Viewpoint: What is 'Training'?

N Cooper

Abstract

This edition's paper on 'How doctors spend their time on an AMU' defines 'training' as time spent on senior ward rounds. But the idea that senior ward rounds are training and the rest of work is not is a huge assumption that must be challenged. This article explores some false ideas about postgraduate medical education; why teaching and learning activities needs to be made more explicit, and why we need to stop talking about 'training' and start talking about learning. The goal of professional education is expertise, not competence. That can only happen through work-based learning, something to which we need to pay much more attention.

Keywords

Education and training, Learning, Postgraduate medical education, Competence, Expertise

Introduction

This edition's paper by Kasfiki, Gosai and Purva, 'How junior doctors spend their time on an AMU'[1] describes life in a busy, inner city Acute Medical Unit in a large teaching hospital. The authors state that, 'Trainee doctors … did indeed spend limited time in training' – 10% in fact. But the authors defined training only as time spent on senior ward rounds. Although the authors concede that *despite trainees' perceptions* [my italics], they are spending significant time on other legitimate training activities (e.g. clerking in, prescribing, discussing things with other team members), they comment that junior doctors felt that 'service provision was overwhelming their education'.

The key here is perception. The very idea that senior ward rounds are always training and everything else is not is a huge assumption that must be challenged. There is a widely held – and false – belief that 'training' and 'service' are two separate things. Why is this so?

There are three possible reasons, outlined here:

1. The first is to be found in postgraduate medical education itself
2. The second is to do with generational changes that require us to be much more explicit about educational activities
3. The third is to do with the language we use: talking about teaching and 'training' (a limited form of education) rather than *learning* – the goal of education

Postgraduate Medical Education

Modernising Medical Careers[2] was published in 2003. The proposals for shorter, more structured, competency-based training programmes were driven by perceived problems with the SHO grade and the belief that specialists could be produced by shorter but more focussed training, as in Europe and the USA. The Foundation Programme was part of this restructuring, designed to provide all new doctors with broad training in clinical and generic skills before specialisation. The curriculum document for the Foundation years was produced by representatives from all the medical Royal Colleges. So, for the first time, postgraduate medical education was on the national agenda, but was also criticised for having 'started from the wrong end, being conceived of as firstly a management initiative, secondly as an educational one and only thirdly as about curriculum development.[3]

In a thought-provoking book written to challenge some of the assumptions of Modernising Medical Careers,[3] Fish and Coles wrote that, '…the pressures to produce, as speedily as possible, safe and simple versions of professional education which conform to formulae constructed by civil servants … has led to some very false ideas and assumptions about what is involved in curriculum design for healthcare which have influenced thinking generally, in healthcare more broadly and in medicine in particular, at both policy and local level.

'The following inaccurate and increasingly dangerous ideas are to be found as 'common sense knowledge' in society, in the requirements of the Department of Health, among healthcare employers and employees and even in the professional bodies specifically tasked

Nicola Cooper
MBChB FAcadMEd
FRCPE FRACP

Correspondence:
Nicola Cooper
Consultant Physician &
Hon Clinical Associate
Professor
Derby Hospitals NHS
Foundation Trust
Division of Medical
Sciences and Graduate Entry
Medicine,
University of Nottingham
UK
Email: nacooper@
doctors.org.uk

with supporting the work of professionals. Though deeply and long held, they are at best problematic, and in some cases false and misleading.'

These false ideas include the following:

- Professional practice is essentially a simple, unproblematic activity and will easily yield to simple rules
- Professional education and development requires professionals to leave their practice setting and study away from it in 'protected time'
- There is a simple applicatory relationship between theory and practice
- Skills make people competent, and thus a 'competency-based' approach to curriculum design is a wholly appropriate term for postgraduate medicine
- The terms 'competence', 'competency' and competencies' – and even occasionally, as in the Foundation Programme curriculum, the invented word 'competences' which in fact does not exist – all mean the same indisputably desirable thing: an able (meaning technically proficient) practitioner
- Educational matters require mere common sense

Actually, there is a lot of evidence to suggest the opposite.[4-7] But we can see how some of these ideas are prevalent in postgraduate training programmes, e.g. the idea that 'training' only takes place during certain activities (like ward rounds and training days).

Generational changes

In her book, 'Generation Me',[8] psychologist Jean Twenge sums up years of research by writing, 'Today's students score higher on assertiveness, self-liking, narcissistic traits, high expectations and some measures of stress, anxiety and poor mental health, and lower on self-reliance. Most of these changes are linear, thus the year in which someone was born is more relevant than a broad generational label. These findings represent average changes and exceptions certainly occur.' The reasons for this are explored in the book. However, the usefulness of this research is in the advice she gives to educators (who by and large are from a different generation). Teachers need to understand this generation's perspectives and realise they are reflections of contemporary culture. *More structured, interactive and explicit learning is required.*

What more perfect place for such a style of teaching and learning than the workplace? However – 'explicit' is the key. A curriculum is everything that happens in relation to an educational programme. A curriculum is not the same as a syllabus, which is a list of learning objectives (we often confuse the two). *A curriculum encompasses several aspects of teaching and learning.*

Learning is 'internalisation of knowledge' and professional education is a mixture of learning from:[9]

- Daily work / taking responsibility
- Clinical conversations
- Debriefing and reflection
- Observation
- Written or web-based material (e.g. when you look up a hospital guideline)
- Working on projects and presentations
- Formal teaching sessions (e.g. tutorials, meetings, courses – although it should be noted that didactic teaching sessions are the least effective means of learning).

