Project Report and Evaluation

The London Deanery pilot project: Trust-based learning groups to foster professionalism

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**Academic Centre for Medical Education (ACME)**
The Division of Medical Education (DoME) lies within UCL’s School of Life and Medical Sciences and aims to support and advise high quality medical education at UCL. ACME was established as a research unit in 2002 to act as a focus for education research and development within the DoME. Led by Dr Deborah Gill and based in the Whittington Campus, the ACME team ensures that the work of the DoME is supported by a strong pedagogical research underpinning. ACME draws together a range of experienced research and training staff that includes doctors, nurses, psychologists, statisticians and educationalists. The multi-professional nature of the team expertise encourages innovation in a wide range of teaching and learning activities and education research and evaluation utilising a wealth of approaches and methodologies. Research priorities include: assessment, poorly performing doctors, peer assisted learning, development of professional and generic capabilities, ethnicity and gender in medical education, and the development of national selection processes for doctors.
What is the purpose of these Trust Based Professionalism groups?*

"The course is about professionalism in the NHS. It's a group where we get together and discuss our experiences of both good and bad examples of professionalism in dealing with patients and colleagues. It has certainly made me aware of my own short fallings and that there is always room for improvement. And importantly, it's a free course."

"Its a discussion forum where we discuss, reflect and critique our experiences of working with colleagues and patients, thereby evaluating our professional practice and identifying areas to improve this, to ensure continual patient-centred care"

“At the seminars we discuss professionalism in the context of incidents we have experienced and behaviours we have observed, good and bad. It has raised my awareness of professional behaviour with patients and between colleagues'.

“It is an organised session in which we discuss and reflect on different work situations and personal experiences in terms of what was done well and what was done badly with regards to professionalism. It enables us to question what professional behaviour is and allows us to assess our own behaviour with the intention of improving ourselves whilst delivering patient centred care.”

“It is a course about professionalism which entails learning methods to deal with difficult ethical situations that we encounter as doctors on a daily basis as well as teaching us ways to promote professionalism to our colleagues outside the group.”

“It is about the professional behaviour of doctors how they talk, think and behave with their patients and colleagues in their day to day life and dealing with difficult situations. As a group we discuss our experience and support each other. It helps to develop insight to our own professional behaviour and be aware of the others and the situations so we can tackle it better. Such a forum should be an essential part of every department and training”

Written Reflections of Group A: collected by email after the 4th session
1. Executive Summary

In medical education, attempts to define contemporary professionalism and crafting opportunities in which professionalism can be learnt have become ubiquitous across undergraduate and postgraduate curricula. This has arisen due to a huge swell of interest both within the profession and within society regarding the role of doctors in modern healthcare and has created a discourse that identifies medical education as the principle vehicle for change (Hafferty in Cruess et al, 2009).

How learning opportunities in this domain should be provided and how attainment should be measured generates much debate in the medical education literature, but few solutions (Gordon, 2003).

This innovative project, undertaken by the London Deanery, attempts to encourage and support the professional development of doctors in training by forming Trust-based learning groups. These groups, meeting monthly over a six month period with an external facilitator, aimed to provide a pedagogical space to discuss, reflect upon, and become mindful of, issues and events in the workplace that impact on professionalism.

This report provides a project description and report together with a detailed evaluation of the initiative. The evaluation investigates and describes the impact of these groups in encouraging both the professional development of individuals who participated in groups and an increased awareness of professionalism within the host organisation. By exploring this project within a qualitative paradigm, the personal meaning and learning from participation, the effects of institutional contexts on the potential for such professional development and the potential of appreciative enquiry as a theoretical basis for the groups have all been illuminated.

We hope this evaluation provides guidance to a range of stakeholders on how to further develop interventions to foster professionalism mindful of the range of factors impacting on outcomes.

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3. Introduction

‘If you wish to converse with me, define your terms’
Voltaire

Professionalism

‘Professionalism’ in medical practice is defined and empowered in policy and has become firmly embedded as a central theme in contemporary undergraduate and postgraduate medical curricula (PMETB 2008, Foundation Programme 2007, GMC 2009, Academy of Medical Royal Colleges 2009). However ‘professionalism’ in medicine can be defined in a range of ways; and each practitioner has their own individual notion of what professionalism is and how it shapes who they are and what they do.

Conceptions of the term ‘professionalism’ adopted by the regulators and learned bodies will impact on a range of issues including definitions of what constitutes professionalism, how it can be developed, how it can be assessed and how it is maintained. A brief look through the literature and policy in this area reveals a range of definitions of the term: some focusing on the behavioural, others on the moral, some focusing on the personal duty to the patient and others to the contract with society. Most definitions are a complex mix of knowledge, behaviours, skills, attitudes and virtues.

Broadly speaking, commentators and educators conceptualise professionalism either within a predominantly competency-based discourse (Cruess et al 2009, Howe et al 2009, Steinert et al 2005) or within a discourse that places emphasis on morality and culture as the core of professionalism (Bleakley 2006, Coulehan 2005, Huddle 2005, Martimianakis et al 2009). Once a definition is adopted, whatever that definition is, it will have a profound influence on pedagogical approaches to educating doctors (Cruess & Cruess 2008).

Regulatory and education bodies often engage in a broadly ‘competency based’ discourse when defining outcomes from training programmes, even in relation to the complexities associated with the attainment of professionalism; often relating professionalism outcomes to standards set in guidance from the profession, particularly Good Medical Practice (GMC 2006). However, adopting a competency based approach to teaching and learning in the domain of professionalism tends to sideline notions of professional learning as a transformative, social process. Many medical educators challenge this impoverished competency-based model of professionalism suggesting learning in this domain is not an act of accumulation of knowledge or skills, but of participation, (Sfard 1998) and subsequent identity construction (Wenger 1998).

Adoption of this more socio-cultural approach to learning to be a professional supports educational interventions that emphasise the need for doctors to find meaning and value in their work. It encourages positive support of trainee doctors and attention to the learning environment, recognising the need for attention to organisational and cultural aspects of the workplace including role modelling in the development of professional values and orientation:
‘No matter how much we write about professionalism’s importance, or plan its inclusion into undergraduate or postgraduate curricula, it is the day to day experience of working within a clinical environment that will be most influential in its development’


This project from conception through to delivery and subsequent evaluation is framed within this socio-cultural understanding of professional learning. Professionalism is conceptualised as a quality that is acquired and sustained as a result of good modeling, a positive organizational culture, and the ‘informal curriculum’ (Brater 2007, Goldstein et al 2006, Litzelman & Cottingham 2007).

Appreciative Inquiry

Appreciative Inquiry (AI) is a process for engaging people in learning, planning and innovation that focuses on a system or organisation learning about itself through attention to its best practices. Within a large organisation, such as an NHS Trust, when used in an educational setting the aim is to inspire enthusiasm and engagement and build new conversations and relationships. It encourages new perspectives; moving away from the established and often entrenched ‘discourse of lament’ when discussing professional issues (Marjoribanks et al. 1996, Bub 2004).

AI as a developmental and educational tool is best conceptualised as:

“the act of recognising the best in people and the world around us; affirming past and present strengths, successes and potentials; perceiving those things that give life (health, vitality, excellence) to living systems”

(Whitney & Trosten-Bloom 2003)

In practice the approach is used as a dialogue with distinct boundaries between each phase and with each phase leading to the next.

**Figure 1: the AI cycle**
Whilst AI as a technique focuses on the positive, it does not conceptualise appreciation and critique as polarised: it allows and encourages discussion of the ‘shadow’ recognizing that the most challenging times can create positive transformations (Fitzgerald, Oliver & Hoxsey 2010).

In this project (AI) has been utilised as both a method within learning groups and as a theoretical and analytical framework guiding the project conception and the design of the educational intervention. This theoretical perspective formed an overarching approach to the entire project and thus formed the analytical lens for guiding both data generation and data analysis in the evaluation of the project. The evaluation thus focused on encouraging participants and project members to identify what works: encouraging participants to appreciate and communicate achievement and possibility rather than focus on problems. As AI focuses on both individuals and systems, the evaluation also examines the context and cultural specific nature of the experiences and any perceived outcomes.
4. Project report

Context

In August 2009, the London Deanery appointed a lead associate director for professionalism, Dr John Launer, to guide a London Deanery professionalism programme in conjunction with Dr Tim Swanwick, the director of professional development at the Deanery. This appointment coincided with a request from the heads of speciality schools within the Deanery for training activities, designed and delivered by the Deanery and delivered within Trusts, to address professionalism.

The intended aims of this London Deanery professionalism programme were:

- To promote a fuller understanding of professionalism, reflective practice and patient-centred care among doctors in training in London.
- To make a contribution to the London Deanery project ‘Leadership, Organisation and Generic Learning’.
- To meet the requirements of the Directors of Foundation Schools and Heads of Specialty Schools for Trust-based training addressing the generic curriculum.

A range of educational interventions were proposed and piloted as part of this professionalism programme including the pilot project to explore the potential of facilitated learning groups of doctors in training that is the focus of this evaluation.

The intervention: Trust-based learning groups to foster professionalism

The objectives of this pilot project were:

- To develop a method of training that helps trainees gain a fuller understanding of professionalism, reflective practice and patient centred care.
- To evaluate Trust-based learning groups as a contribution to the continuing development of professionalism in all its aspects among doctors in training.

Pilot sites

The Project Lead contacted a small number of Directors of Medical Education (DME), Postgraduate Education Managers and other Trust educators in late 2009 to discuss the implementation of the programme within their Trust. Five NHS Trusts across the London Deanery area were recruited as pilot sites.

The learning groups

According to local circumstances, the DME, Postgraduate Education Manager or another appropriate person recruited up to twelve doctors for the learning group in their Trust. The group members were recruited from a range of specialities and grades to ensure each group consisted of an appropriate mixture of foundation year doctors, specialty training registrars and SAS grades. With the support of clinical directors,
participants gained explicit permission from their clinical supervisors to have time out to attend the group sessions. A timetable was set well in advance and the timing and frequency of the groups was determined according to local circumstances, but typically groups met once monthly for six months. Each session was scheduled to last for 90 minutes during the working day (usually 3.30 to 5pm) to comply with working time directives.

In order to foster and promote an understanding of professionalism in the workplace, the group meetings aimed to provide a pedagogical space for participants to consider professionalism in all its aspects; to reflect on their own professional practice in context, to consider what gives meaning and value to their medical work and to explore how to make a difference to patients and their families, colleagues, teams, the Trust and local networks.

Participants were expected to attend all six sessions and received a London Deanery certificate as ‘Advocates for Professionalism’ on completion of the pilot programme sessions.

Principles and learning approach

The project group and expert panel approached this learning intervention by adopting a perspective of professionalism that places emphasis on morality and culture (Bleakley 2006, Coulehan 2005, Huddle 2005, Martimianakis et al 2009). Accordingly the term ‘professionalism’ was conceptualised by the project group and facilitators who delivered the programme not as a defined term but as an approach to work that is acquired and sustained as a result of good modelling, a positive organizational culture, and the ‘informal curriculum’ (Brater 2007, Goldstein et al 2006, Litzelman and Cottingham 2007). Adopting this perspective within the learning groups meant whilst leaving space for the consideration of professionalism in all its different aspects, there was a particular emphasis on suggesting individual clinicians need to take responsibility for their own professionalism, whilst acknowledging their attitudes and behaviour are also affected by the local setting and social contexts.

In planning of the facilitation of the learning groups, participants were to be considered co-workers rather than recipients and were invited to contribute to the design and conduct of their learning group as well as to make suggestions for the future development of models to promote an understanding of professionalism in the workplace.

Educationally, the main guiding principle was to recognise and disseminate success, using an approach derived from Appreciative Inquiry (AI) (Cooperrider & Srivastva 1987, Suchman et al 2004). Participants were encouraged to talk about their own experience of their professional work, and to think how they are affected by their working contexts, and how they might influence these. They were given space to talk about negative experiences and observations rather than having these glossed over (Oliver 2005).
Facilitators

Five facilitators were recruited to the project. All had extensive educational and facilitation experience but they came from a diverse range of backgrounds and disciplines and had differing experience of using AI in their work as practitioners and educators. Facilitators were given initial training in the use of AI in educational and developmental activities and attended regular peer support meetings to review and develop their educational method and the progress of the individual groups.

The group sessions

With the support of the DMEs, postgraduate centre managers of the participating Trusts, and the educational and clinical supervisors of the participating doctors, each of the five groups met with their facilitator once a month for six months in protected time between December 2009 and May 2010. At each Trust the sessions were run by the same facilitator each month to create continuity and a sense of joint endeavour.

AI and emergent design were used as orientating approaches to the sessions and facilitators applied a ‘four D’s’ approach: Discovery: exploring the best of what is; Dream: imagining a desired future state; Design: deciding and planning and Delivery: ensuring development within each session and the series of sessions as a whole.

