be clearly focused on helping the 'students', whether they are medical students or clinical staff. I felt that the workshop participants were clearly using stage three and four approaches in these discussions.

WHAT MOTIVATES ME TO TRY TO IMPROVE MEDICAL EDUCATION?

In the final exercise of my session, I asked them to brainstorm the question above, in order to recall the satisfactions of this part of their work.

To help produce better doctors
To help produce thinking doctors
Better doctor/patient communications
To feel wanted myself
My own rotten experience as a medical student
To prevent damage that I suffered
Student dissatisfaction
Low morale among students
To protect and develop my relatively young specialty
Anger at inefficiency
Seeing the development process of individuals
Feedback from students when I try something different
Support from colleagues
The challenge of promoting organisational change
Bringing together enthusiastic teachers
I might be the patient!
To improve patient experiences and outcomes
More effective use of the time we have to prepare doctors for their work in a changed world
Teamwork skills
I am fascinated by the process
My loathing of rote learning
My passionate belief in education as development process
I have seen the best and the worst
Visits to my GP
I have a proselytising mission
Better health care for my children
I am the consumer
I enjoy it
Students say 'we'd like more of this'
Wanting to have influence
It's fun
To shake my complacent colleagues
To give students a better deal
I am an idealist
To give students better preparation for what is to come
To develop more realistic expectations of young doctors by society, patients and their seniors.

We ended the session with that reminder of the importance of improving medical education and the pleasure that can be had from this work, so often done part-time and seen as rather a thankless task.

In this setting we had worked as equals, sharing experience: we were in what I would call a stage four approach to the day. It felt like a good way for medical teachers and staff developers to work together.

HAVING A GOOD TIME

BRIAN JOLLY, JOINT ACADEMIC UNIT OF MEDICAL & DENTAL EDUCATION, ST BARTHOLOMEW'S HOSPITAL MEDICAL COLLEGE

A well-known university has had a staff development programme for new lecturers for almost as long as I can remember, certainly since 1974 when I was asked to participate. The striking thing about the early courses was how boring they were. They were totally boring for the participants, who were compelled to attend by the university, and they were mildly boring for me. In fact, they were so tedious that I did not even commit them to my curriculum vitae. Now, running similar courses is 25 per cent of my job and constitutes 20 per cent of my cv.

The conference session was about making courses enjoyable – only that. It was not about what objectives to set, or what skills to cover, or who to get to teach, or how to evaluate – all exceptionally important issues for successful staff development. No, it was just about how to have a good time. Because having a good time is an essential part of staff development. Certainly people can learn without having a good time and can have a good time without learning. But together these elements constitute a powerful force for change and a distinctive and memorable expression of the best aspects of staff development.

Naturally the essential procedures and conditions needed for learning to take place must be provided on courses. But these attributes are well known. Less well known are simple rules to ensure that a good time is had by most, if not by all.

Occasionally, of course, the things to be learned may be inherently unpalatable – redundancy, bad prognoses, editorial disfavour. But this was not the remit here either. Nobody should expect to 'feel good' about the sack. These things lead to coping strategies rather than to the development of skills influencing rational, positively motivated personal development. But what we need to know is how the cultivation of useful knowledge and the development of skills can be made even more enjoyable to the learners.

First, it helps if the issue you have chosen to address is amenable to change through staff development. Sometimes banging one's head against a brick wall is enjoyable, but not often. For example, sexual or racial prejudice awareness courses can be very effective with people who believe they are not racially or sexually biased. But would they be useful with openly bigoted groups? Probably not.

Also, most staff development is carried out under several constraints or tensions:

- In medicine, at least, participants are likely to be very busy people.
- They usually work in teams.
- Often they are attending slightly reluctantly.
- Total autonomy, for them or you, is usually impossible.
- Participants are usually 'adult' learners.

There are three features of the programme over which you have some control to enable you to deal with these constraints: the course; the participants; and the course team (the teachers).

THE COURSE

The types of courses I am talking about are those in which medical teachers are taught some aspect of how to deal with students, for example on teaching or counselling. But they can apply to other areas.

In line with modern thinking about learning, the course **must involve some activity** on the part of participants, usually in groups. It helps if there is a lot of this, which is easier in a long course than in a short one. It also helps if there is some positive useful outcome or product from this endeavour.

The activity must be **challenging** at an appropriate level. The most satisfying previous educational experiences described by participants at the King's Fund workshop were when they had been taken to what they thought were the limits of their capabilities and yet came through in a productive fashion. If, at the start of your workshop, you set goals to which senior clinicians respond, with apprehension and uncertainty ("you don't want *much* do you?"), you have made considerable progress.

In accordance with this your course must **practise what it preaches**. You would hardly expect a group of highly intelligent physicians or general practitioners, on a course on small group teaching, to sit and listen to two hours' worth of lectures on this topic.

A demarcated period of reflection on what individuals have learnt, sometimes followed by discussion, is very useful on longer courses (more than one day). Use a 15-30 minute period of **evaluation discussion**. The purpose here is not to evaluate the course but to evaluate what each participant got out of the course in the previous session(s).

Apart from during the evaluation discussions, the course must move at a **fast pace**. These are busy people used to working quickly, so respect them by not labouring issues.

Other features of the course should include using '**islands of content**' within the overall activity. A 'touchy-feely' group dynamic may be your overall aim, but anyone can do that! If you have expertise distilled from years of hard work it is unlikely that the participants will be able to develop such skills themselves within a few activities. Show off your skill. Give them the tools and make the activity the means to apply their (your) skill. Keep these islands short; do not make them into continents.

Use some **mildly coercive and competitive strategies**. Coercion is not generally to be recommended. However, since most of us would not have chosen some of the more personally rewarding situations in which we have found ourselves, some people may need encouragement to become involved. "Do it and if you don't like it tell us afterwards", along with suitable appeal to the rational benefits of an activity, is usually sufficient. We often experience a need to use this tactic when getting lecturers engaged in peer-reviewed microteaching tasks. Almost inevitably after the unpalatable comes the reward of comprehensive and detailed comment on strengths and weaknesses. Along with this you can give prizes for good individual or group performance which generates increased motivation between groups and promotes group cohesion.

Sometimes it is necessary to **embed development concepts within otherwise academic content delivery** – to teach how to teach the content as part of the course content. This is because some methods may only be applicable to certain content or it may be the only opportunity there is available to introduce issues about teaching and learning. I am thinking here of the type of courses run by the Royal College of Surgeons on Advanced Trauma, both at provider and instructor level.

THE PARTICIPANTS

In institution-based courses we have found that training senior members of staff about six months to a year before junior ones, and using a cumulative approach, has benefits. The seniors are always one step ahead and have a broader experience.

In group activities it is vital to **define the groups** very carefully. Not too many surgeons or too many GPs, etc. in any one group. Balance sexes as far as possible. If you do not have enough women to put at least two in any group then it may be necessary to have some groups without females. Regrettably we have come to this decision because in an effort to balance everything we have frequently witnessed the, sometimes hostile, stifling of the female perspective in groups because the ideas of the lone female member were ignored or quashed. Also, over the last five years we have gradually eradicated the evening component of day courses because we have found the extra hours, though socially and educationally useful, to be unacceptable to participants with family responsibilities. Of course we still run evening events but much less frequently than hitherto.

Which brings me to the next, somewhat counterdemanding point. The best courses tend to be those which are **residential** and take participants out of their normal environment or away from constant bleeping or other interruptions.

Finally, we have noticed in our day-to-day interaction with course participants that frequently, contrary to all common 'group theory', a quiet participant does not mean an antipathetic one. This paradoxical behaviour is more frequent when people are being challenged continuously. Such challenges often produce a sort of internal debate in the participants which must be resolved before more proactive demeanours can be released.

THE COURSE TEAM

Naturally it helps if the course team members are accomplished teachers who practise what they preach and are nice people to boot. But this cannot always be assured. There are therefore a couple of simple rules which, if followed, will result in a short time in vastly improved enjoyability.

Use a team approach. Moreover, certainly when running a new course using the above rules for the first time, **all the faculty or teaching staff should be at all of the course**, even if they are not actually doing the teaching at that moment. This enables sharing and criticism of course ideas and methods among the team, and also prevents overlap.

Finally, **do not let any one teacher do too much**, even if they are your trump card. Everyone needs a break from teaching, which is an extraordinarily draining activity. And everyone needs to share in the administration. You cannot be an administrator and teacher on the same course – there are too many things to think of.

Many of the ideas in this paper have come out of detailed discussions with my colleague David Newble, to whom I am grateful.

CHAPTER 4: Examples of staff development and change

This chapter comprises 18 case studies submitted by conference participants. Some illustrate different models of staff development and others describe personal insights and perspectives drawn from experience of various staff development initiatives. The cases have been grouped into six sections, although some cases could fall into more than one category.

a) Staff development and curriculum change

The five cases describe staff development initiatives which have been introduced in relation to curriculum changes such as the introduction of a new course or new approaches to learning. The five cases describe staff development in relation to: a communication and learning course; a personal and academic development programme; a general medical firm in general practice; communication skills teaching; computer-based learning.

b) University-led initiatives

The two case studies illustrate some approaches which universities are taking to staff development (see page 2) and the impact these are having on the medical faculties.

c) Enterprise in Higher Education initiatives

A number of medical schools are receiving assistance towards staff development from the EHE scheme (see page 3). Two cases are given in this section, although Case Studies 4 and 5 also relate to EHE initiatives.

d) Initiatives from Departments of General Practice

Within medical schools, it is these departments which have put the most time and energy into providing training for their tutors. Three such case studies are described.

e) Postgraduate medical education

Improving the teaching and tutoring skills of senior consultants to enable them to provide better quality educational supervision of postgraduate students is now receiving attention at regional level through the postgraduate deans. Examples from two regions are given.

f) Personal experience and views

Drawing on a wide range of experience over several years, five participants reflect on the lessons that they have learned and which may be of help to those planning and delivering staff development.

a) STAFF DEVELOPMENT AND CURRICULUM CHANGE

CASE STUDY 1

STAFF DEVELOPMENT FOR A NEW COMMUNICATION AND LEARNING COURSE

LESLEY MILLARD, UMDS

STAFF DEVELOPMENT IS:

A process whereby the ability of staff to perform their work roles is enhanced. The process is structured according to the objectives which it is designed to meet. The objectives may be pre-determined or evolve within the session through negotiation, so that determining the objectives becomes part of the staff development process.

Staff development is distinguished from personal development in that the former is linked with work roles and sees an increase in the individual's ability to contribute to the organisational tasks as an underlying goal. None the less, personal development often accompanies this work-related development and the two processes enhance each other.

Staff development differs from organisational development in that its focus is at a personal or interpersonal level (for example, skill building and team building), while organisational development focuses on structures, processes and systems within the whole, or part, of the organisation and not on people as such.

CHANGE AND STAFF DEVELOPMENT

Change may simply occur or be managed. This session looks at change as a managed process.

Planning for change involves achieving some clarity about the nature and direction of change:

- What sort of change are we seeking/involved in?
- What new behaviour, attitudes, skills, knowledge will be necessary?

These are fundamental questions requiring reasonably clear answers if a proactive approach is to be adopted.

Staff development sessions (that is, sessions in which staff work in a structured way on professional and organisational issues) can be used to identify and build changes in behaviour, attitudes, skills and knowledge. More fundamentally, staff development sessions may be used to identify what sort of organisational change is required and what sort of processes are appropriate to its achievement.

To summarise:

- Staff development may be used as one of the ways in which a defined change is implemented; and/or

- Staff development may be a means of identifying what change is desirable.

In either case, staff development can be a powerful tool for enabling staff to own change; that is, to participate in shaping their futures, rather than being the passive recipients of change.

On a more limited scale curricular change and staff development need to be tied closely together. Staff sessions to explore curricular issues may not be billed as staff development and yet this is an extremely significant function of such events. They enable staff to discuss topics such as objectives, teaching methods, evaluation. The process of discussion airs beliefs and attitudes, requires that positions and views are made public and may be challenged. It is therefore an essential part of the professional development of teachers.

A specific example of the relationship between curriculum and staff development is provided by one of the United Medical and Dental School's new courses: Communication and Learning.

THE COMMUNICATION AND LEARNING COURSE

This course is part of the new curriculum under development at UMDS. It meets the goals which were set for the new curriculum, which themselves are in harmony with the GMC statements on the needs for curriculum change.

The goals for the new curriculum were:

1. Reduce factual overload.

2. Promote self-directed learning.

3. Increase perceived relevance by strengthening clinical and preclinical links.

4. Increase student work in the community.

5. Foster attitudes and skills appropriate to life-long learning.

The Communication and Learning course focuses particularly on goals 2, 3 and 5. It grows from a curricular model which emphasises the importance of the process of learning and the development of the learner.