Research shows that professionals develop expertise using four key ingredients:[7] experience (that can only happen through work, and takes at least 10 years), feedback (in its many forms), deliberate practice, and reflection (how we 'cook' raw experience and feedback in to an integrated, internalised source of clinical judgment and skills, rather than a paragraph in an e-portfolio). Interactive techniques are also the most effective at changing physician practice.

Rather than thinking about formal teaching, we should be explicit about what professional education involves and how we facilitate all the above activities. Teaching is one way *but not the only way* of facilitating learning. Many aspects of learning, for example, can be facilitated through good rota design.

We insist on removing postgraduates from the workplace to teach them using the least effective methods. We somehow cannot see that communicating, performing direct patient tasks, doing procedures and even admin is part of learning, whereas the original Foundation Curriculum document emphasises that doctors learn from practice in a clinical environment, rather than the classroom. It also stresses the concept of expertise, which is something different to competence, and is the goal of professional education.

Teaching and 'training' vs learning

We talk about 'teaching' and 'training' rather than *learning*. The fact is, teaching and learning are not the same thing. Learning – not teaching – is the goal. However, learning can definitely be improved, and there are two main ways to do this: one is to focus on something called the learning environment, the other is to focus on faculty development.

The learning environment has a significant impact on learning. There are a number of ways in which it can be improved. These include:

- Appointing a qualified lead to co-ordinate and promote education on the AMU
- Ensuring doctors spend blocks of time in Acute Medicine, not just when they are on-call
- Making sure the basic needs of trainees/employees are met (e.g. information and rotas in advance, lockers, breaks, a good education induction at the start of the post explaining how learning will take place)
- Designing rotas for all staff that manage peak admission times (i.e. early evening), are adequately staffed, take circadian rhythms in to account, do not exhaust people (e.g. seven 12 hour shifts in a row) and allow attendance at post-take ward rounds
- Organise shorter, more frequent tutorials that fit in with the AMU workload, e.g. lunchtimes (why do we still think an entire afternoon once a week is a good idea?)

Faculty development is the American term for teaching clinical and educational supervisors how to facilitate learning. Work-based learning can be explicitly facilitated – if you know how. While many Deaneries focus on training for work-based assessments and the mechanics of being a supervisor, little attention is paid to fostering excellence in work-based teaching and learning, with the possible exception of theatres. While the evidence is that interactive work-based learning is highly effective in professional education, it remains the least developed in our specialty.

Conclusion

'Competent' is essentially a legal term meaning 'good enough'. But as Sir John Tooke wrote in his foreword to the Independent Inquiry in to Modernising Medical Careers, 'In reflecting on the evidence it received and formulating its recommendations, the Independent Inquiry Panel was clear: mechanisms that smacked of an aspiration to mediocrity were inadmissible. Put simply, 'good enough' is not good enough. Rather, in the interests of the health and wealth of the nation, we should aspire to excellence.'[10]

Thinking in terms of 'training' vs service is a false dichotomy. It is an unfortunate but widely expressed view that doctors are not learning when they are working! We need to stop talking about teaching and 'training' and start talking about learning, be very explicit with everyone about how learning in professional medical education actually takes place, and use evidence-based methods to facilitate learning.

Conflict of interest

Nothing to declare

References

1. Kasfiki, Gosai & Purva, 'How junior doctors spend their time on an AMU' [this edition of the journal].
2. Department of Health. Modernising Medical Careers. *DH. London*, 2003.
3. Fish D & Coles C. Medical Education – developing a curriculum for practice. Open University Press / McGraw-Hill Education. *Maidenhead*, 2005.
4. Talbot M. Monkey see, monkey do. A critique of the competency mode in graduate medical education. *Medical Education* 2004; **38:** 587–92.
5. Talbot M. Good wine may take time to mature: a critique of accelerated higher specialist training. Evidence from cognitive neuroscience. *Medical Education* 2004; **38:** 399–408.
6. Olle ten Cate. Trust, competence, and the supervisor's role in postgraduate training. *BMJ* 2006; **333:** 748–51.
7. Ericsson KA. Deliberate practice and the acquisition and maintenance of expert performance in medicine and related domains. *Acad Med* 2004; **79 (10 suppl):** S70–81.
8. Twenge J. Generation Me: why today's young Americans are more confident, assertive, entitled – and more miserable than ever before. *Free Press*, 2007.
9. Teaching on the Acute Medical Unit. Acute Care Toolkit no 3. *Royal College of Physicians of London*, Sep 2012.
10. Tooke J, Ashtiany S, Carter D *et al*. Aspiring to excellence. Findings and final recommendations of the independent inquiry in to Modernising Medical Careers. MMC Inquiry. *London*, 2008.