The first session at all sites began with an exploration of the personal meanings of professionalism and an orientation to AI and the use of stories as a stimulus for the work of the group. The subsequent sessions typical started with a recap of learning during and since the last session. This was followed by a ‘discovery’ stage with individuals sharing a dilemma or concern and then the group choosing one or two of these stories as a focus for the rest of the session. The group would help the individual concerned to build on their story by inquiry into the demands, constraints, strengths and choices in relation to the experience. This was followed by a ‘dreaming’ phase with the group hypothesising with each other about the conditions for the dilemma and the emerging narratives of development and resilience. A ‘design’ phase where concrete practical proposals that built on this discussion then led to a final phase where all individuals in the group were encouraged to reflect on what they would take from the session into their practice and how their own personal meaning of professionalism was developing and changing. The final session attempted to build on the learning in the previous five sessions and explored how participants would carry their experience and learning within the group forward.

A total of 47 participants took part fully in the groups and were awarded ‘Advocate for Professionalism’ status.
The evaluation

External evaluation of the project was commissioned at the outset. The aim of this independent evaluation was to illuminate and make statements about the primary research question: "What do facilitated learning groups of doctors in training contribute to the development of professionalism in doctors, their working colleagues, and the organisation?" and to make recommendations to guide and inform any subsequent development of the project across the Deanery.

In view of the small numbers in the pilot project and the nature of the research question, a mainly qualitative methodology was adopted. The evaluation team developed their design in partnership with the project group and the group facilitators. They collected a range of data in the form of observations, interviews, reflective accounts and other documents and used these to provide meaningful insights and conclusions to the project team. A detailed account of the evaluation process and findings follows this section.

The future of the Trust based groups

Despite a successful outcome of this pilot project: the uncovering of meaningful outcomes from participation and the utility of an AI approach in interventions of this nature, the concurrent changes to in the political and economic climate and the subsequent priorities of the Deanery during the course of the pilot, mean that the project will not be rolled out across the Deanery in the foreseeable future. Some work is being undertaken in an informal way in the pilot Trusts, either by the DME or by pilot group participants to maintain the momentum generated by the project.

A small number of publications have been prepared in relation to this project for submission to peer reviewed journals. These include the formal evaluation, reflections of the facilitators and practice points for those involved in faculty development of this nature. The aims of these publications are to inform the wider education community and to contribute to the body of research in the domain of professional learning.
5. Project evaluation

5.1 Context

The groundwork for the evaluation of this project was devised alongside the pilot project development by the London Deanery project team and the expert panel. This meant before the formal evaluation had been commissioned, the project had a clear and declared aim, the nature and objectives of the pilot project had been established, the proposed intervention had been designed and initiated, and some preliminary research questions had been established.

The preliminary research questions concerned the contribution of the intervention on the development of professionalism in doctors in training, their working colleagues and the organisations in which they work.

An established and clear theoretical framework for the project that incorporated: a socio-cultural understanding of the development of professionalism; emergent design in the planned activity; and AI as an approach to learning strongly influenced the methodological approach to this evaluation.

5.2 Research Question

The aims of the overall pilot project and evaluation were:
1. To develop a method of training that helps trainees gain a fuller understanding of professionalism, reflective practice and patient centred care.
2. To evaluate Trust-based learning groups as a contribution to the continuing development of professionalism in all its aspects among doctors in training.

The research question that formed the focus of the evaluation was: **What is the contribution of Trust based groups to foster professionalism on the development of professionalism in doctors in training, their working colleagues and the organisations in which they work?**

Sub questions that will allow purchase on this question include:
1. The perceived contribution of facilitated learning groups to the development of professionalism in doctors in training including:
   a. learning outcomes both actual and anticipated
   b. experiences of participating
   c. effects on individuals
   d. practicalities of involvement
2. The perceived effects of participation on colleagues, patients and the organisation in which participants work
3. What additional value, if any, has been brought both to the Trust and local training programmes?
4. In what ways can organisations embed interventions that foster professional growth?
5.3 Research approach

The nature of the research questions, the scale of the pilot and the ontological lens through which the intervention was viewed, all suggest a mainly qualitative approach to the evaluation. In recognising the complexity of the context, the relatively tacit nature of the object of enquiry, and that ‘human actions can only be understood in terms of their place within different layers of social reality’ (Robson, 2002), an interpretative approach to the enquiry was considered most appropriate: the research questions involve ‘understanding mechanisms at work and the contexts in which they operate’ (Robson, ibid) rather than looking for an objective and generalisable ‘truth’.

This interpretive stance led to the use of approaches that afford access to human perspectives of events and meanings. Interviews, involving participants, non participants, facilitators, the DMEs at participating Trusts and the project lead were deemed the most appropriate way of gathering data that would allow the evaluation team to generate rich and nuanced answers to the research questions and gain meaningful insights into the outcomes of the project.

A mixed methods approach was felt to be appropriate; to address the research question in its broadest sense, to enable the research team to add richness to the data collected in interviews, and to provide meaningful evaluation outcomes data for a range of stakeholders. Therefore observations, documentary analysis, participant questionnaire data and basic quantitative data were also included to inform the evaluation of the project.

The main guiding principle for the learning groups, as established at the outset of the project, was to enable participants to recognise and disseminate success as well as to have permission and space to talk about negative experiences and observations. This principle also guided methodological decisions and thus the data gathering process: with the spirit of AI and emergent design embedded in the data collection.

5.4 Methods

The main methods of data generation were a series of in depth semi-structured interviews with a range of key informants and observations of a selection of activities.

The interviews were conducted with group participants, group facilitators, the project lead and the DMEs at the Trusts hosting the groups. Interviews were conducted with participants immediately after the six sessions had been completed and again with a sub sample six months after the end of the activity to try to capture both immediate and detailed accounts of experiences and longer term reflections and possible changes in practice or outlook as a result of participation.

The observations included both structured observations of a small number of group sessions utilising a non-participant observer approach and of facilitator and project group meetings where a participant-observer role was more appropriate.
This ‘thick’ data was supplemented by a small amount of quantitative data including a brief questionnaire.

Data gathering methods included:

5.4.1. Questionnaires:
- A pre and post intervention questionnaire given to all participants

5.4.2. Interviews:
- One-to-one interviews with a purposive sample of participants at the end of the pilot
- Interviews with all group facilitators at the end of the pilot
- An extended interview with the project lead at the end of the pilot
- Interviews with DMEs at all five participating Trusts four months after the completion of the pilot
- Interviews with a small sample of participants who dropped out of the programme
- Follow up telephone interviews with a purposive subsample (telling cases) of group participants who took part in initial interviews, conducted 6 months after the participation in a group

5.4.3. Observations:
- Observation data from a sample of the groups in action
- Quantitative data concerning attendance, time taken to arrange groups, length of group meetings and withdrawal rates of participants

5.4.4. Document analysis:
- Notes both formal and informal in the form of field notes, notes taken during project group meetings and facilitators meetings and discussions with the project lead, email exchanges
- Reflective notes made by facilitators following each session
- A cost and activity analysis of the project from the Trust and Deanery perspective
**Table 1: Data sets collected and utilised in the evaluation**

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<tr>
<th>Data source</th>
<th>Sample</th>
<th>Responders/numbers</th>
</tr>
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<tr>
<td>Pre participation questionnaires</td>
<td>All participants who initially joined groups for session 1  n=56</td>
<td>43</td>
</tr>
<tr>
<td>Post participation questionnaire</td>
<td>All participants who remained participants by the end of the group sessions n=47</td>
<td>24 (of which eight were anonymous and could not be linked to pre-participation questionnaire)</td>
</tr>
<tr>
<td>Interviews with participants at the end of six sessions</td>
<td>Stratified sampling frame used to generate 12 potential interviewees from the total group of participants with the aim of conducting eight interviews</td>
<td>Eight interviews</td>
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<td>Interviews with facilitators at the end of six sessions</td>
<td>All five group facilitators</td>
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<td>One</td>
<td>One</td>
</tr>
<tr>
<td>Interviews with DMEs at the end of the pilot</td>
<td>All five DMEs (or acting representatives) at participating Trusts</td>
<td>Five interviews</td>
</tr>
<tr>
<td>Interviews with those who withdrew from the groups participants</td>
<td>Total sample size = 9. Stratified sampling frame used to generate four potential interviewees with the aim of conducting two-three interviews.</td>
<td>Two interviews</td>
</tr>
<tr>
<td>Observations of groups</td>
<td>Stratified sampling of three of the five groups: aiming to observe one session in a specialty specific group and one session in each of two general groups at more than one site</td>
<td>Three observations of the final group session</td>
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<td>Field notes from meetings</td>
<td>Notes from four of the total of five project and facilitators meetings</td>
<td>Four sets of field notes</td>
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<td>Reflective accounts by facilitators following meetings</td>
<td>22 submitted</td>
<td>221 submissions used</td>
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<td>Follow up interviews</td>
<td>All interviewees who consented at first interview for a follow up interview were considered. This provided a sample of four ‘telling cases’ who we re interviewed at six months post participation</td>
<td>Four interviews</td>
</tr>
<tr>
<td>Documents: formal notes from project meetings, emails, registers, administrative details</td>
<td>A total of 70 documents: 64 emails, three registers, one set of formal project notes, one set of training notes and two project introductory papers.</td>
<td>All available documents used</td>
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5.5 Data collection

5.5.1. The interviews

The data collection was mainly from interviews so it is important to clarify here the nature of the interviews. The interviews were conducted in a relatively informal narrative-style described by Burgess (1984) as ‘conversations with a purpose’; to allow the exploration of aspects of the experience and ideas concerning professionalism that are often tacit and unarticulated. The interviews were semi-structured in that interviewers worked to brief agreed schedule of questions (see appendix 2) that represented ‘orienting concepts’ (Layder, 1998), but interviews also ensured space and time was given for interviewee’s understandings and perspectives to be explored. Some of the questions cast the interviewee as informant: telling the interviewer about experiences. Others cast the interviewee as respondent: with the interviewer posing a question and considering what interviewees said in response. The initial interviews with participants, facilitators, the project lead and the DMEs were face to face interviews. They ranged from 32 to 56 minutes in length. Interviews with those who withdrew from the programme and the six month follow up interviews were conducted on the telephone. These lasted between 17 and 56 minutes. All interviews were audio recorded and fully transcribed.

The approach to the data analysis generated from the interviews was thematic analysis: both inductive, utilising elements of grounded theory with meaning flowing from the data, as well as deductive, to answer the questions posed by the project team (Miles and Huberman, 2002).

Initial themes for coding were generated from the theoretical framework and the research questions with further interpretation and generation of themes and constructs produced iteratively. The data management package NVivo 8 was used to manage and organise data.

Data analysis took account the complex nature of the system being studied and personal meaning from the participants was foregrounded. Data analysis aimed to generate theory and develop further outcomes both for the duration of the pilot intervention and to inform subsequent iterations of the learning groups.

Throughout the process the evaluation team were reflexive; examining whose interpretation of events were being prioritised and why and how the data generated supported or conflicted with developing theoretical understandings.

5.5.2. Observations

Both project group meetings and some learning groups in action were observed. In project group meetings the observer acted as a participant-observer taking detailed field notes regarding events and parallel notes regarding initial thoughts and observations. Immediately after these meetings further reflections and notes were added to the observations. In the learning groups, following a brief introduction and consent, the
observer acted as a non-participant observer. The observer completed an observation schedule (see appendix 3). Special attention was paid to AI in observations: both in field notes and the observation schedule. References to AI and observation of AI in practice were foregrounded.

In both types of observation the observer was looking both at the processes of the meeting or session and the content of what took place.

5.5.3. Questionnaires

Participants were asked to complete a questionnaire before beginning the programme and again at the end of the six sessions. Participants were asked to put their name and the date at the top of the questionnaire but could choose to leave this section blank.

The questionnaire used a mixture of free-text qualitative and quantitative items. For the quantitative items, participants were asked to rate on a 10-point scale where they felt they were in relation to the following five statements:

- Understanding the nature of professionalism
- Your desire to improve your own professionalism
- Your need to develop your own professionalism (pre-questionnaire only)
- Your confidence that there will be positive change in your own professionalism in future
- Your capacity to influence change in others' professionalism

The post-participation questionnaire used the same format as the pre-participation questionnaire, and asked many of the same questions (see appendix 4 for a copy of both questionnaires). Again, participants were given the option of putting their name and date at the top of the post-participation questionnaire, but were told they could also complete it anonymously if desired.

Median scores for each of the quantitative items were calculated for both pre- and post-questionnaires. Mann Whitney U tests were used to analyse the differences between pre- and post- answers to the four items both questionnaires had in common. Where the same participants completed both questionnaires a Wilcoxon signed rank test was used to compare the pre- and post-participation results.

The data from the free-text items were analysed using thematic analysis in a similar way to the rest of the qualitative data generated.

5.5.4. Documentary analysis

A range of documents were used as data in this evaluation. Indeed throughout the process of project development, revision of the intervention and evaluation, every conversation, document and meeting was regarded as data.
Each document set was analysed differently depending on the purpose of the documents in relation to the project and the evaluation. Some of the documents were secondary data sources: they contained material not specifically gathered for the research question at hand (Stewart 1984). However some, such as the reflective facilitators notes, were created partly for the evaluation and so can be considered as similar to other textual data such as interview transcripts.

Formal minutes and notes from project group and facilitators meetings, informal field notes taken during meetings with the project lead and during project group and facilitators meetings, and e-mail exchanges were considered primary documents: primary sources written or collected by those who actually witnessed events which they describe.

Each facilitator was also asked to produce reflective notes after each session and to share these with other facilitators and the evaluation team if appropriate. These were considered as secondary documents; written after an event that has not been personally witnessed.