The twin themes of learning and communication are interwoven within the course in recognition of the fact that much learning is dependent on communication, from formal sources such as lectures to informal ones such as unsolicited comments on behaviour. In the same way, effective communication requires skills, attitudes and knowledge which are acquired in formal and informal learning situations.

The course is largely experiential: it offers activities in which students participate and follow this active involvement with structured reflection.

STAFF DEVELOPMENT STEPS

1. Meeting to brief any interested members of staff on proposed course and ask for reactions and suggestions. Interested people asked to 'sign up' for possible involvement as facilitators.

2. Facilitator group identified. This was made up of: eight preclinical staff, most with little experience of the facilitator's (as opposed to the tutor's) role; seven social scientists and one general practitioner, all with considerable experience of facilitation.

3. Staff development session for facilitators to give them some training in the skills which would be required of them within the context of the course and to enable them to go through the proposed programme in detail. This skill practice was felt to be very useful and practical changes were made to the timing of the programme as a result of staff comments. The organisers attempted to demonstrate facilitative skills and then encouraged reflection on, and discussion of, these as well as providing structured exercises to enable the staff to practise facilitation.

4. One-to-one interview sessions were held to gain feedback from staff on their individual experience of acting as a facilitator on the course, once this role was completed (end of week 1).

5. A group feedback/staff development session was held to share views, and to evaluate and identify what worked well and what needed changing. A key point which emerged was the benefit felt by staff who had worked as facilitators with the groups they subsequently tutored in other parts of the first-year course. These staff felt they had gained greatly by building a good relationship between themselves and the students via the Communication and Learning course. Staff also felt they had benefitted from learning about and putting into practice, skills applicable to facilitating groups.

Issues raised by the staff development activities:

- How should facilitators be chosen: for their degree of existing skill or for the role they have in the rest of the curriculum and skills they may acquire?
- How much time can staff/departments be persuaded to give to staff development – especially where a course has no departmental base?
- Should attendance at staff development sessions be mandatory for facilitators?
- How can we give recognition to the value of the work of staff on such a course?

CASE STUDY 2

A PROCESS APPROACH TO STAFF DEVELOPMENT

JOYCE GODFREY, SHEFFIELD

Staff development is the bringing about of personal and professional change in staff so that future performance, activities or understanding are enhanced, and a proactive response to organisational and curriculum change occurs.

The stimulus for change in the medical school at Sheffield University comes from the GMC report on medical education and a recent in-house extensive evaluation of the medical undergraduate course. A major recommendation of both of these is the need for ongoing formative assessment of medical undergraduates. Additionally, curriculum and organisational changes have occurred within the medical school itself, the foremost of which is the move towards modularisation. All the foregoing highlight the need for personal and professional change.

A decision to produce and pilot a generic Personal and Academic Development Programme (PADP) for undergraduates across university departments, and a request from the medical school for a programme which included professional undergraduate development provided a timely vehicle for staff development. The programme itself would involve student self-assessment and have a strong formative orientation.

RATIONALE

We started with the belief that innovation would be more successful when staff had influenced its direction. The detailed changes which emerged would be the result of discussion, disagreement and compromise. Imposition of changes by an expert from without was definitely not on the agenda. In this context staff development was not separate from but occurred though the process of formulating, influencing and agreeing the innovatory changes needed – bringing about curriculum change would result in individual change.

We resolved, therefore:

- actively to involve staff;
- to draw on staff expertise;
- and to build on what was already known.

METHODOLOGY

In the first instance we looked separately at the possible format of a PADP for the sciences and for the clinical because these had been separate parts of the course. Twenty-four members of staff were identified to constitute our initial working groups. All had many years' experience in the education of medical undergraduates.

In order to create opportunities for involvement an experiential approach was adopted. The recent GMC report and the King's Fund Centre paper on medical education informed the formulation of a list of skills, personal qualities and, to a lesser extent, knowledge, that should characterise a medical graduate. Several sets of stimulus cards were produced, each

containing one of the items on the list. These sets were then divided into those relevant to the sciences and to clinical aspects of the course, respectively.

At the initial meeting for the sciences (in June 1992), sets of the appropriate cards were distributed with the brief that participants work in small groups in order to agree a hierarchical sequence of the items, based on their temporal appearance in the undergraduate course. Opportunities were provided for participants to reject any items deemed inappropriate and offer substitutes and/or additions. The sequences which emerged were transferred to a large chart covering the years of the course being addressed.

In order to maximise participants' involvement the first meeting had been left very open. The learning that came out of this was an obvious need for a more structured approach. This learning influenced the approach that was adopted for the meeting with the clinicians. Each small group was asked to consider a particular year of the course and received only a proportion of the total number of stimulus cards. Groups could negotiate with each other for the exchange of cards and could make their own additional cards in order to arrive at a set of items relevant to their year of the course. Again, the results were displayed on a large chart and in addition comments were invited.

The meetings were followed up by sending the summarised results to both groups of participants, and to the small number who had been unable to attend the meetings. Further comments were invited. The individual responses indicated a mixed reception to the items and the sequencing that had been agreed on a group basis. While the positive responses were encouraging, the negative responses in the main yielded constructive criticism which suggested support in principle for the development to date. In ensuing meetings with individuals, further discussion, mutual clarification and adjustment of positions enabled most of the criticisms to be addressed. It appeared that in many cases there was commitment in principle to the direction taken so far. However, it would be true to say that there was not at this stage complete conceptual and philosophical accord.

A further meeting for each group took place following the summer vacation. Time was spent outlining and clarifying the relationship between the PADP and a modular curriculum and anxieties regarding the human resource implications of the programme were dealt with. By this time the generic PADP was in an advanced stage of development, strongly influenced by the feedback from our earlier meetings and feedback from a sample of students and academics from other university departments. Sample items had evolved into student goals with descriptive criteria attached to each goal. These were passed round the groups as concrete examples. Following further discussion the sciences group consented to the use of the finished generic PADP with second and third year medical undergraduates on a pilot basis this academic year.

PROGRESS TO DATE

At the present time the PADP has been introduced and distributed to second and third year medical undergraduates. Initial staff briefing notes have also been distributed and follow-up student and staff support and development is planned.

The clinical group has agreed to be involved in developing professional goals for the student programme. This is to be achieved through meetings with individual group members to discuss and develop criteria appropriate to a chosen professional goal. While at the present time these meetings are in their early stages, a facilitative and discursive approach has enabled significant progress to be made.

LEARNING

In retrospect, it is possible to identify a number of stages which, while not discrete, are involved in a process approach to staff development.

Awareness

Pre-dating the PADP initiative, developmental activities with academic and clinical staff had heightened awareness of the need for change. Arguably this awareness of need is a powerful prerequisite to the change process.

Involvement

The participatory methodology adopted enabled staff to engage with the stimulus materials and to contribute to developments on their own terms, and in a way which valued their expertise. Such an approach, which starts from where the participants are in their thinking, is more likely to secure personal involvement and in terms of personal development, increases the possibility of new meanings emerging (Ausubel, 1978).

Commitment

The provision of opportunities for discussion, criticism and contribution of ideas at different points in the process increased the likelihood of intellectual and personal commitment. Knowles (1984) has pointed to the value of participation in the process of development as a powerful means of ensuring commitment to development.

Ownership

Individual discussions with clinical staff were undertaken to confirm the professional goals for medical undergraduates and facilitate the emergence and understanding of the criteria which could usefully describe a goal. The purpose of these discussions was two-fold: i) clinical staff would own the learning that resulted from their involvement in the developmental process; and ii) they would have a sense of ownership of the student programme as a new innovation.

FUTURE DEVELOPMENTS

The staff development undertaken to date represents the tip of the iceberg. The medical school operates a personal/social tutor system. The aim for the future is to use the completed PADP as a formative tool which informs tutorial discussion and guidance. With approximately one hundred and twenty personal tutors the staff development task is large. While it has not been possible to involve all these tutors in the initial design of the PADP, account will be taken of any feedback offered during the pilot period. Additionally, staff development with the personal tutors will be guided by the need for involvement, commitment and ownership.

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CASE STUDY 3

STAFF DEVELOPMENT FOR A NEW GENERAL MEDICAL FIRM IN GENERAL PRACTICE

ELIZABETH MURRAY AND VIVIENNE JINKS, UNIVERSITY COLLEGE LONDON

In September 1991, the Department of Primary Health Care piloted a six-week firm for first year clinical medical students which aimed to teach general medicine in a general practice setting. This pilot was extended in September 1992 to take double the number of students per firm (eight) and to include oncology. The course structure is that students are divided into pairs, and each pair is allocated to a GP tutor for the duration of the six-week firm. Students spend half of each week in the practice; the majority of this time is dedicated to visiting patients at home, taking a full history and examining the patient thoroughly, and subsequently going through this clerking with the GP tutor.

Staff development sessions were started in September 1992 with the following aims: to encourage a sense of ownership of the new course among the GP tutors teaching on the course; to ensure that the aims and objectives were agreed by everyone involved with the course; to promote agreement about ways of achieving these aims; to provide support for the tutors; to foster and encourage good teaching practice; and to provide education and updating about clinical topics, in particular oncology.

In terms of effecting change, the main change that we hoped to achieve through these staff development sessions was to enable GP tutors to change from teaching general practice to teaching general medicine. Many of the tutors were very experienced in teaching general practice to undergraduates, but most thought they had no previous experience in teaching general medicine.

The structure of the staff development course is that of a two-hour evening meeting held once a month. Food is provided by the department, and the sessions are chaired by a senior member of the department. Sessions are divided into two halves; in the first hour tutors bring 'hot topics' which are discussed in the group and solutions are proposed. The second half is more structured: a paper exploring a particular issue is circulated in advance and forms the basis for a group discussion. The topic of the paper may be determined by the previous month's 'hot topic' or by the department's underlying agenda for the entire course.

Topics discussed to date include: how to organise the practice to maximise the educational value of the student's attachment; how to teach the students to take a full medical history; what is the best way to teach students examination techniques; and ideas on helping students to learn through a mid-firm assessment interview. Topics to be discussed in the future include: further ideas on student assessment within the practice; further discussion on how adults learn; how to teach in a problem-oriented way; recent developments in oncology; how to evaluate the course; and looking forward to expanding the course.

The course seems to be helping GPs overcome their initial lack of confidence in teaching general medicine, in that the tutors are realising, first, how many teaching skills thay already have, and second, how much general medicine they actually do know. It also seems to be encouraging a greater adherence to the course aims and objectives, in that students are spending more time clerking patients with common medical conditions and having these clerkings supervised than was happening last year.

The barriers to change are the usual ones: it requires effort on the part of the tutors to change, and the tutors are all very busy people. It requires time from both tutors and department staff. It requires resources within the practice to liberate the tutor to teach. It requires space where the students can be taught.

Some of these constraints can be overcome: tutors are enthusiastic about the programme, and therefore interested in changing. We aim to maintain the enthusiasm through promoting a sense of ownership. Tutors are paid for the time spent teaching, and attendance at the staff development sessions is recognised as part of the commitment. The staff development sessions are recognised for the Post-Graduate Education Allowance, which rewards tutors for attending, and encourages them to find time at the end of a hard day's work. More fundamental questions about resource allocation are being explored by a small working group.

CASE STUDY 4

STAFF DEVELOPMENT FOR COMMUNICATION SKILLS IN THE NEW CURRICULUM

ANNIE CUSHING, CITY & EAST LONDON CONFEDERATION

Communication skills are emphasised throughout the new medical and dental curricula at CELC. Skills include communication with patients, relatives and carers, colleagues, the health care team and other agencies related to health care, including the media.

My post, funded by the Enterprise in Higher Education scheme, involves collaboration with clinicians and tutors from psychology and social science to develop and integrate teaching and learning opportunities in a vertical and horizontal approach. The challenge is how to raise discussion, practice and feedback of communication skills in all fields and not just those that have traditionally recognised their importance (that is, psychology, psychiatry and general practice).

STAFF DEVELOPMENT

I have run a number of Training for Trainers courses. These are of two types. Generic courses are run on facilitating learning of communication skills and teaching on the consultation, using role play, videotape feedback and actors as simulated patients. These are intended for interested individuals to incorporate opportunistically within their existing teaching. Specific courses and training are also undertaken to support communication skills courses with defined objectives at key places in the curriculum. Some of these are already in place (Breaking Bad News and a General Practice Consultation and Communication Skills Course) while others are being introduced.