The evaluation team were also copied into a wide range of emails exchanges. These ranged from organisational exchanges through to reflective comments shared between facilitators or between the facilitators and the project lead.

Finally a brief written summary was requested from administrators at each project site at the Deanery asking them to highlight strengths and difficulties associated with running the project groups.

Documents were analysed both as a separate data source in themselves and alongside the other sources of data concerning events (such as group observations) and concerning opinions and experiences (such as interviews and meeting observation notes). Documents were analysed from an interpretivist stance. While primary documents can be considered reliable and accurate data they were considered in their social context and open to selective interpretations and biases in their reporting of events.

Secondary documents were considered as constructions or ‘accomplishments’: based on reasoning by the author that renders the events comprehensible, yet open to negotiation and manipulation (Duffy in Bell 2005). Unstated, tacit and implicit meanings and structures embedded within the documents as well as the content were considered.
5.6 Ethical Considerations

Ethical consideration at the planning stage concerned access to groups and the confidential nature of disclosures both within the group and in interviews.

Research was conducted in line with British Educational Research Association guidelines (BERA 2004).

Approval to carry out the evaluation was sought and granted at each contributing Trust. NHS Ethics advice and approval was sought at the earliest opportunity. NRES exemption was granted once the nature of the project and the purpose of the evaluation had been discussed (see Appendix 1).

All interviewees in the evaluation process received detailed participant information and signed a consent form both for the interview to take place and the data collected to be used, in an anonymised form, in a range of reports and publications (Appendix 1).

The nature of the groups and their focus of confidential and difficult subjects made the observations of groups potentially problematic and so further consent was gained by all group members before an observer was permitted to join the group.

At the data analysis stage, participant validation involved ascribing comments to individuals so access to the raw data was limited to the evaluation group.

All data was anonymised prior to sharing with those outside the evaluation team and before publication however the size of the pilot made concealment of identities of some groups, such as the DMEs and facilitators, difficult.
5.7 Results

5.7.1 Questionnaire data

Questionnaires were distributed to all participants by either the group facilitator or the postgraduate centre manager during the first and last session of the programme. Participants were reminded that the evaluation was being conducted by a group that were not involved in the delivery of the programme and that their honest responses would be valued. Participants could choose whether to identify themselves on the questionnaire or remain anonymous. They were reminded that the data generated from the questionnaires would be anonymised in the project report and that comments would not be attributable to identifiable individuals. The pre-course and post-course questionnaires are shown in appendix 1.

5.7.1.1 Numerical Questionnaire data

77% of participants (43/56) completed a pre-participation questionnaire and 24 of the 47 doctors who completed the programme completed a post-participation questionnaire (51%). 12 participants provided both pre-and post-questionnaire responses and gave their names, allowing their pre- and post- responses to be linked (27%).

The medians and ranges for each item at pre- and at post-participation are presented in Table 2. It is important to note that the pre- and post-participation data are not always from the same participants, although there is some overlap (see above).

Participants’ self-rated understanding of professionalism post-participation was higher than it had been pre-participation (median pre-participation= 6; range 3-8; median post-participation=8; range 5-9). This change was statistically significant ($z$=-5.8; $p<0.001$). There was a non-statistically significant trend for participants post-participation to have a greater desire to improve their own professionalism, and also to have greater confidence that there will be a positive change in their own professionalism in the future.

For the 12 participants who completed both pre- and post-participation questionnaires, there was a statistically significant increase of two points in their self-rated understanding of professionalism ($z$=-2.9; 0.003). There were no other statistically significant changes.

Table 2: Change in responses to questionnaire items pre- and post-participation

<table>
<thead>
<tr>
<th></th>
<th>Understanding the nature of professionalism</th>
<th>Your desire to improve your own professionalism</th>
<th>Your confidence that there will be positive change in your own professionalism in future</th>
<th>Your capacity to influence change in others’ professionalism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>n</td>
<td>43</td>
<td>24</td>
<td>43</td>
<td>24</td>
</tr>
<tr>
<td>Median</td>
<td>6.0</td>
<td>8.0</td>
<td>9.0</td>
<td>9.5</td>
</tr>
<tr>
<td>Range</td>
<td>3-8</td>
<td>5-9</td>
<td>6-10</td>
<td>7-10</td>
</tr>
</tbody>
</table>
5.7.1.2 Free-text questionnaire data

**Professionalism**

In the pre course questionnaires, participants were asked to give a personal definition of professionalism. As might be expected most definitions described a mix of behaviours, skills, attributes and relationships. The most frequently described attribute was related to integrity, honesty or trustworthiness: with a quarter of all respondents including this in their descriptors.

Other commonly included attributes of professionalism were; providing a good standard of care, taking responsibility, keeping up to date/continuing to develop, being respectful of patients and colleagues, recognizing the value of the multidisciplinary team, behaving in a way that was in patients' best interest communicating, putting patients needs before ones own and recognising ones limitations.

Participants were asked the same question at the end of the group meetings and there was a change in emphasis noted with only one participant still mentioning honesty or trustworthiness. References to how one behaves and communicates with colleagues, often linked to the aim of providing best care, was the most common professionalism attribute described. A desire to provide good clinical care, conduct in patient’s best interest, respect and responsibility were still commonly described attributes but post participation more attributes joined the descriptors, including self-awareness, an orientation to the environment and being an advocate for the patient.

A summary of responses and their frequency is shown below in Table 3.
Table 3: Changes in responses to professionalism questionnaire item pre- and post-participation

<table>
<thead>
<tr>
<th>Professionalism descriptor</th>
<th>Pre course questionnaire n=43</th>
<th>Post course questionnaire n=24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrity/honesty /trustworthiness</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Responsibility</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Keeping up to date/continuing to develop</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Patient oriented:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Providing good care</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>• Respecting patients</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>• Conduct in patients best interest</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>• Putting patients needs before own</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>• Being an advocate</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Team oriented:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Way you behave with others/ respecting others</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>• Recognising/valuing the MDT or other professionals</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Self oriented:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Recognising limitations</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>• Self awareness</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Environment oriented:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Attitudes to ones workplace</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>• An understanding and respect for the environment</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>• Developing a climate of positive change</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>• Dressing appropriately</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Communication</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>A way of behaving with patients and colleagues</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

Reasons for attendance and anticipated gains

The pre participation questionnaire asked participants why they had chosen to attend this programme and what they hoped to gain from participation. The post participation questionnaire asked about actual gains and the way in which respondents think they will change because of participation.

The reasons given for attending could be broadly categorised as: being about self; about self and other participants; or about others external to the programme. There was some overlap with a few participants suggesting attending for reasons relating both to self development and the development or discovery of others however most gave just one reason for attending in this section of the questionnaire. Just over half of participants suggested their reason to attend was to look at their own behaviour and professionalism. 12 comments referred to opportunities to hear what others in the programme think or benchmarking to or comparing with experiences with others. 13
comments were made about the affect attendance may have on others such as: to help members of my team to improve, to discover how you might teach it (professionalism) or feedback to juniors, an opportunity to role model, learning to set an example, and to improve standards of professionalism in the workplace.

Anticipated gains were often linked to reasons for attending; again being oriented to self learning and discovery (18/43); about self and other participants including the value of group working and discovery (4/43) or about influencing others (6/43).

**Impact of attendance**

In questions linked to the pre-participation questionnaire items described above, the post participation questionnaire asked about actual gains and the way in which respondents think they will change subsequent to participation.

21 participants (all bar three respondents) commented on gains related to themselves as practitioners: ten described an increase in self awareness and nine an increase in self reflection or mindfulness.

Half of all respondents (12) identified an increased understanding or awareness of others: their needs, their challenges and indeed their examples of professional behaviour. Two of those suggested they were not just mindful of others but more prepared to challenge the behaviours of others.

Six of the 24 respondents commented on the group process; identifying it as supportive to work with others in this arena, the usefulness of having a forum to discuss professionalism and to ‘talk things through’.

Four mentioned the effect they could have on others by ‘spreading the word’ encouraging and influencing others to inspect their behaviours. Four mentioned the ability to use AI as a tool in learning and understanding events.

When asked to identify things that may change in their practice having taken part in the project respondents identified change to their own professional practice or mindfulness of their professionalism (22/24) such as an intention to tackle behaviour and not ignore it (3/24), to try to remain professional under pressure (2/24), to influence colleagues by being a good role model (2/24) to more openly discuss professionalism at work (3/24). Two participants mentioned that their new understanding of professionalism in the context of the organisation would also affect their own practice. Respondents also felt their awareness of others would be heightened with an increased appreciation of the professionalism and positive aspects of others (7/24), and a belief they would try to influence others (4/24).

**Understanding of AI**

Before participation understanding of AI was limited; as would be expected with an approach relatively novel in medical learning settings. Respondents declared no knowledge or left the section blank (over half) or give simple statement about AI (17/43) such as being about seeing the positive side of things or a philosophy of looking at what
works rather than what is wrong or a facilitated group process: many acknowledging that this level of understanding was gleaned from the introductory letter for the project. Following participation all felt able to describe AI. The type of description varied. These included most commonly: focusing on/seeing the positive, look at and managing situations with 4 Ds, exploring practice with plans to improve it, looking at things more widely that just the problem to be solved and using the past to learn about how to tackle the future.

Many of the themes identified by respondents in the free text sections of the post participation questionnaires were also identified in initial interviews with participants (see below).

5.7.2 Interview Data

Interviews took place with a range of informants: participants, participants who did not complete the programme, group facilitators, the project lead and the directors of medical education (DMEs) in Trusts where the programme took place. Due to the purpose of the interviews and the nature of the questions asked, the interviews with group facilitators, project leads, the non-completing participants and the initial interviews with participants who completed the course all took place immediately after the completion of the six sessions. The interviews with DMEs took place approximately four months after the intervention in their Trust and the follow up participant interviews took place six months after completion of the course. The full interview schedules are detailed in appendix 2.

5.7.2.1 Participant interviews

Eight participants were interviewed after attending the sessions. Interviews were conducted in the spirit of AI.

During this interview participants were asked about their experiences, what they had learnt from taking part both about AI and about professionalism and what they were going to take forward. In the follow up interview they were asked to look back at the six months since participation and to describe the effects of participation on themselves and those around them (see appendix 2 for details of interview schedule).

Six main themes were identified, which were mainly inductive, relating to the interview questions:

1. Understanding of professionalism
2. Encouraging professionalism in others and advocacy
3. The groups and the group process
4. The utility of appreciative inquiry
5. Making the development of professionalism enduring
6. practicalities of participation

Participant theme 1. Understanding professionalism

As would be expected professionalism; what it means, what encourages professionalism and what inhibits it, and the effects of participation on ones own
professionalism, were a central theme of all of the interviews. Four subthemes where identified:
a) Defining professionalism
b) Effects of participation
c) Professionalism and the organisation
d) Challenges to professionalism.

a) Defining professionalism

Interviewees provided sophisticated description of what professionalism means; sometimes revealing the colleague-focused orientation seen in the post participation questionnaires:

‘.to start off with I guess I would have thought, you know, well
[professionalism] is putting the best interests of your patients first and being committed to your job and not doing anything to put people in danger. But I guess now my understanding’s a lot broader … it’s not just about patients, it’s about the way you communicate with your colleagues’
B2

‘I guess [professionalism means] ensuring all the basic principles are carried out on a day to day basis in everything that I do. … Probably the biggest part of professionalism in terms of my clinical practice is the sort of concept of mutual respect. And that’s with others including patients particularly’
C1

Three of the interviewees pointed out the intangible nature of professionalism:

‘We did start off our group with a discussion about what professionalism was, and you know people did trot out the same old standard ‘oh well it’s about integrity and it’s about altruism’ and all of that. And you know I was saying ‘Well what do you mean by that?’ … you know we’re using language that we’re not clear about. So I don’t think professionalism means anything in particular … or it certainly is not reducible to a key point.’
C1

‘I think it’s very … it’s dynamic, it’s fluid. Professionalism is about looking critically at what you do and what you’re being asked to do, and what somebody’s telling you that you need to do. And it’s evaluating that to saying well what’s actually in the best interest of the patient. And I don’t think you can read a GMC document particularly and say if I religiously follow this I will serve the best needs of my patient.’
E1

b) Effects of participation

Interviewees were asked about the effects of participation on their own professionalism and their own behaviours. They talked about how previously issues of professionalism tended not to get thought about in the normal working role and a new increase in
mindfulness and reflection about their own professionalism and the professionalism of others:

‘I take myself more seriously…I feel more responsible: ‘I am not just someone working, I am here to represent the staff and the Trust and all it wants to be’
D1

‘You become much more observant and actually start looking for these sorts of behaviours, which perhaps you probably wouldn’t have done beforehand because you were just so busy trying to get things done. So it really does make you much more receptive to how people deal with things, what things are good, what things aren’t so good. So you’re sort of constantly evaluating’.
B1

‘I think it’s provoked me to think a lot more, you know. I found myself at work like considering how I’m behaving towards other people … especially when you’re in more difficult situations’.
B2

‘It has supported some of the work that I’ve done before and some of the thoughts I’ve had about work I’d like to do in the future – very much so. I think it’s helped me reflect on my own practice, and also reflect on some of the other things that perhaps I could or should have intervened with. You know so a lot of the information that was shared actually is not new information. And so it was really interesting for me to think about why people behave like that. How I behave sometimes, or how I could be perceived to be behaving sometimes, and how people would find that … could interpret that as unprofessional.’
E2

c) Professionalism and the organisation

For some participants the course brought a new realisation of professionalism not being a personal notion but in fact a distributed notion at the level of the organisation:

(professionalism is) ‘the way you portray the values of an organisation or group; like a Trust or doctors in general’……I am more respectful of others; everyone is working together to create this organisation. If I treat others professionally they will treat me well.’
D1

(we) ‘spoke about … organisational structure and more of the team structures and how professionalism impacts on that, where you as an individual, how you can use your abilities and skills to improve things in a wider perspective. So again that’s something that this has sort of brought forward in my mind and [The course] made me think about how to develop things as I go through my training and developing into a consultant, how I can think about that within organisations as well, rather than just at an individual level.’
B1
'one of the biggest problems that came out from that group discussion is about professional behaviour amongst the leaders of the organisation. And that’s interesting from where I sit, from my medical management perspective, cos that’s reflected at an organisational level.’
E2

d) Challenges to professionalism

Many participants outlined challenges to their professionalism; most of which were related to workload and interpersonal factors:

‘It’s easy to be professional when you are not stressed.’
A1

‘Life, lack of time and other doctors and nurses putting pressure on you.’
D1

‘Junior doctors need mentoring and support (to develop professionalism) as they often do not get it from seniors.’
A2

Participant theme 2. Encouraging professionalism in others and advocacy

One of the anticipated outcomes was that participants would become advocates within their teams and within the Trust. The interviewees were divided in their opinion of the feasibility (or indeed desirability) of this. Some felt this was possible and what they would endeavour to do:

‘I’m more aware of need to lead by example….I have a duty to disseminate what I have learnt.’
A1

‘Maybe we could set up a small group with other colleagues: but would anyone do it in their free time? But you can alter the lunchtime conversation about difficult patients….’
D1

‘..I feel much more confident of being able to talk about the things that we’ve been doing, and hopefully being able to take these sort of skills and things back to teams and develop them … especially when I become a bit more of a senior member on a team. And a lot of the things that we’ve been doing with the group work have been really useful skills that I think we can take to different situations that will help different members of the group develop.’
B1

‘I feel almost like I do have a responsibility, maybe not to be going round going ‘I think that you could have done that in a more professional manner’
(laughs) but you know to support people to think about things better You know like saying to that doctor ‘Why didn’t you use it as a learning opportunity?’ you know ‘You could have made it … it was annoying and you’re busy so it’s a bit of a rubbish situation when you’re on call and now you’ve got to do something else that you didn’t think you were going to have to do, but why didn’t you make into a positive situation?’

B2

‘Potentially one of the useful things about the group stuff is that we’ve got a … we’ve had an opportunity as a set of individuals to potentially conduit amongst a much broader group.’

E2

Others felt it was a role they were performing already:

‘If I can be brutally honest [being a professionalism advocate means]–nothing. Because I hoped I was that beforehand. ….but now I’ve done a course, so I’m competent. I’ve got a certificate that says I am. Brilliant (laughs). I would be really disappointed if someone said I wasn’t an advocate of professionalism before I went into the project… But I was able to put it on my CV and my … you know for my RITA assessment, so I was able to put it on, so it’s great. (laughs)’

C1

it was not possible:

‘It is a challenge to improve (your) own behaviour. How do you engender professionalism in others?’

A2

or that it was a pointless outcome:

‘It means nothing at all. It’s a joke. It has no meaning and no value at all. It’s a made up name so that somebody could print a certificate.’

E1

Participant theme 3. The groups and the group process

Participants were unanimous regarding the usefulness of meeting as a group. This included the opportunity to meet doctors from other specialties and grades, the opportunity to discuss things that would otherwise go un-discussed:

‘It was good for so many reasons: I became closer to other doctors in the hospital, I had the opportunity to discuss in depth… issues that affect all of us and it made me think of times I just thought were work but where in fact I had an influence.’

D1
‘...the fact that the group is very varied, so from ST2 doctors up until sort of people who are ready to be consultant who are just doing their last years of registrar training – you get a real breadth of experience and different people’s views .. which has been really useful.’

B1

‘The best thing about it was having the chance to sit down in a protected time and talk to my senior colleagues … you know just examples, things that had caused me to have pause for thought and things I wasn’t sure about. And also they would bring cases that they thought were interesting to discuss. And so I think the major benefit was to see how other people managed you know kind of standard problems that we all encounter, and that that was done in protected time and was facilitated as well.

‘…it was called ‘project professionalism’ but you know discussions regarding professionalism were a minuscule part of … it was sharing narrative – I think it was building relationships between doctors.’

E1

The above interviewee suggested that not all participants had felt so positively or seen the benefits so clearly:

‘You know some people who were quite freely admitting of it afterwards would say ‘Well you know it’s an hour and a half with tea and biscuits where I don’t have to do my day job’ and they were quite dismissive of it on the face of it, but you know who knows whether they actually got something out of it as well.’

E1

Participant theme 4. The utility of Appreciative Inquiry

There were mixed feelings about the utility of AI. Some felt it was useful in the group settings and some felt it could be useful outside:

‘It’s useful to think how you would like it to be and how you might make it happen.’

D1

[A facilitated group using AI] ‘I thought was quite useful because it kept us all on track that we didn’t deviate off into negative ‘Oh isn’t it awful, you know it’s dreadful’ kind of thing…… Because the appreciative enquiry thing I mean was quite useful and that always brought us back to what the good points in it were.’

E1

Two interviewees had previous experience of AI and felt it was used in a considered and elegant way by the facilitator. One of these interviewees remained unconvinced of its utility:
‘I think it’s a really good concept. I think um … my experience of it in this group was that it was used less overtly. You know I’ve been in facilitated groups where people actually take you through the four stages and they say ‘Right, 15 minutes are up, we’re going on to the next stage, I want you to visualise blue clouds (?) in 15 minutes’ – and that doesn’t … wouldn’t really work for me. And I think the nice thing about using appreciative enquiry in these facilitated groups was it was very discreet.’

C1

‘I was quite sceptical about it at first and I probably still am. But I think it helped having a facilitator that was trying to think ‘well, what are the good points out of this bad experience’. ……But initially it was concentrate on the positives … and we couldn’t do that without talking about the bad bits of it. Because you know good only means good if it’s in relation to something bad. Otherwise it doesn’t have any meaning. So I think it was quite important for us to be able to you know, to moan if you like, to moan and say how awful it was. Because then you’re able to say ‘okay what were the good points that happened.’

E1

There was also a range of understandings amongst the interviewees about AI: this ranged from very sophisticated understandings to not remembering what it was:

‘I guess it’s more of a … something that’s not so tangible, you know a concept …you know like professionalism, and discuss it in a way where you’re thinking about the positive aspects of it and learn about it through thinking about those positive things. And then on no you have to through these four stages – I can’t remember what they are. One of them’s dreaming … and I can’t remember what the other ones are. (laughs) I can’t remember.’

B2

Participant theme 5. Making the development of professionalism enduring

Most participants spoke at length on this issue. Concerns were often raised about the sustainability of any change without ongoing group meetings and the ability of participants to truly influence others.

Two sub-themes emerged:

a) building professionalism into existing structures

b) the role of past participants in ensuring professionalism in the future.

Interviewees suggested building the work into existing small group sessions such as ‘Balint groups’, team away-days or junior doctors’ fora. The limitations of building such development work into existing ‘academic’ structures such as induction or formal meetings was highlighted a problematic:

‘I mean from my perspective, my future career … I think as an organisation … as a hospital … as a consultant in a hospital organising a team, if I could find
that kind of space … and it’s not that frequent … I think it’d be invaluable. I think it’s really interesting.’

C1

‘The trust could do that as a part of an away-day for teams that are struggling or maybe where there’s been teams where the feedback from the patient surveys haven’t been so good. Instead of as a punishment to say ‘Oh you’re team’s rubbish’ it could be more of a ‘Let’s see how we can develop this, let’s see how we can improve things with this sort of work.’

B2

‘Trying to get involved in academic meetings on thinking about professionalism is good, but I suppose you need to do group work with this sort of thing, it’s not sort of something you can really lecture on. And that takes time for people to be in a room and you do need to develop those sort of relationships. So it’s quite time intensive.’

B1

Two of those interviewees suggested that past participants could be facilitators of the future:

‘If that could be done again, you know sort of in a year’s time or in a couple of year’s time to try and catch more people, I think that’s a good way of doing it. And obviously if the people that have then been on the course then you know sort of … either used as facilitators or help facilitate other sort of groups or other sort of projects, I think that’s important.’

B1

‘I guess it’s having the facilitators who … perhaps all of us who’ve done this now could go on and be facilitators and continue – that’d be brilliant wouldn’t it?’

B2

Participant theme 6. practicalities of participation

Despite the need to take time out of work for the sessions and the length of the course overall, no interviewees related any difficulty in getting to the sessions. The interviewees were, of course, those who had attended the sessions regularly and therefore may not be representative of the perceived ease of attending (see below for participants who did not complete the programme, and the facilitators’ views about attendance). More junior participants either described supportive seniors who facilitated their attendance or that they attended in their own professional development sessions. More senior participants described making time to attend.
5.7.2.2 Follow-up participant interviews

Eight participants were interviewed immediately after attending the sessions. Half of participants who took part in these initial participant interviews were selected by the evaluation team as ‘telling cases’ and invited to take part in a follow up interview six months after completion of the course.

Interviews were conducted in the spirit of AI and were carried out on the telephone.

During the initial interview participants had been asked about their experiences, what they had learnt from taking part: both about AI and about professionalism, and what they were going to take forward. In the follow up interview they were asked to look back at the six months since participation and to describe the effects of participation on themselves and those around them. They were also asked to make further comments on key issues they identified in their initial interview (see Appendix 2 for interview schedule).

Five main themes were identified, which were mainly inductive, relating to the interview questions:

1. Personal reflections on the activity overall
2. The importance of the group process
3. Effects on the participant’s own professionalism
4. Effects on others
5. How Trusts might take fostering professionalism forward

Follow-up theme 1. Personal reflections on the course overall

All interviewees were asked to describe their abiding memories of participation during the interview. All were able to reflect extensively about the experience of participation both in response to this initial question and throughout the interview: describing personal meanings gained from the experience. Participation had been a positive experience for all participants although they did not directly attribute this to the topic area. The experience was memorable for being something out of the ordinary:

'It was something unusual. The meetings were special in that they were sort of in protected time with doctors from varying grades, that was what was unusual but very welcome and also it was very equal so you could talk to even a consultant on the same level basically as you would with someone from ... you know an FY2 like me or, you know, a junior doctor basically.’

D1

‘You always go to these courses but there’s a little bit of scepticism and come away thinking that was really helpful because, certainly with this course, I think I felt a little bit sceptical, as you always do with these things but I came away thinking it was a really good course, it will really help me think about things.’

A1
‘(it was) enjoyable in terms of the socialisation aspect. Interesting in terms of sort of, I was going to say exposure or the meeting of fellow professionals who I probably wouldn’t normally have that sort of interaction with.’
C1

‘What I remember was having a group of people I enjoyed talking to and listening to and, you know, listening to their stories and how they worked through some of the issues that were discussed in the group….I remember it being a nice kind of ... a warm group feeling, feeling part of the group … and although it was based at work it wasn’t necessarily work based if you like: if that’s not a contradiction.’
B1

Follow-up theme 2. The importance of the group process

This theme was very similar to a theme identified in the initial interviews (theme 3: the groups and the group process). The group nature of the intervention and the potential for shared experiences and shared learning, particularly outside the formal hierarchy of hospital medicine, was seen as key to its success.