KEY ISSUES FOR ME

- How to encourage staff in a more student-centred, experiential learning approach to communication skills (without being didactic about this myself!).
- How to involve busy staff with limited time in such a way that they are not given a prescriptive course to teach but equally do not have to design their own course from scratch.
- How to address support versus undermining of the communication skills courses within the clinical environment (the 'real world' versus the 'laboratory').
- How to support the fulfilment of communication skills objectives which have now been written into the module documentation throughout the new curriculum.
- How to build in assessment that matches the way that communication skills are 'taught'.

WHAT HAS HELPED ME

- The introduction of a new curriculum which brought with it expectations of new areas of learning. Strong support from the deans and curriculum committees.

- The existence of an already interested group of people (Communication Skills Teaching Interest Group) from whom I am able to get support and assistance with teaching.
- Building upon a successful existing course and bringing in teachers from this course.
- Using two facilitators in teaching sessions, matching those who are less experienced in this form of educational approach with those who are more experienced. This co-teaching has been a novelty for a number of teachers who say they have benefitted themselves from support in developing these methods and looking at their own skills.
- Working with module convenors in developing their communication skills objectives, designing course programmes and back-up materials.
- Funding staff to attend learner-centred communication skills courses and then incorporating these people in teaching programmes.
- Involving staff in assessment of students' communication skills tasks which provides them with feedback on their students' achievements following communication skills courses.
- Involving clinicians in the communication skills sessions who are also teaching in the concurrent clinical skills course. This helps in supporting and reinforcing what has been covered in the communication sessions within the clinical setting.

CASE STUDY 5

STAFF DEVELOPMENT IN RELATION TO COMPUTER-BASED LEARNING

JEANNETTE MURPHY, CITY & EAST LONDON CONFEDERATION

EXPERIENCE OF STAFF DEVELOPMENT ACTIVITIES

Within medicine

In the nine months I have been in post (senior lecturer in medical informatics in the Enterprise Team) at CELC I have participated in a variety of staff development activities organised by the Enterprise Unit. Some of these activities have been specifically related to information technology and medical informatics and some have been more generic. To increase awareness of available information technology (IT) resources, I organised and led a workshop on computer-assisted learning and interactive videos. This was attended by staff from the Faculty of Basic Medical Science as well as clinicians from the two medical schools. I also contributed to a workshop on assessment; my input was to acquaint participants with developments in computerised methods of assessment. I have organised training sessions for staff to prepare them to run word-processing workshops for first-year medical students. Finally, I have acted as an adviser to staff who were setting up projects which involved computers. As a member of the Enterprise Unit I have helped to plan and run a two-day away session on self-directed learning for staff from the Faculty of Basic Medical Science.

Outside of medicine

In my previous post I was Chair of the Research Consultancy and Staff Development Committee for a faculty of social studies. My responsibilities included formulating a staff development policy, vetting applications for staff development, negotiating with departmental heads and senior management over the terms for staff development, costing proposals for staff development, monitoring outcomes from staff development awards, and establishing a mentoring programme for new members of staff. I also ran induction sessions for staff who were to join a team teaching an undergraduate IT skills programme and a basic numeracy course.

FUTURE PLANS

Over the next 12-18 months at CELC, I am intending to initiate the following activities:

- A workshop on computer-based learning resources for clinicians to help them to evaluate and implement the most appropriate courseware.
- A workshop on automated assessment – staff are especially interested in assessing the feasibility of using optical scanning devices to automate the assessment of OSCEs.
- Explore with staff the benefits of various administrative tools (for example, computerised timetabling package; scheduler or computerised project management package).

- Investigate potential interest in producing in-house learning resources using authoring software.
- Provide assistance to staff who wish to set up personal databases to facilitate teaching and research.
- Work with the appropriate committees to ensure that adequate IT training is available to enable staff to keep up-to-date with technological advances.
- Work with staff on the three sites to design a database of available computer-based resources.
- Provide support to staff groups involved in selecting, implementing and monitoring computer-based learning resources.

MAIN CONSTRAINTS/BARRIERS

- Staff development is only part of my role; there are other demands on my time.
- Staff involved in medical education are very busy people. It is not easy to identify people who have the time and energy to get involved in staff development activities.
- Not all of our three sites have the facilities for running workshops (that is, a purpose-built teaching laboratory).
- There are still some staff with an anti-computers mentality.
- Finding the resources to support projects – technology is not cheap and it quickly goes out of date.
- Not all staff have ready access to computers or interactive videos.
- Some staff have developed negative attitudes to computer-based learning as a result of past experience with systems which have failed to deliver benefits.
- Some staff have unrealistic expectations as to what technology can deliver.
- Overcoming the 'not made here' syndrome – that is, getting staff to accept learning resources which have been produced by other academics/other medical schools.

POSSIBLE SOLUTIONS

- To identify sources of funding (both internal and external) to improve IT facilities and to acquire appropriate resources to support staff development.
- To publicise available resources and to suggest ways of overcoming practical problems which make staff resistant to experimenting with computer-based learning resources.
- To demonstrate the benefits which good courseware can deliver (even if it is not produced locally).
- To acquaint staff with the ways in which other medical schools are making use of computer-based learning resources.

- To identify individuals who are prepared to experiment with computer-based learning methods.
- To publicise the good work which is currently going on in the three sites so as to encourage those with less experience to seek help and advice from those who have first-hand experience.
- To clarify the role of technical and support services with regard to developing and supporting courseware.
- To highlight the role of Computers in Teaching Initiative (Centre for Medicine, Bristol).
- To address the practical and logistical issues associated with the introduction of computer-based learning methods.

b) UNIVERSITY-LED INITIATIVES IN STAFF DEVELOPMENT

CASE STUDY 1

THE ROLE OF STAFF DEVELOPMENT IN A CHANGING TEACHING ENVIRONMENT: EXPERIENCE FROM THE UNIVERSITY OF LEEDS

PENNY HATTON AND DAVID BULLIMORE, LEEDS

THE THEORETICAL CONTEXT FOR STAFF DEVELOPMENT IN THE UNIVERSITY

Universities are perhaps in the greatest period of change ever. Over the past decade and more we have suffered severe financial cutbacks and greater intervention by government and its agencies, and funding is becoming ever more tied to performance. This is already the case in research and is intended for teaching. There is pressure to widen access but at the same time concern about the cost of expansion and about the implications for quality. Staff appraisal, research selectivity, quality audit and quality assessment are just some of the externally imposed changes taking place. Internally-driven changes include devolved budgeting, modularisation, franchising, Enterprise in Higher Education, internal restructuring and pressure on staff and departments to undertake new activities, for example, CPE. All these changes are making unprecedented demands on universities – from its top level managers to lecturers and administrators to support staff. The concept of 'management' is now accepted in most departments whereas it used to be a dirty word, and 'aims and objectives' are now everyday words.

ORGANISATIONAL DEVELOPMENT

Organisational development can be defined as the process of initiating, creating and confronting needed changes so as to make it possible for organisations to adapt to new conditions, solve problems and learn from experience. I would argue that staff development must be located within this process of organisational development. It can provide a vital link between individual and organisational development: on the one hand it can satisfy individual staff development needs (staff are our main resource) while, on the other, linking these into organisational needs and thus increasing the university's capacity to engage in, adapt to and promote change. While it is easy to say that staff development should be an integral part of organisational development, this is less easy to achieve because it implies that:

- the organisation has clearly defined and well understood and accepted goals;
- staff development has the strongest support of management and is seen to have a role to play in developing organisational goals, for example, by helping to create discussion.

- staff development is well resourced.
- the university culture supports innovation and tolerates mistakes during the learning process.

Staff development cannot be an integrated part of organisational development without these factors being present.

CHANGE AGENTS

If a change is to be conceived, planned, negotiated and adopted, then the different participants have a number of roles to play. Even if the change is not conceived internally but imposed from outside, the last three stages should take place. Change agents can be categorised as generators, implementors or adopters.

Change generators – those who select issues and communicate the need for change (for example, the Enterprise in Higher Education (EHE) team).

Change implementors – those who help implement changes. These might be internal or external people, for example, staff developers, departmental Enterprise coordinators, external consultants. Their role is to motivate people to adopt the change by exploring values and getting the change into the culture. Their role is about awareness and attitudes rather than knowledge and skills.

Change adopters – those who take up the change, for example, course leaders, heads of departments, those who look after departmental finances.

MODELS OF STAFF DEVELOPMENT

Staff development is an evolving process itself which can be characterised as four separate models or a four-stage process: the random or pre-stage; the fragmented stage; the formalised stage; the strategic stage.

1. The random or pre-stage

At this stage there is no recognition of staff development as an explicit or necessary function at either the individual or organisational level. Development takes place by a process of osmosis, trial and error or being thrown in at the deep end and left to sink or swim. While individuals might wish to take their own development seriously there is little reward for engaging in such professional development. On the whole, most universities have gone beyond this pre-stage. For many years, however, with notable exceptions in the 1970s, staff 'learned' to teach by the above processes.

2. The fragmented stage

At this stage, staff development does exist as an explicit function but it takes place in a culture where academic staff are autonomous, with a primary allegiance to their discipline, and where relationships are collegial. Staff development is not linked to organisational goals but rather to individual needs only. We have certainly been through this stage at Leeds and I would argue that it is vital for creating a culture in which staff development is seen to be useful and important. Essentially this stage can be characterised as reactive to individual needs, where a central unit can demonstrate that it is not a management-imposed bureacracy working to a fixed top-down agenda, but rather exists to help staff. We ran a centrally

organised programme which met needs identified by individual staff – for example, induction for new staff, teaching, research, management skills, personal development. Indeed, we still run courses on these topics and they still prove to be popular. Nevertheless, this type of staff development is fragmented and carries no guarantee that anything will result from it, as there is not necessarily any follow-up or departmental support.

3. The formalised stage

Staff development at this stage is not just about responding to individual needs in a random way but rather in a systematic way through individual performance review/appraisal, where individual aims, objectives and needs are linked in with those of the department which in turn are linked in to those of the university. At this stage staff development becomes both a reactive and a proactive activity. Seminars and workshops might be run on issues of institutional importance – quality audit, modularisation, resource centre funding, etc. Nevertheless, staff development is still course driven, with little emphasis on alternative forms such as networking, and there is little provision for follow-up support because of inadequate resourcing. At Leeds we are probably part way between this stage and the fourth stage.

4. The strategic stage

At this stage each individual has a personal development plan, linking their development needs to those of their department and the university. Development needs are met in a systematic way, either through specialist courses or other means, such as on-the-job coaching or networking with others. There is systematic and on-going induction for new staff or those with new responsibilities, linked in to their individual responsibilities and departmental or university activities. There is departmental development in the sense that whole departments have a common purpose and meet (either as a whole or as subgroups) to develop their collective skills, procedures and plans. And there is organisational development, characterised by mission statements, aims and objectives and a linked staff development strategy. Networking between individuals from different areas takes place and there are cross-disciplinary links and exchange of practice. Now staff development is not the only agent which promotes this but it is an important one. The difficulty of reaching this stage should not be underestimated.

At Leeds we have a career development appraisal scheme linked to departmental aims and objectives, and we are developing a modular programme for new lecturers on teaching and learning and the management of teaching and research. Greater development opportunities exist for administrative staff but we are still greatly deficient in staff development for established academic staff, for heads of departments and for non-academic staff. And staff development is still greatly under-resourced. One area where the strategic stage has been reached is that of EHE where the central EHE team acted as the change generators, set up a network of departmental EHE coordinators to be change implementors, who in turn work with their departments and course teams to adopt new methods of teaching, learning and assessment in their courses. Staff development and curriculum development are integrated and there are cross-university networks and groups.

PRACTICAL EXPERIENCE AT THE UNIVERSITY OF LEEDS

Background

The University of Leeds is a large multidisciplinary university with well over two thousand academic and academic-related staff and over 15,000 students. In addition there are several hundred NHS clinical staff in neighbouring and peripheral hospitals involved in undergraduate teaching.

The Staff and Departmental Development Unit (as it was renamed from 1 January 1992) comprises a director, with responsibility for the co-ordination of staff and departmental development throughout the University, a training and development officer with specific responsibility for non-academic staff development, and a half-time project officer and half-time academic adviser. The Unit's remit covers all aspects of staff development (teaching, research, management, etc.) and the Unit liaises closely with other units in the University (for example, CBL/Multimedia Support Unit, EHE Unit, Research Support Unit, and Medical Education).