‘The thing is getting together in the week discussing things. There were like one or two people who had problems and experiences and I think as a group it made quite a big difference if you can talk about the feelings and experiences that people had, especially the junior doctors’.
D1

‘Shared experiences always make a difference and if someone can talk about a personal experience like that in the group, I don’t know if we were particularly lucky with our group but I think xxx is a very good facilitator for this process so it made it very easy for us just to talk about things quite openly and not have any fear of reprisal. Often that’s the case in the NHS where you don’t want to anger your seniors because you always have the impression that they have influence in your career, which they do to a certain extent.’
B1

‘One of the benefits is that I’ve come back into clinical practice and gone to another hospital and there’s a load of people who we’ve all been in the project together and now, you know, these people I didn’t know particularly well beforehand, they’re all relatively senior and relatively junior formal confidents and we interact in a different, more sociable way, which I think is much better, that’s how it should be.’
C1

‘It was the actual process of having some dedicated time where you could go and talk with other doctors who are more senior, from different specialties and you could just say, you know, God, isn’t this awful or isn’t this brilliant or isn’t this challenging, you know. And that was the nice thing because there was a certain freedom associated that it wasn’t about discharging a patient and all
those kind of things that you have on the ward, there was freedom that came with it.’
B1

Follow-up theme 3. Effects on the participant’s own professionalism

Two of the follow-up interviewees felt at initial interview that their professionalism and their work behaviours had not been affected by participating in the group. They both maintained this position in the follow up interviews. However the other two interviewees described a new orientation to their understanding professionalism as more of an interpersonal issue: concerned with interactions with professional others and the organisation, not simply a personal issue or an issue confined to interactions with patients:

‘the Professionalism Project helped me gain more ... identify more with my job, with my position in the hospital and I decided I was representing not just myself, that’s right, yeah, but the whole of the establishment really. I was also part of the establishment.’
D1

‘Certainly it makes you more acutely aware of people’s behaviour, not so much in terms of dealing with patients and things ’cause most of the time dealing with patients is absolutely fine but it’s made me more aware of the doctor/doctor relationship and dealing with colleagues…. The course has had more of an affect on my reaction with my colleagues interacting and watching other people…’
A1

Follow-up theme 4. Effects on others

Interviewees were asked to describe their effect, if any, on the professionalism of others. One said she had been away on maternity leave since participation and another had been busy with exams. However on reflection both felt they had influenced others:

‘The other day actually, thinking about it, ......there was a mistake in one of the scans that one of the guys did, you know, and rather than just glossing over it I actually went and spoke to him and said, by the way this is what’s happened, it’s nothing serious but just for help in your future practice…. I think because of that course I was a lot more, ...you know...before you always ask yourself whether you should be talking to someone about possibly making a mistake and certainly as a junior. But I think because of the professional course I thought ‘well this is a good opportunity for someone to learn from this situation’ and again approaching it ... when I spoke to him about it I did it more, I guess, an appreciate enquiry type thing. I said ‘well this is what’s happened, the silver lining to this, the way to think about this is that you need to take certain images and do certain things’. So instead of becoming ‘you made a mistake’ (it was) ‘in the future this is how you can
actually do these things to not only avoid doing this but also being better at doing scans and things’ and all this. So I think it gives you a bit of a … it helps your confidence in approaching a potentially tricky situation’
C1

‘I don’t think I’ve actually influenced anyone with what I can say but I do think I’ve tried to act professionally and maybe from my behaviour … or maybe (they) picture me as professional, so for example when we are doing nights, I won’t just sleep for example I would go on working through the night and I think that’s, for example, more professional than others.’
D1

The two remaining interviewees had moved onto new posts (and in one case a new Trust) since taking part in the groups. One felt he had less opportunity not more to influence others in the domain of professionalism due to the change in the nature of his role. The other interviewee described how when taking part in his group he had actively looked out for things to discuss in the group. He had since moved Trusts and tried to initiate conversations about professionalism issues in his new job but had not been successful:

‘I’ve encountered lots of things that have raised my eyebrow and, you know, made me think about things in a bit more detail. I think it also put into contrast the difference of not having a group to discuss it with, not having a group of likeminded individuals to process it with because when I did try in my new job people looked at me in a way as if to say what on earth are you talking about?’
B1

Follow-up theme 5. How Trusts might take fostering professionalism forward

Responses in this domain concerned:
 a) the difficulties of bottom up intervention creating change
 b) the role of Trust based groups
 c) the role of advocates

a) The difficulties of bottom up intervention creating change

Interviewees were sceptical about the possibility of effecting change from the bottom up. They felt the hierarchical nature of the NHS, the transient nature of junior doctors’ jobs or the small number of participants in this sort of a project all inhibited change at the level of the Trust:

‘Whether it’s had a direct influence on the Trust with only a couple of us doing it I can’t quite honestly answer that to be honest. … Unfortunately medicine is still very hierarchical and changes generally have to come from the top down, it’s very difficult to influence things from the bottom up…. If I said that actually this consultant takes on the principles from this course and gives it down to his juniors you will benefit as a Trust from it in the long run definitely.’
A1
'In terms of organisation I think that you need to have, you know, an executive board who foster professional kind of behaviour and confidentiality worked at board level. There are several Trusts where that is not the case so that unprofessional behaviour at very senior level is clearly reflected elsewhere in the organisation, so I think that’s important.'

C1

This same interviewee questioned whether Trust were really interested in fostering professionalism in anything other than a performance related way:

‘….so I come for a year here, six months there, three months somewhere else and no one really gives a monkeys who I am, what I do as long as I don’t kill anyone and don’t kick up a fuss.’

C1

Another could not see how brief educational interventions could affect change and suggested that changes to service organisation were needed to improve professionalism:

'I don’t necessarily see that us talking about it inevitably means that we become more professional or that patient care is improved. … what we’d be measuring is that we were talking about it more often or we were doing something like that but they’re very false outcomes to favour a programme such as this would foster increased professionalism…. You know, looking after the staff in the NHS, that’s what they need to do. …what the Deanery needs to do to foster professionalism is to train people properly not get them delivering service all the time at the expense of their training.'

B1

b) the role of Trust based groups

Despite anxieties about the groups effecting change two interviewees felt there was some benefit in continuing or expanding the intervention:

‘Continue running projects similar to the one I participated in because I think more people would actually benefit from attending workshops like this.’

D1

‘I absolutely think the course is a good idea and I think that it was actually mentioned amongst us that if more consultants went on the course…If I said that actually this consultant takes on the principles from this course and gives it down to his juniors you will benefit as a Trust from it in the long run definitely.’

A1

One felt that without a group professionalism issues would never get discussed:

‘If you said I’m going to set something up or I want to start this and there’s no accreditation and there’s no certificate it’s just not going to happen even if you wanted to do it informally, it’s not going to happen. The benefit for the group
was it had institutional backing and it had protected time more or less and it had tea and coffee and it was away from work, so it had all the things that you needed to have really in order for them to work… it’s got to be organised, it’s not something you can do over coffee and it was helpful to have people from different specialties and different grades… Certainly my experience has been that when I’ve tried to initiate discussions around these points it doesn’t quite work. The forum of having people there for that particular purpose seemed to be one think that made it work pretty much’.

Interviewees however suggested the self selection nature of these groups influenced the outcomes:

‘We were a self-selected bunch…. I rapidly came to the conclusion that most people [are not] interested in that [talking about professionalism]. That taught me the difference between a self-selected group and then a kind of random group … it kind of highlighted the importance of having a group of like minded individuals and we discussed in our group at the time that it was funny that the people who applied to do it were the people who already had professionalism in their mind.’

And identified the limitations of extending groups where doctors were required to attend:

Respondent: ‘it would be nice if you could put people down for It [the course].’
Interviewer: ‘Like that guy you were talking about at the beginning [of the interview]?’
Respondent: ‘Yeah, it wouldn’t make any difference to him anyway. When they have a personality disorder there’s not much you can do about it.’

‘Of course not everyone could benefit from taking part’

The role of advocates

One of the planned outcomes of the project was that participants became advocates within the Trust. One interviewee remained adamant that he was an advocate before the course but that a recent change in role would probably mean he would be able to be less of an advocate that he had been previously. Another participant, who had been sceptical about the status of advocate at initial interview felt the title was meaningless:

‘Well of course on one level yeah having the piece of paper is ... you know, it goes to my portfolio and although it doesn’t prove anything to me and it shouldn’t prove anything to anyone else who has half a brain, it proves things to educated people in the hierarchy that you’ve done a course, you’ve got a certificate therefore X might happen because it’s based on some ridiculous premise that if you’ve attended a course on something you must therefore be an expert or in other ways informed about [inaudible] which we both know to
be complete rubbish. And so on one level it’s useful because it goes in my portfolio and on another level it’s completely useless as a concept because, I mean, it’s just ridiculous, an advocate for professionalism. What is it? Does it mean anything really?'

B1

Another suggested this was rather more responsibility than she felt prepared for:

‘something also that we discussed during the project towards the end when we were to think about suggestions to introduce the idea of advocates to the doctors on their induction day so that people knew who the (advocates) were basically and could find them and ask questions, ask them questions and ask them for their advice. My only concern about actually naming the advocate to everyone in the beginning, .... is that There’s a worry that [the advocate] might make a mistake, you know. No one is perfect... we also can make mistakes so I’m not sure ... it’s a big responsibility being known as the advocate for professionalism for the hospital, you know.’

D1

5.7.2.3 Participants who did not complete the programme:

Of the nine individuals who did not complete the programme, initial discussion with facilitators about possible causes of their non-completion allowed the identification of four likely ‘telling cases’: representing different possible reasons that the participants did not complete the programme.

Two of these four identified participants who did not complete the course agreed to, and took part in, a telephone interview. One had attended three sessions and one had attended two.

NC1 had taken part fully on joining a group but was relocated through work part-way through the sessions and was no longer able to attend. NC2 attended the whole of the first two sessions and most of the third session but then stopped attending.

The remaining two ‘telling cases’ were identified by their facilitators as ‘having difficulty in getting to the sessions for practical reasons’ (email exchange May 2010) as ‘probably disengaged; not entirely sure he ‘got it’’ (email exchange May 2010). However, we were unable to conduct an interview with either of these two individuals.

Interviews were conducted on the telephone in the spirit of AI. For details of the interview schedule see Appendix 2.

NC1, relocated through work a considerable distance away from the venue for the sessions, described enjoying the sessions and finding value in them. The frequency of moves in the lives of junior doctors was identified as a barrier both for her and for others:

‘Well no it is important, because that’s part of the evaluation. If you run something over 6 months people move on.’
‘….and the foundation guys change every 4 months, we change hospitals often every 6 months as SPRs so yes it can be a problem..’

NC1 had similar motivations to others who continued to attend the groups for participating: seeing professionalism as a ‘tricky area’ and valuing a learning space to devote to professionalism.

Although she engaged with the process of the group, particularly with AI:

‘I am a psychiatrist: I am used to this sort of set up. …its good to have a chance to discuss with others because deep down we actually know what we are supposed to do.’

‘I think AI is a useful tool to try to create change. Doctors often end in ‘negative spirals, and so it is useful, you know, to try and see things in a different way; from um, a different perspective’

she was unsure about what she had taken away from the experience:

‘Its hard to say really.. I am sure I would have enjoyed, would have got a lot more from it, if I had been able to stay. We were only getting started really.’

NC1 felt that the approach to fostering professionalism was the right one: when asked if she had the chance to design something herself to address professionalism she suggested a similar approach:

‘…no I think it is the right way to go about it. Obviously it needs some planning; perhaps you need to ensure that those who started were committed and could actually stay; perhaps run it over a shorter period. it would also be good to do it in teams, you know, get the whole team to look at their behaviour and experiences and to try to move things forward, to think more positively as a team.’

NC2 was identified by the group facilitator as likely to have disengaged: by the last session having stopped contributing fully to the group discussion and leaving for a number of periods to attend to her bleep.

This was borne out by NC2’s description of events:

‘I mean part of it is just being busy, on the job and trying to find time during the day – which is always difficult and um … I was asked after the first session that I shouldn’t hold my bleep while I’m attending the session … but I found it quite difficult to hand that over. So I was having to pop in and out of the sessions when I was there.’
'But the other aspect of it, and probably a larger part of it was that I got a little bit frustrated with the way that the sessions were run and I thought it wasn't ... possibly it wasn't very structured and I didn't feel that we were achieving much.'

Whilst NC2 again had similar motivations to those who continued to attend for participating: seeing professionalism as important and valuing a chance to address it, her dreaming about what the activity would be like was a little different to many participants and focused on her helping others to develop their professionalism:

“Well I was hoping ... I mean we'd had an email about the project, and it had sounded good, and I was hoping that it was going to be some kind of an active process really to try and improve professionalism within the hospital or the area among junior doctors – that was what I thought was going to happen. But then when we ... once we'd had our introductory session it had seemed that actually it was more about discussing our experiences of professionalism and our thoughts about it rather than making active plans and trying to improve things.'

NC2’s experiences about the processes within the group were to describe them as 'woolly'. This included the use of AI:

‘...it felt at the time like it was quite a long-winded approach with a lot of discussion. And it didn't feel like we were getting anywhere following the discussion.’

When asked how an activity to foster professionalism might be delivered we again see her desire both for something more concrete and for the chance to influence others. NC2 describes professionalism from a behavioural perspective and this influences her choices about what might influence professionalism:

‘I think from the first meeting I would have had a definite plan and a goal of saying on this day we're going to do something ... and you know to try and come up with a definite intervention where we would spread the word of professionalism and have an action that we would achieve to try and you know improve professionalism in the local hospital or the area – whatever our goal was.’

It is worth noting the tenor of the interview with NC2. Despite many of her comments appearing concrete and disparaging, the whole interview was littered with apologies and remarks about feeling guilty for not completing, for complaining about process or imagining she had the right or ability to help others. Field notes that accompany the interview particularly emphasise the use of apologies.

Of course both NC1 and NC2 represent those who did engage with course. We have gathered no data here on those who did not hear about the course (so can say nothing about the communication channels used to engage doctors with the programme), those who were interested but were unable to attend, (so can say nothing about barrier to attendance for those individuals) those who expressed initial interest and then did not
follow it through, and of course those who having heard about the programme were not interested in attending. We can also not say anything meaningful about the two remaining ‘telling cases’ that we were unable to follow up.

5.7.2.3 Facilitator interviews

All five group facilitators took part in interviews shortly after the sixth and final group session.

Group facilitators were asked, again in the spirit of AI, about their experiences of running the groups, what they felt that the participants may have gained from their involvement, the role that appreciative inquiry played in the activity and whether they felt this initiative may have had a wider effect on the Trust or other aspects of professionalism (see appendix 2 for details of the interview schedule).