Staff development as a reactive activity

While staff development has always taken place in the sense that individuals have attended conferences and engaged in a process of self-education and development, it only became an explicit function at the University of Leeds in 1989 when a Staff Development Office (as it was then called) was set up. As many colleagues did not understand what staff development or a staff development office were, they did not perceive a need for them. So, in order to demonstrate what the office could offer, we started off by offering a small programme of workshops and by setting up a small lending library of books and videotapes, many on teaching and learning. We produced a basic newsletter. It was important to demonstrate that we were reacting to colleagues' needs for staff development, as identified by them in discussion, in order to allay any possible fears about the office being a centrally-imposed bureaucracy working to a fixed agenda driven by the university management. The workshops covered topics such as better lecturing, small group teaching, supervising research students, induction for new staff, using the overhead projector, etc. These were immensely popular and usually had to be repeated several times. Although we were hoping to promote change through these workshops they carried no guarantee that change would result, as very often the participants were isolated individuals from different departments and there were no formal mechanisms for participant follow-up (all workshops were, and still are, evaluated and participants were asked how they would apply their learning, but the latter was not followed up). The workshops nevertheless performed and continue to perform a valuable cross-linking function between departments and awareness-raising about different methods and approaches. Such workshops can also have a 'subversive' role, motivating individuals who may be in departments with 'unconstructive' heads.

Staff development as a proactive activity

While it is important for staff development to react to individual needs, it is also vital that it is seen to have a proactive role in promoting change. Over the four years of our existence, the university has seen immense changes taking place affecting teaching:

- We have increased our intake by about 14 per cent to 15,700 students.
- These students are entering with diverse qualifications and from diverse backgrounds.
- We are modularising our courses from October 1993.
- The Division of Quality Audit will be visiting the university in May 1993, and individual subjects are being assessed as from May 1993.
- We have EHE funding.

All these changes are creating immense pressures on staff and departments. EHE is definitely 'a good thing' and is having a positive effect in helping departments to re-examine their courses in order to develop student competencies and skills. The convergence of all these developments means that more than ever staff and departments need help and support, and staff development is playing its part in the change process. We have first tried to operate at the level of attitudes – raising awareness of new developments. Next people need to know what they can do in order to cope, for example, what is good course design? How can we teach 50 per cent more students while remaining sane and preserving the quality of the students' experience? What methods are available? How do we actually develop the skills so that we can effect change?

At Leeds we have tackled these various stages firstly by holding general awareness-raising seminars, sometimes targetted at particular faculties or groups (for example, heads of departments) and sometimes at anyone, and secondly by running workshops on issues such as course design and evaluation, assessment of students, innovative methods of teaching and learning, developing students' communication skills. This summer we ran a series of workshops on computer-based learning and the use of computers in teaching. We also produce good practice guidelines to help individuals and departments, for example, on evaluating courses. Departments are increasingly sending a representative or pair of representatives to the workshops so that they can take back some of their learning for discussion in the department. Now whole departments are asking for these workshops as a means of raising awareness and developing the knowledge and skills of all their staff as opposed to a few isolated and enthusiastic individuals. Here a keen, or at least interested, head of department is important. This is exciting because it has been rare for whole departments to get together to discuss their teaching in the past, and a lot of change is resulting from this process. So EHE, which operates at the curriculum level, and staff development together are now acting as important agents in the change process.

Staff development at its different levels of operation

From the above it can be seen that while staff development still operates at the individual level (and must always do so if individual motivation is to be maintained) and at the 'nice to do' level, individual staff development is now taking place in the light of departmental and university aims and objectives and we are now moving towards working with departments or departmental teams at the 'need to do' level to meet departmental and organisational needs.

Implications of staff development

A number of developments are pushing the quality of teaching higher up the agenda than ever before; some of these developments have been referred to above. No longer is course content important to the exclusion of serious considerations of good course design and appropriate teaching, learning and assessment methods. In order to develop these, the staff

development process is important. Indeed, at Leeds we are developing a modular programme for new lecturers on teaching and learning in higher education. A consequence of this is that high quality teaching and learning must be shown to be valued by universities and the individual teacher must be rewarded accordingly. So we have set up an academic development fund to which departments may bid for course development funds. We have also revised our criteria for promotion so that individuals are required to collect evidence about their teaching so that committees have a sounder basis on which to judge individuals' achievements. The university is also working on other means of promoting the importance of high quality teaching from the outset of an individual's career.

Staff development for change in medical education

Initial workshops were largely reactive (demand led) on topics such as lecturing and participatory learning methods. Subsequently workshops were proactive. In these, a need was identified and interest generated in a workshop which was then organised, for example, on problem-based learning or the OSCE. Some workshops were a mixture of reactive and proactive, for example, selection interviewing of medical students.

Workshops do change practice. The workshop on selection interviewing is an example. More structured interviewing is to be used and lay interviewers are to be included within the panels. A relatively limited group of staff attend workshops and frequently the same staff are involved in a whole series of workshops. With some exceptions it is rare for those involved with curricular change at the highest levels to attend workshops. Other staff development activities being undertaken at Leeds in relation to medicine include work with individuals/departments on specific topics, such as the incorporation of clinical material in a basic science course, and the use of mini-projects. Computer-based learning facilities and a clinical skills laboratory are also being developed.

The main pressures for change relate to the recent GMC report and 'threat' of academic audit and assessment, although personally I would view academic assessment as an opportunity rather than a threat. The barriers to change are those barriers within the institution between the majority of those who teach our students (NHS, University, GPs, peripheral hospitals), the students themselves and those wishing to introduce change. The barriers are more often those of inadequate communication rather than differing philosophy. The importance of adequate communication is both under-rated and misunderstood. Communication is too often seen as a one-way passage of information from above down rather than a two-way process of active debate. Where a newsletter reflects a one-way flow of information from above down it will induce antagonism and non-participation rather than true communication. To help promote debate we intend to introduce a newsletter which will be sent to all those involved in the education of our students. The aim is to promote a genuine two-way flow of information and capitalise on the wide experience of all staff and students in planning curricular change, and the staff and student development required for successful change.

In summary, while workshops will continue as a valuable part of staff development, which do change actual practice, the main challenge is to promote better communication. Only if communication is improved will the teachers and students obtain any ownership of the changes involved in introducing a new curriculum, and only if ownership is achieved will the curricular change be successful.

CASE STUDY 7

ACADEMIC STAFF DEVELOPMENT AT UNIVERSITY COLLEGE LONDON

FRANCES LEFFORD, UNIVERSITY COLLEGE LONDON

EXPERIENCE AT UCL

This is limited. A coordinator of academic staff development and training has recently been appointed with limited financial resources. A statement of intent is given below. Courses planned for the 1992-93 session include: managing research grants; writing up research for publication; interviewing UCCA candidates; understanding and reducing stress; managing change; presentation skills; time management; skills of supervision; assertiveness skills; team building.

THE PRESENT TASK

I am the representative of the Faculty of Life Sciences to the Academic Staff Development and Training Committee. With the coordinator of the unit and the representative on the committee from the Faculty of Clinical Sciences, we are looking at the issues involved in teaching large student groups, that is two hundred students or more, specifically in the lecturing situation. Although medical students are my own immediate concern, there are occasional groups of this size in the non-medical Biological Sciences and Humanities (for example, Laws).

OBJECTIVES

Firstly, to elicit and analyse the factors in the teaching situation that staff and students find problematic, difficult and stressful.

Secondly, to prioritise the problems and work out feasible strategies for staff to select on the basis of individual preference and perspective.

INITIAL APPROACHES

1. Access all teaching staff by calling a meeting (write/persuade/coerce) or arrange a group meeting limited up to ten individuals of whom the majority are staff (two to four students). Query over the criteria for selecting staff; agreed necessity for an experienced facilitator rather than a staff chairperson.

2. Brainstorming session to work out strategies; invite specialist advice. Query over size of group and selection.

POSSIBLE PROBLEMS

Firstly, training staff so that they feel comfortable and willing to use the teaching methods proposed, and, secondly, the necessity that may arise for attitudinal changes in staff and students.

UCL STAFF DEVELOPMENT AND TRAINING UNIT POLICY STATEMENT – ACADEMIC STAFF

Background

The Staff Development and Training Unit is located within the Personnel Department. It aims to provide a comprehensive service of information, advice and training activities to all those who work for UCL.

General

Training and staff development are comprehensive terms used to describe all the different ways in which people can be encouraged to increase, update and adapt their knowledge, skills and personal abilities and competencies in order to fulfil both current and possible future demands at work. Both are important in order to maintain the existing excellence of the College and enhance the potential of its departments and individual members of staff to enable them to achieve the objectives of a major centre of learning and to respond positively to change. They should be available on an equitable basis for all staff upon whom depends the efficient and effective functioning of the institution.

Objectives

- To provide a comprehensive and cost-effective programme of courses, seminars and workshops for all staff.
- To act as a resource centre of information on national, regional and federal provision. To develop a library of information and resources.
- To provide information and advice on training and development activities.
- To establish mechanisms for the identification of training needs; to analyse these needs and to plan a strategy to meet them.
- To encourage the integration of staff development into the culture of the College generally, and the planning and management functions in particular.

c) ENTERPRISE IN HIGHER EDUCATION INITIATIVES

CASE STUDY 8

ENTERPRISE AND STAFF DEVELOPMENT AT CELC

ANGELA TOWLE, CITY & EAST LONDON CONFEDERATION

Staff development is an essential component of the CELC Enterprise project, without which the overall objectives cannot be achieved. The main thrusts have been twofold:

- to enhance the ability of the institutions (St Bartholomew's Hospital Medical College, London Hospital Medical College and the Basic Medical Science Faculty at Queen Mary and Westfield College) to provide staff development within their overall staff appraisal programme; and
- to offer training and support for staff in relation to those aspects of the curriculum in which Enterprise is concerned, namely: the Community Module, the teaching of communication skills, and in the exploration of new teaching techniques (for example, computer-assisted learning and self-directed learning).

Two other case studies in this report deal with staff development in relation to communication skills teaching (Case Study 4) and computer-based learning (Case Study 5). This case describes a set of staff development activities organised in 1992 to meet perceived staff needs for improving educational skills.

ENTERPRISE STAFF DEVELOPMENT WORKSHOPS

A series of workshops was held during 1992 as a result of responses to a staff development questionnaire which was sent out to all those involved in teaching at the three institutions, including NHS consultants. The questionnaires were sent out in December 1991 to approximately four hundred and fifty teaching staff and 90 responses were received. The questionnaire sought to discover what existing expertise was present in the institutions by asking questions about formal and informal educational training, and also to identify future training needs. The suggested training options given in the questionnaire and numbers of respondents indicating a need for training (figures in brackets) were: computer-assisted learning (40); lecturing/audiovisual aids (36); small group work (32); student assessment (32); interactive videos (27); self-directed learning (26); outpatient teaching (22); course evaluation (21); writing objectives (19); role play (18).

As a result workshops were arranged on the following topics: audio-visual aids and refreshing lecturing; computer assisted learning and interactive videos; academic goals and assessment; self-directed learning; student assessment; role play; outpatient teaching. All except the informatics workshop were held twice, on different days of the week, once at each medical college. A brochure containing information about the workshops was sent to the same staff as received the questionnaire and copies were also distributed at the Education

Fair (see below). Staff were invited to sign up for the workshops and dates of their choice.

Each workshop was designed to model for participants interactive, small group techniques, with an emphasis on active learning. Each workshop was evaluated by participant questionnaires. Attendance at the workshops ranged from one to eight, with an average of five. This was somewhat lower than we had expected on the basis of the responses to the questionnaires and there were frequent last minute cancellations. The workshops held later in the year were progressively more poorly attended, despite reminders being sent out. However, the ratings from those who attended were generally high (the majority said that the workshop had met their needs; nine said their needs had only been partially met and one not at all). Positive features of the workshops were: the informality; the enthusiasm of the workshop leaders; the opportunity to meet new people; taking time out to reflect on their teaching; new ideas. The main areas noted for improvement were: increasing the number of participants; more input from the 'experts'(several of the workshops had been run by experienced members of staff rather than medical educators); more factual information (distributed beforehand). It was interesting to note that as a result of running the workshops as self-directed learning sessions in order to model this way of learning for participants, their responses were similar to those of students engaged in SDL – a plea for more hard information and facts from the tutors!

EDUCATION FAIRS

The Enterprise team organised two open days or education fairs in February 1992, one at each medical college, in order to allow staff to learn about the new curriculum and the innovative features which are being supported through Enterprise, and also some general innovative ideas and techniques in medical education today. The two events comprised a similar array of standing exhibits and timed demonstration sessions of role play, clinical skills teaching and running OSCEs. The open day at the London Hospital had the added advantage of coinciding with student admission interviews and several potential entrants into the medical college looked around the exhibition and took part in the demonstrations. Several people from other medical colleges attended the open days but overall attendance was a little disappointing, especially at the second fair.