Four main themes were identified from the interview data which were mainly inductive, relating to the interview questions:

1. The professionalism groups
2. The experience of being a facilitator
3. Appreciative inquiry
4. Organisations

Facilitator theme 1. The Professionalism Groups

Three subthemes emerged from the facilitators talk about the professionalism groups:

a) Participant’s motivations
b) Facilitator’s views on outcomes
c) Working in groups.

a) Participants motivations

There was an idea amongst facilitators, as mentioned by participants in the follow-up interviews, that these were selective groups who had an internal motivation and put themselves forward for this study:

‘they are, as they said themselves, a self selected group…….They said ‘We are the ones that care about this. Actually there are people who are not here who should be here’ you know. So there was a recognition that they were already a bit of a special group. So I think they did already have those qualities there.’  
Fac D

Participants may not have initially appreciated that they were expected to actively contribute to the learning. However, the participatory nature of the programme soon seems to have been established and described below:
'I suspect this will come from everybody, they keep expecting a course, and what they got was somebody saying 'Do you know what, I'm not going to be teaching you very much, I'm just going to show you this process and model some of it, and engage with you in it, and explore some of these, and I'll ask more questions than I'll ever give you answers.' You can see them kind of going 'Oh but …' and um … so by the second or third time they came expecting that.'

Fac B

'One doesn't always talk about work when you attend courses, you don't think of yourself 'doing work' – but they had, they'd worked you know, we'd been doing thinking work and telling work. And I think they had invested of themselves in that group energy, thoughts and themselves.'

Fac A

b) Facilitators' views on outcomes

Facilitators raised some interesting reflections on the outcomes these groups may have produced. Firstly there was an idea about what it really meant to be professional in the real world context, that professionalism was enacted on a daily basis and that these groups fostered a heightened sense of awareness:

'I think they got out of it a sense that professionalism isn’t something abstract but is something that is played out in every minute of every working day. That it is expressed both individually and collectively in the moment … moment to moment decisions that go right or go wrong '

Fac C

'I think they also learnt a lot about investigating their own thoughts and feelings, and identifying for themselves the particular challenges that are thrown up by their everyday workers. …So I think they did go away with ideas, but I think they also just went away with this heightened sense of ideas about professionalism. [Professionalism] had just become much more on their own agenda.'

Fac A

In addition to this more internal construct, facilitators reported that the group had generated concrete ideas which could be used to enhance professional practice, these ideas included: enhanced communication with other professionals involved in healthcare, enhancing the interaction between seniors and junior doctors to foster supportive professional practice and to be more proactive about giving constructive feedback:

'They had some very concrete ideas of how they could improve something such as the communication between you know doctors and management, and they had some very good suggestions there … and between consultants and younger doctors – they even described a forum where they could be brought to.'

Fac D
‘And because of that, more likely to value and give feedback to others about the good things that they were doing, because that was one of the things they felt you know within the shadow of their organisation didn’t happen often enough.’
Fac A

c) Working in groups

Working in groups generated three sub-subthemes:

i) group functioning
ii) telling stories
iii) practicalities

i) Group functioning

Working as a group raised some challenges in terms of group dynamics. In one group senior colleagues seemed to be overly controlling and a lack of a stable group impacted negatively on the cohesion between participants in another:

‘...they were having to manage somebody dominating this, who’s actually the most senior person. And I think what they got was seeing somebody not being flexible.’
Fac B

‘There was that lack of a sense of you know the real solid group that you know met every time. And so that was missing a bit – made it difficult.’
Fac E

However, most facilitators commented on the positive aspects of the work of the groups, the ability to talk of personal contexts and issues, and the idea of ‘rehearsing’ challenging professional situations as preparation for the future.

‘I think it allowed them to think ...– yeah it’s almost that kind of meta-analysis of your own behaviour ... by listening others’ accounts, we’d been rehearsing what they might do in the future. And by making it explicit to them what their choices would mean for others possibly, because that’s what we’d done.’
Fac A

Being able to share issues, getting support and validation from the group, as well as rethinking their conceptualisations of professionalism were commonly ascribed attributes of the function of the group.

‘what they found very much was the shared experience, that they were not alone in having these conflicts and difficulties. And I think they found that very reassuring. ...It reinforced that they were going in the right direction.’
Fac D

‘I think there was a lot of kindred support really, a lot of identifying common ground, common difficulties, a lot of sharing of issues. And I think they were
also able I think to identify examples of professionalism in much greater depth.’
Fac A

‘[The group] would be very supportive and they would provide explanations and perspectives and understandings that could enable that doctor to see it in a different light.’
Fac E

Doing this work free from the restraints of assessment was seen as vital to one of the facilitators:

‘(it) is a place to think about their work that’s not tainted by assessment, perceived outcome, individual performance I think is really really helpful.’
Fac D

ii) Telling stories

Narrative was important in the process of group work. Story telling was encouraged by facilitators and became central to discovery and problem solving:

‘everyone told stories within that group, irrespective of their grade or seniority, and they all showed themselves to be vulnerable, they all showed themselves to be struggling, they all showed themselves to be problem solving.’
Fac A

iii) Practicalities

There were some practical issues around making the groups happen. Attendance was variable amongst the groups:

‘So then when the first day everybody came … so there was a group of at least ten … and very quickly there was that … there was a kind of attrition and that fell. Yeah, so the average was you know really four to six in the group.’
Fac E

‘The group did vary each time because there was one or two who managed to come practically every time but there were several who only dipped in three or four times, or less even.’
Fac E

‘I was fortunate with my group because they all attended really.’
Fac A

The length of the sessions raised mixed feelings, some facilitators wanting a longer period others happier with the allotted time:
'We sometimes over-ran a little bit, but by and large we seemed to fill the time and the time felt about right. I think any longer and it might have got too tiring actually.'
Fac A

'I really would have appreciated a longer day. By the time people wandered in … and one day I was late, there was roadworks … there was really an hour – and that was very very quick for a group of ten.'
Fac D

Facilitator theme 2. The experience of being a facilitator:

The experiences of facilitating on this project were largely two-fold, a) it raised a host of affective responses and b) resulted in a rich learning experience for facilitators. Although most (4 out of 5) facilitators talked about their facilitators support group this subtheme was not at all as prevalent as the other two themes outlined above.

a) Feelings
All facilitators talked about their feelings around being involved in this project. Typically, facilitators described feelings of initial trepidation about engaging with their groups. Sometimes feelings of frustration were realised when participants failed to perform at a level facilitators felt they were capable of but the overall feelings raised was the satisfaction and enjoyment felt working with these professionals.

'For some reason I was very anxious about it, and so I’m not sure whether it’s generalisable to anybody else. Um … I don’t know.'
Fac D

'I think my feelings was … there was always this sort of rather ghastly uncertainty about whether you know anyone would turn up. And the first time I started thinking about it, you know thinking it was all my fault.'
Fac E

'It was this sense of ‘You can do better than that. If this was an exam you’d be doing better than that!’
Fac B

‘So it’s a delight to meet young people, who are just like young people are – enthusiastic, idealistic, looking forward to the future, full of decent values, alert, articulate – that was the best bit of it for me.’
Fac C

‘And I think it worked well, so it was enjoyable, it was great to work with the group and I think they gained a lot. So that was naturally quite pleasing for me.’
Fac A
b) Learning
Facilitators reported learning a lot during this project. Some reported changing notions of professionalism and how it operates with the setting of the Trust:

'I was discovering these things as well, I don’t think it’s just true to say they’re discovering it – I was discovering the power issues round professionalism, and particularly the issues to deal with moral risk taking.'
Fac C

'In the process I learnt a lot about AI and I learnt a lot about … more about professionalism you know because I’ve looked at the literature and so on. So you know for me it was a learning experience – a very valuable learning experience.'
Fac E

For some it was working with doctors or a particular specialty:

'[Facilitating] made me think around … made me learn much more about psychiatry because my group were a group of psychiatrists. And I learned a lot from them about some of the real issues of maintaining and enhancing professionalism within that particular specialty.'
Fac A

Using Appreciative Inquiry as a way of facilitating a group was a further source of learning:

'I did learn a lot about ways of working with groups that was quite different to my normal experience of facilitation. So I’ve learnt a new way of going on, I’ve learnt a new way of facilitating groups from that experience.'
Fac A

'I think the combination of having a model and a new model meant that there was a learning and self training aspect that there isn't usually. Usually one’s asked to do something because we’re already seen to be fit for purpose. I think that’s the biggest difference – it’s not that you don’t have kind of review meetings and thinking about it.'
Fac D

c) The facilitators group
As alluded to above, an important part of the experience for some facilitators was their own support group:

'That’s like coming home for me, that sort of capacity to challenge and support and share in. So it’s been a really lovely project, so just to say in terms of the sort of … how we’ve worked, it’s been great, I've really enjoyed it.'
Fac B
'I found the structure of the training group was a sort of parallel and integrated development amongst the trainers both interesting and very helpful.'
Fac D

Facilitator Theme 3. Appreciative Inquiry

There were two important subthemes about using AI:

a) preconceptions
b) the experience of using AI.

a) Preconceptions of AI

Most facilitators described reservations and concerns about being told to work within an AI framework, some of these issues were about the ethos embedded in AI, an unfamiliar cultural approach to declaring the positive, and in one case because AI was a completely new way of working with groups.

'I didn’t have an awful lot of respect for Appreciative Inquiry before I started… but what I did know led me to regard it as excessively idealistic in the American tradition of ‘gee, isn’t everything wonderful’ – trying to find the best in things, ignoring the shadow, not allowing people to talk about pain and suffering, all that stuff.
Fac C

'I was intrigued … there was a slight reservation – is this some American you know psychology you know … you know we can fix everything kind of thing. So I was a little bit reserved about it. But then you know I read some good stuff and I felt you know this actually makes sense and it’s about building resilience and developing resilience in individuals and in systems. So I liked the underlying philosophy.’
Fac E

'We were sent a lot of background material, you know um … which I read, and though I felt that I had much more of a clear theoretical grasp about it, it was just that … and I did have reservations about how I was going to apply this.’
Fac A

There was, however, one facilitator who had previous experience of AI to which the whole process was very comfortable:

'I was the person who came very willingly to this project. It just makes a lot of sense to me. And you see it resonates with how I teach.'
Fac B

b) Working with AI

Most facilitators found their initial engagement with AI a little tricky, being conscious of the model and feeling a bit clumsy about its implementation, in particular moving from the various stages:
'I spent a lot of the early groups in particular trying to apply the model in a very clunky way, and then getting worried when I brought it back to the facilitated groups that I would be judged… Like when you try anything out for the first time as a methodology – I really struggled with it, because it’s different from what I do.’
Fac C

'[Facilitating] was much easier to stay in the earlier stages, and the kind of thing that people enjoy doing was telling their stories.’
Fac A

Again, it was not uncommon for facilitators to comment on the initial ‘unnaturalness’ of talking positively:

‘One of the things that I’ve found most difficult about the whole process was staying with the positive. Because often when you think about professionalism you think about all the things that really challenge your professionalism, make your everyday life quite difficult. And it is possible to kind of do the flip side, that you can actually view professional life through a different lens.’
Fac A

However, it would appear from the interviews that despite initial fears, facilitators began to see what this had to offer, a different perspective that is focused on helping participants reframe their worldviews:

‘What AI’s methodology did very much so was provide a context and a structure to do that in a way that at its best enabled people to use the structure themselves to enhance the creativity, maybe thinking a bit outside the box, maybe less tied to what injunctions they think there are about professionalism and their behaviour. And I think the structure did that.’
Fac D

‘By last time, last session was the pinnacle for me actually - last session they really got into … got Appreciative Inquiry. I was hearing them framing questions which were much more sophisticated.’
Fac B

It’s an ‘expert thing’, was mentioned specifically by two facilitators, the ability to seamlessly apply AI needing practice and know-how.

Facilitator Theme 4. Organisations

Facilitators were reticent about making claims about the impact this project would have outside the group sessions themselves. One idea was making the most of the dispersed nature of the group with individuals spread across a wide geographical base. An
ambassadorial role of one of the group members, keen to develop the initiative, was cited as having the possibility to embed the scheme:

'I think the most hopeful thing from a trust point of view is that there was an SAS doctor in the group who appears to be some kind of shop steward ... in other words she represents SAS doctors in the trust generally. And she appeared to love the experience and she's got the bit between her teeth and at the last session was already asking if she got together a group of SAS doctors, would it be possible for the deanery to run a group just for them, and would be able to give them funding if they got funding – could they buy it in. And she was going to talk to her director of medical education about getting that moving. And I think I would feel thrilled if that happened actually cos I think that's such a needy group.'  
Fac C

Institutional culture was raised by several facilitators:

'I didn't get the sense that this was a trust with a very very strong ethical you know, vision.'  
Fac C

The inability to say and to be heard, were barriers faced by participants when they were trying to enhance organisational culture:

'I sometimes felt a little bit concerned that ... not that we were being listened to, or listened in on or any of that, but we were naturally raising ... they were naturally raising issues which were related to their organisation and some of the difficulties of their organisation....People always have stories about their organisations when things weren't done or aren't done in a way that they would want them to. And we did go into those areas, because those areas were some of things that were challenging their professionalism as they saw it.'  
Fac A

'..and in the hospital culture ... that there wasn't a reasonable experience of using conversation and dialogue to move things on.'  
Fac D

### 5.7.2.4 Project lead interview

The project lead was interviewed within one week of the final group session. As he had acted as both the project lead and as one of the group facilitators, he took part in two interviews on the same day. The project lead was also involved in a number of other face to face meetings and telephone calls with the evaluation lead and therefore the notes of these meetings and discussions were analysed together with the interview transcript here to build a more detailed picture of the project from the perspective of the project lead: from it inception to it the end of the pilot phase.
The background of the project lead is important in contextualising these texts. In his clinical role he is involved in systemic therapy and in his educator role is the driver behind a large Deanery wide project on developing and extending clinical supervision skills for those with a responsibility for the education of doctors in training. This background and educational leaning no doubt flavour comments and perceptions.

**Setting up the project**

Reasons behind setting up the project were four fold: a desire by a number of educators, including the project lead to find ways of legitimising the provision of space and time for discussions among doctors in training about their work, an interest in the ‘muddy’ nature of what professionalism means and how it might be learnt, to have the opportunity to use AI as an education technique and finally the more ‘official’ story; to provide training on behalf of the specialty schools to address the area of professionalism in the generic training curriculum:

‘I hoped the project would be a way of introducing into all Trusts in London the option for all their doctors in training of having a confidential space once a month or so to talk about complex issues that were troubling them.’

‘Professionalism is so much in fashion that it was likely to be marketable as a hook for hanging this on. And again AI has got for people who know anything about it, this positive feeling that would make it less threatening to commissioners, managers, whoever than if one went in with something that sounded a little more challenging.’

‘I think there was a need to tick a box on the generic curriculum. I think the heads of specialty schools knew that this was one of the things that needed to be delivered and didn’t feel particularly capable to have the capacity or the skills to be delivering it themselves.’

‘This intervention is not at level of creating and maintaining it (professionalism) across Trusts, but in bringing together groups.’

**The facilitators**

Choosing and training the facilitators was felt to be key. The project lead was used to working with many facilitators over the years but felt that the unique features of this particular group and how they operated was one of the reasons for the successes of the project. It was felt the facilitator being; external to the Trust, a consistent resource for the group across the six meetings, involved in regular training and review and central to the design of how the groups would operate were the reason behind the positive outcomes of the groups. The engagement of a trainer: for both initial orientation and ongoing support was also felt to be important in using a relatively new technique such as AI:

‘To have identified and commissioned a trainer to make sure that everybody was using a similar enough methodology and was on message … but being allowed to be themselves as well – because these were … all the facilitators were very, very experienced educators, so there needed to be permission for
them to be themselves, but also a collective agreement that they would work in a similar enough way to be reproducible: and that was a very useful.’

‘All the facilitators are happy to work with in (professionalism) as a fuzzy concept which is great’.

‘I think it has shown that engaging outside facilitators including non medical facilitators is helpful, that they enjoy it, they learn from it and the group seem to benefit from it. To the best of my knowledge this is the first time that the Deanery’s engaged a family therapist to do this kind of work…, it’s the first time that professional medical educators like XXXX and YYYY have worked alongside people with little or no experience of postgraduate medical education but who know a lot about AI.’

Outcomes
The project lead felt that the pilot intervention in itself had a number of positive outcomes. For him this included establishing that the creation of discussion groups within Trusts could have meaningful outcomes. Although the project was not continuing he felt it was possible that the effects on individuals could be long lasting:

‘We know that getting a group together of trainees from different specialties and different grades once a month works.’

‘I’m a great believer in throwing a pebble into a pond and seeing where the ripples go, and there’s lots of pebbles in lots of ponds. And in a sense one can never know … you know you can have somebody as you know sit through six sessions of a course without saying a word and you think you know they’ve been day dreaming, and then you meet them a year later and they say it’s changed their life, or it’s like a religious conversion for them. So I’m sure there will have been those sorts of experiences for a number of participants’.

The project lead was clear that the decision that the pilot would not be rolled out was not due to a poor evaluation or lack of outcomes but due to other policy and financial constrains. Despite the lack of a roll out plan he felt hopeful that some momentum could be maintained:

‘I think others … two other Trusts may seriously develop it, or own it themselves, I would hope so. And certainly the longer I know the DME personally, I think it’s likely that I’ll have conversations with her about where to go next. Interestingly there’s another Trust as well … so I could talk to the DME there about using that as a model.’

‘I suppose this did have the potential at the beginning … and it hasn’t happened. And uh … but its actually produced far more than I expected it to … at the midpoint I thought this was just going to go out with a whimper and that actually the changing economic political climate is just going to demoralise people so much that it’s going to produce nothing. I don’t believe that’s the case and I’m feeling surprisingly positive, given the lack of the
Some of the outcomes were dependent on the Trust. These included the way in which the groups were put together, and thus the ability for participants to attend regularly and fully. The project lead felt the DME was central to the success within a Trust: the interest shown by the DME and indeed by the Medical Director in education in general and in professionalism in particular was crucial in creating positive outcomes:

‘I also think it depends to some extent on how closely involved the DMEs have been, and I think DMEs in some places have felt very closely identified ... even to the extent in one place I think of the DME wanting to attend. ... but there was a very strong vibe from DMEs in some Trusts and in others, the DMEs just gave their consent, and that was the end of their involvement.... I think some are passionate about the job, and some are doing it cos it’s got to be done.’

Tensions
A number of tensions arose in the planning and delivery of the project. These included administrative difficulties in running the project, administrative and other difficulties at the individual Trusts, the tensions of being a facilitator and project lead and issues to do with sharing information concerning the long term future of the intervention.

‘The admin side was a nightmare at times. We had a horrendous turnover of admin staff..... out of the three or four administrators we had during the lifespan of the project I would say only one was strongly identified with it personally and rest appeared to be doing it as an add-on to their other jobs..... ... I mean there was a short period in which we had an administrator with real oversight who was very, very good at chasing people up. But either side of that, it wasn’t so good.’

‘I felt ambivalent at the beginning about being both a project leader and a facilitator..... it was important for me to get experience at the coalface, and that even if ... if the project then developed I could withdraw to being the senior figure who coordinated it, but it would be very useful for me..... But it did create tensions for me, and the two .... because the tensions it caused were in facilitating the facilitators group where I increasingly felt there was a tension between my role as project lead and my role as facilitating reflective discussion in that group.’

‘...and the other tension was that as I became aware of the changing economic and political landscape and I was torn as to how much I should share that with the other facilitators – had I been a pure manager, I could have stepped back from that and said well let them run the pilots, and then at the end I’ll tell them it’s going nowhere. I couldn’t do that because as a member of the facilitator group I felt it would be dishonest not to share one of
5.7.2.5 Interviews with Directors of Medical Education (DMEs)

Five DMEs were interviewed approximately four months after the completion of the activity in their Trust. Interviews were conducted in the spirit of AI.

As the exact role of a DME varies between Trusts, important contextual information concerning their role, their professional background and how long they had been in post was gathered at the beginning of the interview. They were asked further contextual information concerning aspects of their Trust they felt helped to foster and develop professionalism in general and their relationship with the medical director in the Trust. They were asked to comment on professionalism and professional development: to what extent they felt doctors understand the nature of medical professionalism and whether training prepared them for this aspect of their work. They were also asked about the professionalism groups: what they had heard or seen of the Trust based groups, what they felt were the benefits for the Trust of being involved in this activity and how the focus on professionalism could be maintained within their Trust beyond the lifespan and membership of the groups. For details of the interview schedule see appendix 2.

Five main themes were identified from the interview data which were again mainly inductive, relating to the interview questions:

1. The nature of professionalism
2. The professionalism of today’s junior doctors
3. The treatment of junior doctors by employing organisations
4. The contribution of the project to a professionalism culture
5. How professionalism be “taught” more effectively

DME theme 1. The nature of professionalism

The DMEs had all been enthusiastic in supporting the professionalism project and had each had spent time reflecting on the nature of professionalism. Yet they struggled to come up with a definition they were satisfied with during the course of the interview:

[‘Professionalism] suppose ‘professionals’ are such a big umbrella term, it could cover a whole multitude of roles couldn’t it? …………….I mean it covers everything doesn’t it? ………I mean I suppose it’s your attitudes, your ethos as a professional.’

DME B

‘the trouble with professionalism is that it’s … we all know what it is until you’ve struggled to define it in a sentence or two. It’s like love or the human mind – yeah I know what it is until you ask me to put it down.’

DME A
'I think it’s partly that I found it hard to define what professionalism was, and thinking there must be a way that we can make this easier for people to understand, and then understand that if you’re adopting these behaviours then that will fulfil that description. Because I think people are very woolly about the idea. People are very woolly about the idea of professionalism.’

DME D

Given the challenge faced when trying to define professionalism, one DME found it easier to identify what was unprofessional instead: using this when discussing professionalism with juniors:

‘I mean I speak to them all when they come and we have a little you know ‘This is unprofessional behaviour’. I suppose it would be fostering a culture where professionalism is spoken about and you know behaviours that are unacceptable are not left unchallenged.’

DME B

DME theme 2. The professionalism of today's junior doctors

The DMEs identified a difference in how today’s junior doctors appeared with regard to ‘professionalism’ compared to how they felt themselves and their peers had appeared and behaved as juniors:

‘I do worry about junior doctors and their attitudes towards professionalism and their professional role. I think there is … I know it’s a bit of cliché but there’s a generational shift happening isn’t there, where people don’t regard medicine as a vocation any more, it’s more a job. You know it’s just part of your life and not the whole of … whereas I think people of our generation and maybe older even still – [professionalism] was much more an all-encompassing part of your life’.

DME B

The same DME highlighted how poorly some of today’s junior doctors behave with regard to their responsibilities as employees, as one example of their (lack of) professionalism:

‘Junior doctors, yeah. They didn’t have a sense of what professional behaviour really was in terms of, you know, responsibility to employees, as an employee etc. ….. We go through the sick leave policy, because that’s where we’ve had lot of problems in terms of … you know there are certain responsibilities that they have to fulfil as an employee – which they don’t, you know they don’t phone in. I can’t tell you how many we’ve had where we’ve … I mean in one case we had to get the police out because we were so worried.’

DME B

There was recognition however that this difference was not all a deterioration in standards and that the context and experience were very different in contemporary practice.
One DME highlighted the contextual nature of what might be seen as professional: suggesting that adherence to the European Working Time Directive (EWTD) may be seen as either professional or unprofessional:

‘The other thing I think has been a little counterproductive is things like the European Working Time Directive because actually what was considered professional not too long ago was that you would work above and beyond the call of duty, if it was in the patient’s interests – and that was your requirement and expectation as a doctor. Now it is considered anti-professional to work beyond, a minute beyond, whenever it is you’re due to finish and not to take the breaks and so on – for the reasons that go with it. So we’re potentially training people who are … I don’t mean ‘Jobsworth' in a malign way, but you know ‘I work to this dot, I will only do this’. It’s going to be a very different sort of doctor and a very different sort of professionalism that comes out of that.’

DME A

DME theme 3. The treatment of junior doctors by employing organisations

There were many examples given where the DMEs felt that the junior doctors were not treated professionally by employers: particularly with regard to the way in which their support and learning from others was fragmented by service organisation. They recognised that this led to difficulty in supporting juniors to develop their own concepts of professionalism:

‘This day and age what is happening unfortunately is that the trainees are working under one person in the morning, under someone else in the afternoon and someone else in the evening. So it’s not fair on the trainers and it’s not fair on them. On top of that the EWTD doesn’t help either.’

DME E

‘I think that we have really made an effort as I said to try and increase the cohesiveness of our junior doctors, you know in terms of … to try and make them feel part of a team amongst each other, even though they’re not going to be you know in sort of firm structures, but to foster that sort of cohesiveness.’

DME B

‘And you talk to the trainees and you realise they see very little of their senior colleagues, in a way that I used to in the firm structure and valued. …………..And now I think we have trainees sort of wandering around a hospital being berated by all and sundry for things that aren’t happening and things they’re not responsible for, and I think we miss that.’

DME A

‘I think not having a firm structure where you’re in a family who’s all doing the same things and all guiding you and all there – whether they’re a good or bad family – is actually quite difficult. Because you don’t pick up the values of that group, or you don’t identify yourself as that group.’