'TIPS' WORKSHOPS

In September 1992 a new model for staff development workshops was initiated based on a programme devised by the University of Kentucky known as the Teaching Improvement Programme System (TIPS), which has subsequently spread through various faculties of health sciences in North America (Craig, 1988). The TIPS course is based around the self evaluation of video recordings of two ten-minute microteaching sessions given by each participant. A TIPS workshop was run by two facilitators from British Columbia in Dundee and attended by two participants from CELC. Subsequently a similar workshop was held for 12 participants at CELC, with the two CELC members shadowing the facilitators from British Columbia. Three workshops have so far been run in 1993 by the two CELC staff, and the cascade principle will be continued with an identified GP attending a future workshop to train as a facilitator. In this way it is hoped to build up a cadre of staff from the three institutions who can run staff development programmes and thus spread educational expertise more widely through CELC than could be achieved through the efforts of the Enterprise scheme alone. It is intended to extend the training offered to NHS consultants in the three institutions and also the outlying hospitals.

ISSUES/LESSONS LEARNED

With the exception of the TIPS workshops, attendance at general staff development events has been poor even though they were planned to meet expressed needs. Activities (not described here) which were more specifically linked in with curriculum changes (for example, away days for module convenors on self-directed learning and assessment) were better attended. It is possible that at these institutions, which have had a long history of medical education courses, those most likely to attend educational events have already done so, and that more concerted efforts need to be made to reach the majority of teachers who do not place a priority on such training. Certainly publicity has been a problem, since communication across the institutions is poor and people do not hear about things until after the event – or at least claim this is the case. A more targetted approach seems more efficient than blanket publicity – sending out information to all staff is very time consuming for very little return. Personal recommendations from people who have been on courses are helpful. Advances have been made in specifying attendance at a teaching course in the contracts of newly appointed academic staff and this has encouraged people to attend who otherwise would not. However, in general there needs to be more encouragement from the top (deans, heads of departments) for staff to attend and, above all, there needs to be a coherent strategy for staff development.

Reference

Craig, JL (1988) Teacher training for medical faculty and residents. *Canadian Medical Association Journal* 139, 949-952.

CASE STUDY 9

ENTERPRISE ACTIVITIES AT LEICESTER

ANNIE GRANT, LEICESTER

The Enterprise Learning Initiative (The Leicester and De Montfort Universities' joint Enterprise in Higher Education scheme) is a government-funded project whose aim is to ensure that all graduating students are well equipped for their future careers with a wide range of personal transferable skills. Grants are given to departments for programmes of course review and development that result in greater opportunities for students to develop the skills needed for, for example, effective verbal and written communication, problem solving, leadership and teamwork.

The involvement of Leicester University's School of Medicine is in its very early stages, and the first focus of its 'enterprise' activities is to be the development of communication skills. As the first phase of action, resulting from a review of the teaching of communication skills to undergraduate medical students, key staff in the school attended a course on communication skills teaching in January 1993. Those who attended the course will then provide further training for others involved in preclinical small group teaching, prior to the implementation of the second phase of the project, which is the development of a 'student portfolio'. The portfolios will focus on the students' communication skills, reinforcing their awareness of the importance of these skills, and recording the development of their abilities as effective communicators; the trained tutors will act as mentors for the students. This second phase of the project will be developed during 1992/3 for implementation in 1993/4.

One of the main barriers to progress seems to lie in the structure of the Medical School, with its division into a relatively large number of rather autonomous departments. Some members of staff have shown an interest in reviewing their teaching methods in order to encourage students to feel more responsible for their own learning and to be more self-aware, and this interest will certainly be encouraged and supported. However, it is difficult to gauge the likely effects of any changes that they make on students who will only spend a very brief period with them, but may spend much more time in departments which are not particularly interested in developing their teaching (or perhaps in teaching itself). Most staff development sessions that focus on teaching are attended by staff from the medical school, and this is encouraging, especially since some sessions have been attended by departmental heads. However, they represent only a very small proportion of the total number of staff involved in teaching in the medical school.

d) INITIATIVES FROM DEPARTMENTS OF GENERAL PRACTICE

CASE STUDY 10

SUMMARY OF DEPARTMENTAL FACULTY DEVELOPMENT ACTIVITIES

ELAN PRESTON-WHYTE, LEICESTER

ACADEMIC STAFF

There has been a structured induction course for new lecturers in the department for five years. We are now formally addressing the needs of established lecturers using our tutor/co-tutor system and structured feedback forms which will be collected into individual portfolios held by the lecturers. We hope to set up a research project, the first stage of which will be to test the validity and reliability of our feedback form in assessing teaching competence.

INDUCTION OF NEW LECTURERS

There are three distinct phases.

Phase 1

First Session: New lecturer discusses past relevant experience of teaching with supervisor. Written statement of perceived needs (knowledge, skills and attitudes) agreed by lecturer and supervisor. Bibliography of recommended reading made available.

Second Session: Supervisor views video recording of lecturer's consultations with real patients. Video recordings analysed jointly by supervisor and lecturer. Emphasis on self-assessment by lecturer.

Third Session: Supervisor analyses video recording of lecturer's tutorials given to students in order to observe 1:1 teaching skills. Supervisor assists lecturer to draw analogies between consultation and teaching style.

The end of Phase 1 is indicated when the supervisor constructs an educational prescription for the lecturer in terms of strengths observed and the strategies to be employed to produce improvements.

Phase 2

Part I: Lecturer observes teaching in the department throughout the five weeks of a fourth-year cohort. Key seminars are video recorded, including co-tutor feedback.

Part II: Analysis of these video recordings is carried out by the lecturer together with the supervisor, with particular attention to:

- effectiveness of particular teaching skills;
- group dynamics;
- appropriateness of co-tutor feedback.

Phase 3

Part I: Lecturer acts as co-tutor in teaching cohort. Sessions video recorded to include feedback to tutor using feedback form (see established lecturers, below). Video recordings analysed by lecturer in conjunction with supervisor.

Part II: Lecturer acts as tutor teaching each type of session, for example, diagnostic process, PMQ, anticipatory care. Sessions video recorded and/or observed by supervisor. Video recordings analysed in conjunction with supervisor using techniques of simulated recall and microteaching.

End of Phase 3 is marked by a review of the original educational prescription and this is then rewritten addressing the lecturer's teaching strengths, the improvements needed in teaching skills and the strategies to be employed to achieve this.

If no immediate further training required, lecturer joins the faculty development programme for established lecturers.

FACULTY DEVELOPMENT FOR ESTABLISHED LECTURERS

Co-tutor provides tutor with structured feedback using feedback form at end of small group teaching session during fourth-year departmental component of five-week general practice course. Tutor keeps record of feedback in personal file. Teaching session video recorded and tutor able to view tape at leisure to make self-assessment.

Supervisor (member of staff designated to provide faculty development within department) available for tutor to discuss portfolio and to arrange specific training to address identified needs, for example, to improve organisational skills in teaching, and to improve questioning skills, etc.

Tutor practises skill during next teaching cohort; co-tutor provides structured feedback.

NON-ACADEMIC CLINICAL TEACHERS

(that is, general practitioners based in teaching practices)

The department uses a core of 40 practices for the clinical attachment in the fourth year of the curriculum. The clinical teachers are offered a variety of experiences to improve their teaching skills.

a) Teaching fellowships (currently sponsored by Eli Lilly Pharmaceuticals) allow established or potential clinical teachers the opportunity to participate in the departmental teaching programme, one day a week for five weeks. These are accredited for PGEA.

b) Specific courses/workshops which employ the principles of adult education encouraging the maximum participation in small group teaching. For one of these courses an educationalist was recruited from the School of Education in Leicester.

EXAMPLES OF WORKSHOPS

Clinical skills workshop – 1:1 teaching in the consultation

Aim: to improve the teaching skills of fourth-year clinical teachers with particular reference to 1:1 teaching in the consultation.

Objectives: 1) assess the consultation competencies of fourth-year medical students in a systematic manner; 2) provide appropriate feedback on a student's strengths and weaknesses; 3) select and implement specific strategies to improve the consultation performances of the individual students.

Method: three full days. Small group work using students and trainees and their video-recorded consultations.

Family placement tutors – skills needed for teaching in small groups (clinical teachers and academic staff who are tutors in the preclinical curriculum).

Aims: 1) to familiarise participants with the theory of group work, group dynamics and stages in group development; 2) to examine ways in which such theories apply to small group teaching for 'Man in society'; 3) to reflect on and practise the skills needed for group work.

Objectives: 1) to have knowledge and understanding of group work theory and practice; 2) to be able to identify and practise group work skills.

CONSTRAINTS

Expansion of these activities is limited by lack of resources: that is, the courses are staff-intensive and we have a potential pool of 200 clinical teachers to provide faculty development for.

To evaluate the activity in this field we have some interesting ideas and proposals to make but we do not have access to a reliable source of funding to underwrite the costs.

We believe that setting the criteria for competence in teaching performance and developing the strategies to improve skills are important, relevant and necessary to provide a satisfactory staff development programme.

CASE STUDY 11

EXPERIENCE AT LEEDS

DAVID ADSHEAD, LEEDS

Dr Biran and other members of our staff have run a series of workshops for our GP tutors, who have a single fourth-year student in their practices over a period of two weeks and up to six times per year.

In the workshop, each tutor had to consult with a simulated patient and teach a student on the basis of the consultation, much as they would do for a lot of the time in their practice. This was observed by a small group of tutors and students, and followed by discussion involving the students and a member of the Academic Unit.

Immediate evaluation suggested a high degree of enjoyment of this format and much educational value. In particular, the tutors said that they had learned a lot from their colleagues and that the experience would change their teaching; their remarks suggested this would be in a student-centred direction.

Similar results were obtained when I used a similar format with GP tutors in Liverpool. Clearly, this is a model which could be used by any group of teachers who were frequently in this 1:1 opportunistic teaching situation.

We are now developing a two-day course for our tutors, to consider teaching physical examination, teaching consultation skills and time management in relation to surgery teaching.

CASE STUDY 12

EXPERIENCE AT NEWCASTLE

JOHN SPENCER, NEWCASTLE

MEDICAL EDUCATION

Our 35 or so GP undergraduate clinical tutors meet regularly (two or three times per term plus an annual residential weekend) and have done so for many years. Lately we have made the emphasis more explicitly 'teaching for teachers' with the intention of effecting change in the following areas: improving the quality of teaching; preparing the tutors for curriculum change (and involving them in that change); increasing their professional esteem as 'teachers'. The programme has been based on a needs assessment exercise (involving a two-stage Delphi and feedback from group discussions) and a small steering group organising the sessions. An important structural change in the session has been more time spent in small group work. Feedback so far has been good.

PRIMARY HEALTH CARE TEAMS (PHCTS)

My other main area of 'effecting change through staff development', has been in team building in primary health care, both as member of a PHCT that has had several 'awaydays', and as part of our local teambuilding initiative.

PLANS FOR THE FUTURE

Continue to develop the programme of 'teaching for teachers' – I would like to think that some of what we do could act as a model for similar programmes in other departments in the medical school (so far as I am aware very few other departments do anything similar with their tutors).

CONSTRAINTS/BARRIERS

- Needs assessment is difficult.
- GPs are very busy and the model of medical student as passive absorber of wisdom and knowledge is still prevalent.
- Remuneration for the job of teaching undergraduates in general practice is token.
- The department's resources are seriously stretched.
- Outcome measures!

POSSIBLE SOLUTIONS

- Hang on in there!
- Imminent appointment of teaching administrator and additional academic staff (including lecturer with specific remit in the area of curriculum development).
- Divert SIFTR funds into general practice.

e) STAFF DEVELOPMENT AND POSTGRADUATE MEDICAL EDUCATION

CASE STUDY 13

TEACHING HOSPITAL DOCTORS HOW TO TEACH: THE WESSEX POSTGRADUATE MEDICAL EDUCATION RESEARCH PROJECT

COLIN COLES, SOUTHAMPTON

BACKGROUND

Hospital doctors do not receive the training they require from the consultants to whom they are attached (1, 2, 3). The General Medical Council has recommended that every medical trainee should be attached to an educational supervisor, normally that person's consultant, who has received training in educational methods in much the same way as general practice trainees are trained (4, 5). In the Wessex Region, developments over the past seven or eight years in training GP trainers (6, 7) are now being applied to hospital training, and in August 1991, the Regional Postgraduate Dean received a grant from the Department of Health to extend this initiative into a research and development project.

THE PROJECT

The project introduces hospital consultants to a learner-centred approach to the education of their trainees (8, 9, 10). It is being run in the Region's 13 postgraduate centres by the local clinical tutor. The project lasts from November 1991 to August 1993.

AIM

The overall aim of the project is to implement in the hospital environment the Wessex Region's strategic plan for postgraduate medical education through the following:

- The provision of regular learner-centred, in-service educational sessions for all trainees in order to complement their experiential training.
- The regular appraisal by consultants of all trainees and their training programmes on the basis of private supportive discussions which address strengths as well as weaknesses.
- The monitoring of all aspects of postgraduate medical education by the formal audit of its resources, activities and outcomes.

At the heart of this educational strategy is the promotion of a learner-centred approach. Consultants are being taught how to encourage their trainees to identify for themselves their educational gaps by appraising their own performance and agreeing with them a way forward which combines their own judgement of what they believe they want to learn with what their consultant feels they need to learn. Consultants are learning how to activate this process of self learning and help trainees to evaluate their own progress.

The problem being addressed is that many doctors have had little experience of learner-centred education themselves and believe that good teaching means clearly telling their trainees what they should be doing rather than helping them see it for themselves. The project fundamentally challenges consultants' assumptions and expectations about education, and shows how teachers can facilitate self-directed learning.

THE TRAINING PROGRAMME

The project's training programme has itself been based on the same educational principles that consultants are being asked to adopt with their own trainees. It involves a series of half-day educational workshops and monthly follow-up seminars over a one-year period.

The half-day educational workshops

At the workshops consultants are first asked to reflect on their own medical education to identify what had been successful and unsuccessful in it. Next they identify the strengths and weaknesses in their existing teaching so as to identify their own goals for the workshop. They then watch a series of five-minute video recordings made specifically for the project which depict typical situations where consultants and their trainees interact, to trigger discussion about education. After viewing several videos consultants are asked to reflect on what they saw and to identify common features that appear to help or hinder a trainee's education. The ideas which participants derive for themselves reflect the principles of learner-centred education with only minimal prompting by the clinical tutor. Finally consultants are asked to devise a project based on some aspect of their trainee's education which, following the workshop and building on the principles emerging from it, they would wish to consider further. In many instances, consultants have chosen to discuss with their trainees their educational programme, and to agree some educational objectives with them.

Follow-up seminars

One month after the initial half-day workshops, consultants attend a follow-up seminar lasting between one and two hours to report progress on their projects and to hear reports from their colleagues. The issues arising are then discussed by the group and clinical tutors agree with them the next stage of their projects. Follow-up seminars are being held at about monthly intervals for the remainder of the project.

CASCADE

The project is part of a 'cascade' of educational training which started about three years ago with clinical tutors learning about learner-centred educational approaches. For this they were asked to video record themselves undertaking some aspect of their work such as a routine clinical procedure, an outpatient's consultation, an educational interview with a junior doctor, etc. They then reflected on their own practice in small groups, using a specially prepared protocol, learning how to give and receive constructive feedback, and through peer evaluation to learn how to evaluate themselves and to see where their own educational gaps were.

THE VIDEOS

The project organisers were committed to the notion of people reflecting on practice and learning about self-evaluation which they saw to be at the heart of a learner-centred educational approach. However, they also recognised that it would not be sensible to ask consultants to video themselves and to reflect on their own practice. It was felt that some might but others would not, a few might be suspicious while the remainder could feel highly threatened. It was decided, therefore, to video record simulated situations which reflected consultants' educational work, and to use these as discussion triggers. It was also agreed that these simulations should relate as closely as possible to reality, so junior doctors were asked their experiences of the education they received from their consultants, and a small group of clinical tutors acted as a steering committee for developing the videos. The videos were then produced with the help of the Teaching Media Department in the Medical School, together with the assistance of some willing clinical tutors, consultants and trainee doctors who acted out the various parts. The videos, then, are simulated but based very much on reality, and most were recorded in the actual workplace using doctors themselves as actors. At all stages, video production was discussed with the clinical tutors who were to be using them with their colleagues in their own postgraduate centres.

THE ROLE OF THE CLINICAL TUTOR

Clinical tutors play a crucial role in the successful operation of this project. They are responsible for organising the various meetings, for explaining the aims of the project to their consultant colleagues and recruiting them to it, for running the workshops and seminars, for keeping records concerning consultants' projects and for issuing reminders to their colleagues to attend workshops and seminars. In addition, clinical tutors need to be skilled in leading group discussions which encourage their colleagues to see for themselves the educational issues and principles underlying the trigger videos and to explore their views of their own educational activities with trainees.

Clinical tutors need, therefore, to be facilitating their colleagues' educational development in a non-prescriptive manner, and to recognise the significance of group processes in achieving these ends. They must understand and promote a learner-centred approach to education, appreciate the educational issues likely to emerge in discussions with their consultant colleagues, and facilitate the emergence of these issues in discussion.

In order to carry out these functions Wessex clinical tutors have received intensive training. It was recognised that they, too, are consultants themselves and that they needed to challenge their own assumptions about education before they could successfully facilitate educational workshops for their colleagues. This training required clinical tutors to attend at least one two-day educational workshop to explore the implications of a learner-centred approach, as well as briefings for the project itself.

Because clinical tutors need to develop these special skills, it is felt unlikely that workshops and seminars of this kind could be run successfully without the necessary training.

EVALUATION

An immediate evaluation of the initial workshops was carried out which showed that consultants generally found them valuable, and perhaps surprisingly intellectually stimulating. Many consultants remarked on the usefulness and the high quality of the video recordings.

The project is being formally evaluated by means of a purpose-designed questionnaire administered at the start and again at the end of the project to all consultants and their trainees in the Region. This assesses the type and quality of training being given, people's opinion of it, and an evaluation of attitudes towards teaching and learning. The findings are likely to be available in the autumn of 1993.

RESULTS SO FAR

The workshops and follow-up seminars have been running since March 1992, and something like two hundred consultants in the Region (approximately 25 per cent) have taken part. It is already clear that the project has generated considerable interest. People who attended are coming back having discussed with their trainees and colleagues the education they are providing. Out of this several interesting projects have emerged. A number of consultants have recognised that there are (at least) two educational agendas – their's and their trainees' – and that successful education is likely to occur best when these agendas are negotiated and agreed. Other consultants have had trainees sit in with them in joint outpatient sessions, discovering that many trainees have never been observed conducting a consultation nor seen their consultants working in an outpatients' setting. Other consultants have, with the help of their trainees, begun to devise a structured training programme. In one or two departments groups of consultant colleagues have come together to discuss more fully the education they are providing. In addition, consultants who did not volunteer in the first wave of the project are coming forward asking for a repeat of the initial workshops. Where possible this is being provided for them too. Some consultants are even asking to see themselves on video! Trainee doctors have also shown an interest in the project. Where possible, clinical tutors have run seminars for them too, usually showing them the same discussion videos as seen by the consultants.

This project also has its weaknesses. It has raised in consultants' minds the importance of carrying out routine appraisal interviews with trainees, yet it has not shown how to do this. There is a need for further training to carry out such interviews. At least the project has shown consultants the need, and they are now asking for such training. Some consultants too have recognised that discussions with their trainees have raised issues that go beyond the immediate work situation, and sometimes extend into more personal areas. How much should consultants become engaged in these kinds of discussions and at what point would it be appropriate to refer trainees for specialist help? Should we be providing them with training in counselling skills too? Then again the project has not directly shown consultants how to deal with the difficult trainee, especially one who is not performing adequately. Most consultants attending the workshops have recognised the importance of giving trainees feedback in a constructive manner, but many find it difficult to do so and recognise they do not have the necessary skills. An extension of the present project is planned to deal with each of these issues.

CHANGE THROUGH STAFF DEVELOPMENT

In what ways does this project show change occurring through staff development? The project itself was modelled on the very learner-centred approach it was hoped consultants would adopt with their own trainees, yet it was acknowledged from the outset that these principles were unlikely to be familiar to many of them. Consultants, it was thought, might be more comfortable with a formal educational approach, that is by being told through lectures what they should be doing; yet, equally, it was felt that consultants would be unlikely to change their teaching approach in this way.

Consequently the project deliberately employed the following principles: active learning; starting where the consultant was regarding teaching; helping them to see for themselves where they were; providing a concrete context at the outset on which to base discussion; encouraging reflection on practice; allowing educational theory to emerge through discussion; allowing participants an opportunity to apply the principles they were learning in the project to their own situation; providing feedback to people on their progress.

The activities which the consultants engaged in, both during the initial workshops and between these workshops and the follow-up seminars, show them beginning to change their educational approach to their trainees. For some this has meant discussing with trainees their educational wants and negotiating any difference between these and what the consultant sees as their trainees' educational needs. In other instances a consultant attending the workshop has surveyed groups of trainees concerning their perceptions of their education and subsequently developed a relevant programme. Other consultants have held joint outpatient clinics with trainees to observe and be observed taking routine histories, and to provide opportunities for giving feedback. In some instances, clinic schedules have been changed to accommodate the trainees' education. Other consultants have discussed trainees' problems with their colleagues who were unable to attend the project's workshops. Trainees, too, are attending similar workshops and appreciating now that they have an active part to play in securing high quality training from their consultants.

Another way in which this project has shown change through staff development is through the cascade by which the project has been implemented. Initially clinical tutors received training in learner-centred approaches, and then ran the project themselves in their own postgraduate centres. An educationist was involved with the clinical tutors in their training, but was unable to attend all of the training sessions for consultants held in their centres. In this way the educationists' influence could be spread as widely as possible. The training clinical tutors are providing for consultants is being further cascaded by consultants training others in learner-centred methods.

Perhaps the most fundamental principle operating in this project has been that 'the problem' was shared with the people who were in a position to do something about it, and they were left to solve it for themselves. In short, this project illustrates a transference of the ownership of the problem. 'The problem' here concerns the quality of the trainees' education and the consultants' educational supervision. However, initially this was the postgraduate dean's problem. He recognised a need to bring about some change. As a consequence, clinical tutors were helped to perceive the problem, but for them the problem became 'How can we get our colleagues – that is, hospital consultants – to recognise the problem and do something about it?' In some ways, introducing the clinical tutors to a learner-centred approach to education only added to this. The problem became exacerbated: 'How can my colleagues come to understand an approach to education which is likely to be foreign to many of them?'

The project arrangement, therefore, was specifically devised in order to enable consultants to recognise that there was indeed a problem regarding trainees' education, that it was a problem that in part is the consultants' responsibility, and then to see that it is a problem that the consultants could deal with if they approached it in a particular way.

Through the project, at first vicariously through the video discussion triggers, consultants were shown examples of the problem. Then, by devising their own projects involving trainees, they had a chance to explore the problem in greater depth themselves as it directly affected them and their own trainees. By discussing with trainees the education they were getting they almost inevitably came to see that the education they were providing was not of the highest quality. In other words the project enabled consultants to ask the right questions

concerning education, to see the problem more clearly for themselves, and to devise their own way of solving it.

However, in a project of this nature it has to be recognised that participants might not go about solving the problem in quite the way you would yourself or even in a way of which you would approve. This is inevitable yet it can be quite difficult for any educationist involved to cope with. Once people own the problem and come up with their own solution they must live with the consequences, and so must the innovator. Having said this, the educator can arrange for participants to receive feedback on their progress, and to provide support for what they are doing. There is then the possibility they will begin to ask where they are going wrong. When this occurs, they can be helped to solve this new problem for themselves.

CONCLUSION

In this project we have seen how consultants have been helped to develop learner-centred approaches to education by taking ownership of the problem of their trainees' education. The project itself has been outlined, and its implementation through a cascade process described. The fundamental principle operating here is that of transferring the ownership of the problem and getting participants to solve it in their own way which suits their own circumstances. Change can indeed occur through staff development, or in other words, staff develop when they see their own work in a new way. The role of the educationist is to help them do this (8).

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CASE STUDY 14

POSTGRADUATE EDUCATION IN YORKSHIRE REGION

MARTIN ROGERS, YORKSHIRE REGION

MEDICAL EDUCATION HAS SUFFERED TOO LONG FROM BEING FRAGMENTED

Those concerned with the professional formation of medical students seldom feel an affinity with the postgraduate processes of the professional and specialist development of doctors in training. Yet senior medics have the major influence on the education and training of both sets of learners.

The awareness that medical students, let alone junior hospital doctors, are 'adult learners' is at last impinging on many senior consultants, whose own 'traditional' style of medical education had influenced them to think otherwise. Many are now realising a need to become more literate concerning 'learning', and more skilled as good facilitators of knowledge, attitudes and skills.

The arena of postgraduate medical education is slowly being appreciated as integral to the totality of medical education. Changes through staff development in postgraduate medical education will profoundly influence medical undergraduate education.

STAFF DEVELOPMENT (TRAINING AND SUPPORT) HAS TO BE A CONSTANT CONTINUING PROCESS

Time is required for change to evolve. There are no 'quick fixes'. Facilitating staff development at every level of an organisation requires practising what you preach. Learning and personal development have to be allowed to blossom and bear authentic fruit in well rooted change.

Staff development cannot be imposed. Professional climate and attitudes of individuals need sensitive understanding and permit only most delicate influences. Slow, persistent support and encouragement enables key individuals to perceive potential benefit, personal and professional, from specifically attuned staff development.

Effective staff development depends on the creation of a sound overall infrastructure to help interlock and give added value to the varied components. Within such an infrastructure, the steady influence of a key motivator helps orchestrate the varied elements that amalgamate into a broad organisation for professional training.

SCOPE FOR EXPANSION

There are the guiding principles that have enabled programmes of dedicated 'staff development' to promote so much change and growth in educational awareness and expertise in the broad sector of general practice. The time is now opportune to widen this influence through staff development across the whole spectrum of postgraduate medical education.

PRESENT INFRASTRUCTURE

General practice in the Yorkshire region has had a consistent programme of staff development over the past fifteen years. This has encouraged the creation of the present infrastructure for continuing professional development (CPD).

(a) The Vocational Training Scheme (VTS): all GP trainers (160) are carefully selected for appointment and attend three introductory residential seminars (a total of five days). Thereafter every trainer attends a residential 'review' seminar (three days) at least every two years in post. All these seminars are run by carefully selected and well trained associate regional advisers (four) who themselves have eight routine seminars per year, and District VTS course organisers (25), who regularly have four residential two-day seminars per year. These course organisers run a potent series of Trainers Workshops (eight to ten per year) in each district.

(b) Continuing Medical Education (CME) for GPs in post in the Region (approximately two thousand): CME tutors, similarly selected and trained (four residential seminars per year) are responsible for monitoring and promoting increasingly varied patterns of CPD in each district.

(c) Staff development is now being enhanced by a comprehensive scheme of individual 'personal appraisal' among all advisers, course organisers and CME tutors.

AND NEXT...

Such developments of educational awareness of skills in the GP sector, as well as in one or two other medical specialties, as yet remain horribly encapsulated. A major next task is to find acceptable ways to promote cross-fertilisation.

A few tentative moves in Yorkshire are exploring ways to share with some interested hospital consultants the benefits of 'trainers' workshops'; the possibilities of methods of formative assessment in specialist training; and, within a large teaching hospital, exploring how opportunities for promoting learning in routine clinical situations can be enhanced.

The needs are apparent. The benefits of shared skills and educational expertise will depend on consistent programmes of staff development, support and training. This requires a determined coordination of interests and efforts within a cohesive programme of postgraduate medical education. All the latest administrative arrangements for PGME within the NHS could enable this now to happen.

f) PERSONAL EXPERIENCE AND VIEWS

CASE STUDY 15

WILLIAM FLEMING, BIRMINGHAM

EXPERIENCE OF STAFF DEVELOPMENT ACTIVITIES

As an educationist, I have made contributions to a variety of workshops on teaching and learning while a member of staff in a medical school. Other activities centred on using various course evaluation methods to provide staff with information about how courses and teaching were perceived by students.

More recently I have developed the use of focus groups (discussion groups) as a way of sensitising staff to issues of concern to students. As a result, courses and teaching practices have (sometimes) changed in ways which are more responsive to students' perceived needs and wants. Some of this work has also been done with NHS provider managers, training them to use focus groups to gather the views of service users.

I have just started work on a project designed to investigate the staff development needs of teaching support staff and to devise ways of meeting these needs. The work will be concerned with optometrists and modern language colloquial assistants in the first instance but is designed to develop models which can be used more widely in higher education.

A CONCERN

Quality is now on the agenda in both health care and education. One of my concerns is that academic audit, being imposed from outside, is being perceived as a threat rather than an opportunity, with defensive and minimalist reactions following. The positive side of quality assurance and quality management, with its strong emphasis on people and participation, is being lost. Medical schools and universities seems to be searching for simple and simplistic indicators of teaching quality. These are unlikely to stimulate change or have much impact on staff development. A more reflective and participatory approach would be more effective and more acceptable to staff.

A POSSIBLE WAY FORWARD

One set of ideas which I believe has positive potential in effecting change through staff development is 'the learning organisation'. A learning organisation facilitates the learning of all its members and continuously transforms itself. The implication is that staff development should go hand in hand with organisational development, with the primary focus being learning. Of course, many formulations of audit have this focus at an individual and professional level, but few work it through to the institution as a whole. There are no clear cut strategies for building learning organisations, only some possible avenues which might be explored in a spirit of experiment. See, for example, the 'glimpses' in *The Learning Company* by Pedler, Burgoyne and Boydell (1991) published by McGraw-Hill. I would like to see some such experimental approaches established.

CASE STUDY 16

DAVID TAYLOR, LIVERPOOL

I am a lecturer in the Physiology Department at Liverpool University and represent the Medical Faculty on our University Teaching and Learning subcommittee. A couple of years ago I attended a series of workshops run by the Oxford Centre for Staff Development under the auspices of the Enterprise in Higher Education initiative. The workshops, particularly those on transferable skills and small group work, showed me a possible solution to one of my very real problems – teaching increasing numbers of students with unchanging resources. I have subsequently been involved in presenting the results of my work to colleagues, and thereby helping them to develop their teaching and learning strategies.

It has become clear to me that colleagues are unlikely even to consider attending staff development workshops unless there is evidence of tangible benefit. We are all under increasing pressure to teach ever larger numbers of students, while maintaining our active research profile. As a result change is not going to be embraced for its own sake. It must also be said that any change must be shown to be of benefit not just to the lecturer but also to the student. The most common criticism I hear is that students should be taught about communication, poster presentation and time management somewhere else. Our job is to teach them science, and any time we spend teaching them other things means that we cannot teach them as much as we would like about our subject.

The most successful way to effect change through staff development seems to be to demonstrate the benefits which are experienced by lecturer and student. It came as a surprise to me that some groups of students were very suspicious of any change, and this has, in fact, proved to be a very significant limiting factor.

My aim for the future is to continue to try to encourage independent learning from my students, particularly during practical classes, using staff as consultants rather than instructors. This requires staff to possess a different range of skills, which we must persuade them to acquire, either through overt 'staff development' or by including them in teaching teams which already use the approach.

CASE STUDY 17

ANITA BERLIN, ST MARY'S

EXPERIENCE OF STAFF DEVELOPMENT – AS A PARTICIPANT

I have been in my current job for only six months and I am now beginning to wonder whether my previous experience of staff development activities had been deceptively positive. Although participation in staff development activities was not a contractual obligation in my last post, getting involved seemed almost irresistable. There was such strong institutional support and staff enthusiasm at all levels – university, medical school and departmental – that programmes organised at all three levels were sometimes over-subscribed. The departmental tutors' meetings were exceptionally well attended, despite being in the evening and some tutors having to make a round trip of forty miles. The annual weekend workshop (usually in the Lake District) was also very popular. These activities were good fun and very productive, largely as a result of the tremendous amount of hard work put in by one member of the academic staff. They firstly gave the tutors an opportunity to learn from invited experts; and secondly, and perhaps more importantly, allowed them to learn from each other and share ideas, problems and experience. The result of this, I believe, was a more cohesive course for the students and more consistent teaching by the tutors in a course they had assisted in developing.

CURRENT EXPERIENCE – AS AN ORGANISER

I am now working in a medical school which has no staff development programme, but I have detected some enthusiasm for this in the individuals dotted around the medical school. Within the department virtually all large scale meetings of tutors, though once very popular, ceased a number of years ago. A small group of teachers still meet but this is mainly for administrative and timetable purposes.

For a long time members of the departments of General Practice, Public Health and Psychiatry (among others) have been trying to develop integrated teaching activities which will begin in 1993. The Steering Group for Integrated Courses were lucky enough to receive a grant from the King's Fund specifically aimed at providing a staff development programme. We are in the process of conducting a school-wide survey to establish experience and perceived needs in staff development related to teaching in the medical school, and a series of meetings with the GP tutors (possibly the most easily isolated and neglected teachers) has already begun.

MAIN CONSTRAINTS AND BARRIERS

An initial survey of GPs showed enthusiasm for a staff development programme. However, the first meetings that were arranged were not very well attended. This suggests to me that although the tutors can recognise their need it is difficult for them to make this a priority when there are so many other competing demands on their time. In particular, many of them have to travel considerable distances within London with the perennial problems of traffic and parking.

The survey of other teachers in the medical school has not been completed yet, but my own hunch, supported by comments and anecdotes, leads me to suspect that as yet there is limited

but growing institutional support or culture favouring participation in staff development activities. However, many scientists and clinicians have been teaching for years without training or support and they may be unlikely (understandably) to be interested in going on a course or attending seminars now.

POSSIBLE SOLUTIONS

Although some of the teaching faculty may feel no need for, or even threatened by, the suggestion, staff development is important and they cannot escape the atmosphere of change prevailing at the moment. Designing and marketing a staff development programme as a means of achieving effective and smooth changes in curriculum content and delivery is an opportunity which is not being ignored by some very competent and influential members of the medical school. This gives me room for some optimism that this institution will also develop a commitment to staff development across the board.

CASE STUDY 18

RICHARD WAKEFORD, CAMBRIDGE

It took me nearly twenty years to realise that just researching into medical education (selection, training, assessment) and publishing the results was insufficient (though probably necessary) to induce developments and change. One of the major obstacles which I see in medicine is that educational functions are often both planned and implemented by those with no relevant training, varying experience, great confidence and – sometimes – considerable prejudice. Access to educational, psychometric or testing expertise is rarely available (or sought). This can apply at any level from the Education Committee of the General Medical Council to an individual university department.

So in recent years I have become involved in a variety of staff development activities, local and international. Local courses (in Cambridge and elsewhere) have included ones on:

- undergraduate student selection
- improving selection interviews
- the assessment of competence
- how to get a consultant post
- introducing and managing change in general practice
- assessment using video recordings of candidates
- selection of examiners
- training *viva voce* examiners
- becoming an external examiner.

Internationally, a group of us have since 1984 convened the 'Cambridge Conferences on Medical Education', week-long invited conferences of test developers and psychometricians working mainly in the field of the assessment of clinical competence. Recently we have, with apparent success, commenced a programme of dissemination by running workshops tutored by members of this group and offered to those responsible for implementing assessment at Final MB and postgraduate levels. The first of these workshops attracted chief examiners from no fewer than eight Royal Colleges out of 40 participants; a second is planned to accommodate those turned away from the first; and the Australian Medical Council is supporting a third.

I regard the current situation in medical education with depression-tinged-with-optimism. Depression because so many people have tried to modernise and improve British medical education to so little effect. Optimism because a variety of pressures (some of them, God help us, 'market forces') seem likely to change the pattern.

These influences for change include:

- With the advent of self-governing NHS trust hospitals, the possibility of establishing explicit educational contracts between medical schools and health care providing organisations.

- The likely movement of government funds for universities to follow and thus support high quality teaching.
- Increasing openness, accountability and competition, following professional external reviews from, for example, the CVCP Academic Audit Unit (compare their reports with those of the GMC).
- The increasing realisation by the customers of medical education (health care providers) that, in association, they can call some tunes.
- Some bodies responsible for the certification of specialist competence recognising that, to develop examinations whose psychometric properties are acceptable to customers and the public, appropriate expertise may be needed.

We may thus soon see changes in the structure, organisation and practice of medical education.

My personal involvement with staff development is increasingly with Cambridge University more generally. Cambridge may be a unique environment in which to undertake staff development. Complicated and sometimes obfuscating arrangements (notably the college/university divide), coupled with a variety of local brands of rhetoric and a consciousness among many teachers that they are special (and many, technically, are), make it essential that all staff development programmes are actually and explicitly based upon local currencies, situations and needs. I have attended many staff development courses in Cambridge run by outside professionals: often these founder among mutterings that the presenter 'doesn't understand Cambridge'. So the work offers new challenges.

CHAPTER 5: Problems and solutions

This chapter summarises some of the main difficulties in effecting change through staff development and suggests some ways in which these might be tackled at an institutional level. There seem to be three main problem areas: lack of clarity of purpose or a planned strategy of staff development; problems concerning motivation and incentives; practical difficulties in providing staff development activities (in particular, shortages of resources such as time, money and expertise).

PURPOSE AND STRATEGY

How much of current staff development is effective? How much of it achieves change? These questions are difficult to answer at an institutional level because rarely is the actual purpose of staff development considered in relation to the overall goals of the organisation. It is easier to gauge the effectiveness when staff development is an integral part of course development (for example, Case Studies 1-3) since there are clearer targets to be met. However, as pointed out in Chapter 2, in the medical school as a whole staff development is largely a series of isolated events, often undertaken by motivated individuals on their own initiative, rather than part of a planned strategy for bringing about the kind of changes which the school requires. It is frequently viewed as an end in itself rather than as a means to an end when, in fact, as Lesley Millard points out (Case Study 1) staff development may be used either as one of the ways in which a defined change is implemented or as a means of identifying what change is desirable.

The promotion of change at the level of the medical school (see Chapter 2), therefore, calls for a statement of the purpose and goals of staff development, and a planned strategy for their achievement, rather than the somewhat *ad hoc* arrangements which currently pertain. At the very least, as curriculum changes are being planned, someone on the curriculum committee might be given the responsibility of overseeing the staff development requirements which any new curriculum will inevitably engender and to propose a strategy for how these might be most effectively met. Such a strategy should clearly define the purposes of staff development, identify the key individuals who should be targeted (that is, those most in need or most pivotal in the success of the new venture) and the means by which they are to be 'developed'.

Such a strategy should take cognisance of the most effective and efficient means of achieving the purposes intended. Limited resources (see below) suggest that cost-effectiveness is of the essence. In particular, any strategy should consider what kinds of activities are most likely to change behaviour. Formal training courses of the type most people are familiar with are not necessarily the only, or the best way to effect change. Staff sessions to explore curricular issues may not be billed as staff development and yet this is an extremely significant function of such events since the process of discussion airs beliefs and attitudes, requires that positions and views are made public and may be challenged (Millard, Case Study 1). Chapter 3 raises various issues about making staff development effective and highlights what helps people, particularly practising professionals, to learn and to change their behaviour. Some of the cases in this report describe effective models for achieving change (for example, Case Studies 1, 2 and 13) based on the principles described in Case Study 2 of awareness, involvement, commitment and ownership.

The strategy, therefore, should contain a whole range of different staff development activities, some of which may not be directly perceived as having this function. Informal discussions, giving people a challenging task (and giving them the authority and support to carry it out), even social occasions may serve staff development functions if carefully planned, and do not require an elaborate infrastructure. As Hatton and Bullimore point out in Case Study 6, one of the basic needs is for effective communication between staff both for information giving and receiving (for example, through a newsletter). It is of concern how few opportunities there appear to be in many medical schools for colleagues from different disciplines to meet together informally, yet this can be one of the most powerful means of learning and changing behaviour. Often people who attend teaching courses comment that the opportunity to meet with colleagues from different specialties is one of the most valuable aspects of the course.

MOTIVATION AND INCENTIVES

The most frequent complaints voiced by those responsible for delivering staff development and training activities are either lack of interest and poor attendance, or else expressed interest but a lack of incentives for staff to spend their time on such activities. There are two separate problems here, both of which can be tackled by a carrot or stick approach.

In relation to medical education, some academic staff clearly still feel little need for staff development at even a basic level of improving their skills. Often those who attend teaching courses or workshops are those who are interested in teaching, possibly already good teachers. It is difficult to attract those whose teaching is in need of improvement or refreshment. Although the following quotation is not from the field of medicine, it does reflect an attitude still to be found among some medical academics. A professor of Modern History at Oxford said he would never agree to being sent on a teaching course: 'It's preposterous' he said. 'I don't think you can teach teaching, though I suppose we get better as we get older. I am certainly better than I was – at first I just talked rubbish.' (*Sunday Telegraph*, 17 May 1992.)

While it will always be difficult to convince some that there is room for improvement and that teaching is a skill which can be learned rather than a gift one is born with (or not), student evaluation can be a useful stimulus for indifferent teachers to perceive for themselves the need for change or improvement or for the academic management to require it. Another way of reaching the unenthusiastic may be to work on a departmental basis, reviewing the teaching collectively and seeking to improve it. One approach being introduced in some medical schools is to require, as part of their contracts, all new academic staff to attend a teaching course. Hopefully this will both stimulate interest in teaching and increase expertise. Certainly in my experience new staff welcome such opportunities: many have been teaching for some time elsewhere but this is usually the first time they have ever had expert guidance for what should be recognised as a difficult task.

Perhaps more importantly in the context of effecting change through staff development, rather than merely improving the standard of teaching, is the need for staff involved in the teaching of any planned new curriculum to be equipped to do so. In some cases, for example in moving from a lecture-based to a problem-based course, this may require the acquisition of new skills. It may also require a change in attitudes: for example if teachers are to move towards self-directed, student-centred learning, they will have to accept some loss of control and a change in role from teacher to a supporter of the students' own learning. Such a shift feels uncomfortable initially and is unlikely to be achieved or sustained in the absence of staff development and support. Any new course or component of the curriculum which demands of teaching staff new skills or ways of working must be accompanied not only by

staff development, but by the incentives for teachers to participate. Often staff, realising that they will be expected to change their teaching practice are keen to take part, especially if they also have an opportunity to develop the course rather than being presented with a *fait accompli* which they are then expected to accept and teach (see for example Case Studies 1 and 2). The problems may then be more ones of incentives rather than motivation – encouraging people to devote their time to this activity as opposed to any of the other pressing calls on their time. As David Taylor highlights from his own experience in Case Study 16, 'colleagues are unlikely to even consider attending staff development workshops unless there is evidence of tangible benefit'.

While motivation is linked to perceptions of need and relevance, incentives are related to the relative value of the activity. If staff development is to be taken seriously by staff, it must be seen to be a valued and important activity within the organisation. This requires that the leaders (deans, heads of departments, curriculum managers) must support, promote and reward participation in staff development (the carrot approach) or must require participation with sanctions for those who do not (the stick). Academic audit and quality assessment are generally perceived as more of a stick: a threat rather than an opportunity. But they are at least forcing institutions to take teaching more seriously than they have done in the past. A few medical schools are showing signs of adopting a carrot approach by taking teaching into consideration in promotion. This has been the policy in several medical schools in the USA for some time, with alternative career tracks in education or research. However, the mechanisms still seem to work better in theory than in practice.

The above problems are not confined to medical education but find resonances in other academic disciplines. What is unique about medicine, however, is that the majority of the teaching is done by people who do not hold an academic appointment. Much teaching is done by NHS consultants, senior registrars and, to a lesser but increasing extent, by general practitioners. To what extent these many teachers should be expected to take part in staff development activities is a difficult question, but any effective curriculum change would be difficult to achieve without some attempt being made to involve them. There are two current kinds of initiatives which may help to address some of the difficulties. Firstly, pressure in the postgraduate medical education field to improve the quality of training is raising the profile of educational skills training for consultants (see Case Studies 13 and 14). Secondly, academic departments of general practice, which have for many years led the way in medical schools by providing training for their GP tutors (see for example Case Studies 10, 11, 12 and 17) are now extending the range of their activities in line with the increasing role GPs are being asked to take on in mainstream clinical teaching (Case Study 3). Such activities are increasingly attracting PGEA approval and so there are incentives for GPs to attend.

PRACTICAL ISSUES

Time and place

As has been pointed out above, time is linked with incentives in that it is difficult for busy people with many other commitments to find time to attend staff development activities. Firstly, they need to be convinced that their participation will bring them benefits (motivation and incentives), and secondly, as far as is possible, events need to be at times when they are actually able to attend. It is not always easy to identify these, and to some extent people always find time to attend those activities which they think are important, especially if they also find them enjoyable. However, an effort should be made to ascertain the most convenient times for people to attend and to aim for some flexibility. Breakfast meetings, lunch or early evening meetings may be attractive for some, and the provision of

refreshments which turn the event into a semi-social occasion sets a good atmosphere. Saturday or weekend gatherings may be acceptable, especially if these are seen as special events, perhaps a faculty, departmental or curriculum committee retreat when people are personally invited to attend by the dean or head of department.

Linked with time is the location. Experience has shown repeatedly that taking people away from their normal working environment is necessary if they are to give their undivided attention to the task in hand and not be tempted to nip back to the office during breaks in order to complete the unfinished business which is still occupying their thoughts. Although using outside conference centres or hotels may raise costs, many academic institutions have access to reasonably priced facilities. The opportunity for social interaction, a relaxed and pleasant environment and the ability to concentrate on the task, all contribute to a productive and yet enjoyable time. In situations where the work to be done is difficult or potentially contentious, there is no better approach.

Money

In few places is there an identified budget for staff development, yet some money is required for internally generated events for items such as: room hire and/or accommodation (if residential); equipment (for example, video recording and playback); food and drink; payment for workshop leaders, facilitators, experts. Staff development may also involve paying visits to other institutions (nationally and internationally) to learn new ideas and techniques, or attendance at externally arranged events such as conferences and courses. Funding may also be required for setting up an infrastructure to support staff development, for improving communication within the institution (for example, through a newsheet), or for the setting up of a database or library of resources.

A few places do have a centrally held fund to support staff attendance at various training events, or there may be departmental funds for study leave. However, in general money is not yet readily available for staff development within medical schools. External sources of funding, particularly Enterprise in Higher Education, have enabled some activities to take place in relation to the introduction of 'Enterprise' initiatives into the curriculum (see, for example, Case Studies 4, 5 and 9) but the money is basically for pump priming with the expectation that the institutions will take over mainstream funding in due course.

Expertise

Different kinds of 'experts' may be required to provide staff development activities. In some cases there is a clear need for skills training where the 'course leader' must have educational or technical expertise of some kind, for example in small group teaching, audiovisual aids, or computer assisted learning. In other cases, the expertise resides within the group itself and the leader's role is to facilitate the group, to provide a framework and proper environment for the group to work together. Sometimes the role of facilitator is not recognised as being an important or legitimate one, but experience has convinced some, at least, of the value of a having a good independent facilitator (rather than a staff chairperson). Neither type of expert is commonly found within medical schools or, perhaps to be more accurate, the existence of such expertise is rarely known. Perhaps a first step would be for schools to identify within their own institutions those who have skills or expertise they would be willing to make available on occasion. This may be a more acceptable approach initially than calling in 'outside experts' who are often regarded with some suspicion, or believed not to understand medicine in general or the local situation in particular (see Case Study 18). Inevitably there will be times when the right expert cannot be found within the institution and outside assistance is required. There may be advantage to be gained from schools working

collaboratively to share expertise or to recommend the names of experts they have used with success. It is important to select outside experts with care, especially at the beginning of a new staff development programme, as mistakes made at an early stage may be difficult to rectify.

Another approach is to build up a critical mass of expertise within the institution: staff who can act as role models, run workshops, seminars, etc, and act as resource people, consultants and advisers. This so-called cascade method, or training the trainers, has been used to good effect in several staff development programmes (see Case Studies 4 and 8) and is a useful way of building up local expertise. Such people can also serve to raise awareness and generate interest in educational matters. However, if they are expected to play this role they must be given appropriate recognition.

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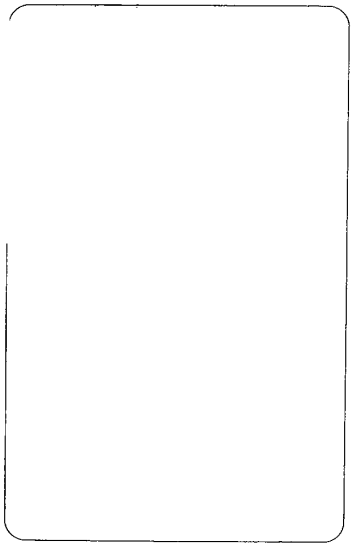

SHARING IDEAS 2

Effecting change through staff development

The current unprecedented interest in staff development in medical schools in the UK is partly a response to internal and external pressures to demonstrate the quality of teaching. In addition, staff development is beginning to be recognised as a necessary prerequisite for effective curriculum change as outlined in the recent GMC proposals.

This report arises out of a conference held at the King's Fund Centre in November 1992 to highlight key issues in effecting change through staff development through the presentation and discussion of case studies and the sharing of ideas and experiences.

The report attempts to answer three main questions:

- What do we mean by staff development and how is it related to change in individuals and organisations?
- What methods are most suited to achieve the various purposes?
- What has been the experience so far and what lessons have been learned?

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