DME D
Examples were given where the Trusts had not included the juniors in their organisational approach to all staff. It was felt this may contributed to the junior doctors not feeling part of the organisation:

‘We’ve found to our horror that there was no record … that doctors were somehow being exempted from the usual sick leave policy and that there was no central records kept of whether they were off sick, and that we had no idea.’
DME B

‘I think the training has been sacrificed for the service component….. In xxxxxx the vast majority of our trainees work at night, you know that’s what they’re there for is to fill the nights. And so they can have a day off before they’re on call, a day off after they’re on call.’
DME D

‘Well I think they just see themselves as automatons, some of them. You know they don’t feel any allegiance. ……. I don’t think they feel that at all…….. and that’s why I think MDECs [Medical and Dental Education Commissioning] might be quite a good thing, because at least they would be there for longer than … you know they’d be there for a year or two years, and you might be able to foster that sort of sense of allegiance to the … not only to the service, but to the health service in general, you know and the NHS I suppose.’
DME B

‘Somebody did bring up the idea of longer rotations – in other words they stay at a hospital for a couple of years…but if they stayed at xxxxxx or yyyyyy or wherever for a couple of years, they get into the bricks and they become part of an organisation, you know linked in.’
DME C

DME theme 4. The contribution of the project to a professionalism culture

All DMEs interviewed had been keen for their Trust to be involved in the professionalism project. Comments in this theme concerned the groups themselves and the immediate impact and the potential for longer term impacts from involvement.

a) Immediate impacts
As with the participants who were interviewed, DMEs felt on reflection that the project’s benefits were limited and somewhat transient but the very existence of a project targeted at professionalism in their Trust did raise awareness of professionalism more generally:

‘Ten people would have had their horizons considerably widened … but nothing else.’
DME C
‘Because it’s done with a transient … a group of people who are only here for a short period of time, then we probably lose the benefit of whatever they learnt.’
DME D

‘I suppose the only benefit that I could think is that it’s focussed certainly my attention on what professionalism might be. But I think in terms of the general Trust … because junior doctors move on so frequently I suspect all of that cohort are not there any more.’
DME B

‘I think the professionalism pilot is good because it’s beginning to say ‘okay there’s wider issues to being a doctor that’s about professionalism than is about book work – how do we maximize learning about that, how do we encourage that?’…. I would say largely by modelling and mentoring….. Which I think is in danger of what we’re losing. So you know there’s still things I remember that has a student or a junior doctor – ‘That’s what doctor so and so did, I like that, that works, that’s important, you know patients value that’ – and modelling that and adapting…..’
DME A

The benefit of the collective and discursive nature of the groups was highlighted by one DME:

‘What [the participant] really valued was the chance to meet some of the people from different specialties and to find out … a lot of their concerns and issues were common, but there was never any forum for them to discuss them. You know and also I think just find out what other people did. Because they’re incredibly isolated now.’
DME B

b) The potential for longer term impacts from involvement
For some DMEs involvement in the project prompted their thinking further on what currently worked well, what currently existed and how they might augment existing resources and opportunities to develop professionalism:

‘….. case based discussion groups where the trainees get together once a week……………But a lot of that is about professionalism and soft stuff. And thinking out loud it occurs to me that’s something we could develop.’
DME A

Others considered the potential to maintain momentum:

‘So … how could it be maintained? I think the other way would be to try and replicate it by running groups ourselves without the deanery, which we’d done … you know in terms of running little focus groups etc.’
DME B

‘ask [the initial participants] whether they think they would like to continue spreading the message wherever they’re going.’ You know would they like to
do a phase 2, would they like to do another module, would they like to take on some … maybe they’d like to teach it to their next generation of colleagues. I think that that’s the way we’re trying to spread initiatives …’

DME D

One identified the longer term benefits for a particular participant:

‘the only one I know is xxxxx who was in the group. But I would say it’s planted a seed within them to … it certainly did in xxxx. You know it certainly encouraged her to go on a whole sort of patient safety type mission.’

DME B

DME theme 5. How professionalism can be taught and learnt

When asked about how professionalism can be taught and learnt all DMEs felt that explicit teaching about professionalism was a good thing but that this should be supplemented with experiential learning supported by meaningful relationships with other juniors and senior doctors both informally and via role modelling as well as via supervision and mentoring. Experiential learning was judged more important than the acquisition of knowledge (book work) about professionalism:

‘I guess that (learning about professionalism) in a large part comes through the educational supervision system in xxxxxxx where ostensibly as a trainee you have an hour a week with your educational supervisor…….Now discussions of course would be about clinical issues and the acquisition of knowledge, but there would be sort of broader discussions. … But it is partly in role modelling, and I think it’s partly in thinking … thinking more consciously probably about what the training is that we’re delivering, and ensuring that its above and beyond textbooks.’

DME A

‘Because we were always paired up together when I was an SHO…..you know sometimes you didn’t get on with the person, but you still … you sort of learnt from them, it was very much a mentor mentee – you know that sort of role. Maybe I was just lucky in that I usually had quite good registrars, but that’s I think where we don’t have that any more.’

DME B

Whilst they recognised the value of having an explicit discussion about professionalism, some were circumspect about the effects:

‘I suppose having facilitated groups like the one that Professor xxxxxxx ran was invaluable. So maybe having more of those sort of events…..I don’t think you’d be able to force all of them into that sort of role, but maybe having more opportunities for that……. But I wouldn’t be in favour of sort of didactic compulsory sessions where they all had to go you know, because one size won’t fit all.’

DME B
'Well you can take horses or children to water, but you can’t make them drink.’
DME C

One DME described how her Trust aims to promote professionalism by encouraging the juniors to get more involved in the running of the organisation:

‘We encourage juniors to participate in other roles in the Trusts like being an associate college tutor and being reps for their year for their learning set, so that they will report back to the faculty, and be part of the faculty. So they have a responsibility, but they also have a responsibility to bring us the voices of their colleagues. So I think that’s one way that we try and foster it.
DME D

But, unfortunately, this approach was not successful in another Trust:

‘I’ve tried to find representatives from junior doctors and it’s been nigh impossible.’
DME B

Finally no DME felt that promoting professionalism and high quality training was in conflict with the strategic aims of the Trust: In fact some felt it was in the Trust’s best interests:

‘Our main remit is to provide high quality and safe services, and therefore we need high quality and safe doctors as part of that. And a large chunk of that will be professionalism. You can look at it from a business model as well - if your staff are rude and bolshie your customers won’t come back and your business will fold, and xxxxx next door will take over quite happily.’
DME A

5.7.3 Added information from observations and documents

5.7.3.1 Reflective Accounts

These documents were produced by the facilitators at the end of each session. Conceptualised as a learning tool for facilitators to help with the emergent design of the project, they became an invaluable evaluation resource. Although ‘accomplishments’ and just one reality or interpretation of events they had a ‘warts and all’ nature as accounts of events.

A total of 22 reflective accounts were produced ranging from half a side of A4 to four pages. Each facilitator submitted at least four reports. These reports were shared amongst facilitators between sessions and formed the focus of much of the discussion in training sessions. Each tutor was free to create a document that was best suited to their purposes but each reflection tended to reflect back over the session (reflection on action) and forward to the next session(s) (reflection for action).

Most of the facilitators identify struggles for them as facilitators in the first one or two sessions. This tended to relate to either their unfamiliarity with Al or to running groups in
a way that was not naturally their own style, or in relation to the difficulties in getting the group functioning in this way. The struggle to keep the group engaged in AI continued even to later sessions:

I began with a review of previous time and the questions they raised in dreaming phase with the hopes of moving to how to bring these ideas into their practice. …. – felt it was important to get them back to this way of thinking – had been feeling this wasn’t as embedded as hoped it would be and tendency to only look at what was difficult etc over the intervening time. They recognised how easily they could lose an appreciative stance or the power of the ‘un’ appreciative stance.

Fac C, session 3

Some of this struggle to grasp and maintain AI was ascribed to themselves:

I think I am still struggling to apply an AI conceptual framework and methodology which is new to me.

Fac A, session 3

By sessions 4, and 5 facilitators were beginning to feel more comfortable with the sessions and were picking up messages from the group that they were ‘getting their feet’ and beginning to perform.

When administrator returned to lock up she said “wow” this was a good session don’t usually see them this animated. Two participants said it was really great. Small group much better but I wondered whether we had just reached a critical point in the process?

Fac D, session 4

Feel like group has formed now, beginning to explore phenomena and really use the ideas of appreciative enquiry helpfully – only time is up!

Fac C session 4

The interview data, although also highlighting this difficulty and eventual resolution, did not identify this theme so strongly: perhaps a reflection of both a difference in projection of self in interview and written comments and also the ‘after the event’ nature of the interviews as opposed to the ‘in the moment’ nature of the reflective accounts.
Within the written reflections there was also the acknowledgment of ‘reverting to type’ by the facilitators but in written accounts it was framed as both a strength and a weakness: concern that the ‘plan’ to use AI was not always followed, but an understanding that other techniques were also sometimes appropriate:

*I already have an established methodology that I regularly use for discussions in groups of registrars, and end up having to restrain myself from reverting to it – as well as having to stop myself thinking all the time that it might be better for the group since I would be so much more comfortable if I was applying what was familiar rather than unfamiliar.*

Fac A session 4

*...the assertive communications teacher in my soul came to the fore...*

Fac D session 4

*no-one including myself mentioned the words professionalism or appreciative inquiry once! Oh dear. And I have a niggling worry that they worked in this way because they realise I have a strong prejudice in favour of peer supervision of this kind*

Fac A session 5

The value of the groups as ‘pedagogical spaces’: a place to focus on, and become mindful of, professionalism was mentioned by two facilitators in their reflections. This was an issue also identified in both the facilitator interviews and the participant interviews:

*They spoke of a very challenging environment which nonetheless provided a rich case mix which provided lots of opportunity for learning their professional role as psychiatrists. This led us to talk about the need for mutual support and "mutual, nurturing" conversations.*

Fac B session 5

*Towards the end of the session the doctor said she had found all of this tremendously helpful. In fact, she was glad she had had the opportunity to discuss this case with only the two of us present, and without anyone there who was much more junior or from her own specialty. The two doctors both said they felt these kinds of opportunities were essential for doctors and it was amazing they didn't happen as a routine.*

Fac A, session 5

In some areas there was a high degree of concordance between written reflections and interview data. The opportunity for dialogue and discussion was seen as a vital source of learning and professional development for the participants. There were reports which included participants revealing how useful these sessions were as well as others reporting on the heightened level of enthusiasm they had seen in participants who had left the sessions from which facilitators ascribed much satisfaction.

However, there were also a number of differences between the reflective accounts when and facilitator interviews. It seems although written for an ‘audience’ as well as for themselves these documents represented less inspected spaces and therefore provided
less managed accounts of the group meetings than the more formal setting of the facilitator interviews. Two examples of this are given below.

Whilst in interviews facilitators were more likely to describe a group learning process and benefits for all, the session by session accounts of two of the facilitators noted their concern about the differences in session outcomes between the benefits to the group and the benefits for the problem bringer; and their struggle to maintain the opportunity for individuals to make meaningful personal progress whilst ensuring the group were also learning:

For the problem bringer more involved through focus on personal learning. (I) moved emphasis from problem bringer back into group focus and so?
Fac D, session 3

Secondly, the session by session nature of the reflective reports also revealed far more detail than the interviews with facilitators about irritating practicalities such as late arrivals, absenteeism, room booking difficulties etc. It seems that by the time of the interviews, when the practicalities of running the sessions were over, facilitators were less concerned about these issues and more reflective on the benefits of the experience as a whole.

5.7.3.2 Group observations

Three observations of groups in action took place. These took place during the final group meeting of three of the five groups. In each observation the evaluation team member undertook the role of non-participant observer. The observer took detailed field notes and completed an AI observation checklist.

For all three of the group observations, reflective notes were later written by the facilitator and so some cross checking on perceived events was possible.

The main benefit of the observations as data sources were i) to get a more nuanced feeling about how the sessions actually ran from an objective rather than subjective description and ii) as a way of validating the reflective accounts as accurate descriptions of events.

All three groups had perfect or near perfect attendance although there was some drift in of participants in the initial few minutes of the session as had been noted in facilitator accounts of previous sessions. All three groups functioned well with good and often animated engagement of all participants noted. In all three of the groups the cycle of AI was observed in action with elements of the 4D’s observed and talked about by both group members and facilitators.

A good balance between listening and talking was noted in two of the three observations. This appeared to be a purposeful action on behalf of the facilitators as noted in the facilitators’ reflective accounts of the same session. In the third group there was more talking by the facilitator (mostly in terms of reframing, moving discussion on,
summarising etc) than was described in both their reflective account of the same session and in their general description of how the sessions ran in their interview.

The word ‘appreciate’ was noted as used frequently in two of the groups however this was a common usage application of the word rather than in the context of AI: for example ‘I appreciated his concern’. One observer noted ‘it was as if the participants were trying to ‘please’ the facilitator by talking in over-bright terms and using the word to show they had ‘bought in’ to AI.’

Whilst a stated intentional aim of the groups was that participants were considered co-workers rather than recipients, the observed sessions did not reflect this: with the facilitators still being very much ‘in charge’ of the session: encouraging movement around the 4Ds cycle and adherence to the principles of AI. Facilitators often seemed to ‘take charge’: again this was something identified in the reflective accounts: often as a purposeful intervention.

Some profound moments for both facilitators and participants were observed in these sessions as participants reflected on the end of the sessions and how they would take this focus on professionalism, and their advocacy, forward.

The use of stories and generative metaphors, a common device in AI, was observed in all groups. Examples of these included: ‘the things that you leave behind’ as a description of markers of professionalism you leave in memories and notes; ‘shadows’ within organisations where professionalism is left un-talked about; and seeing ‘outlines where things should be when they are not’ using an example of the emptiness left by a stolen bike: causing you to stop and take note when something that you expect to be there is missing.

In all three observations a deliberate attempt seemed to be made by the facilitator to ensure both self and others, and the relationship between the two, were considered in relation to professionalism.

All three sessions were final sessions for the groups and so some time was spent on wrapping up and saying goodbyes. Participants seemed reluctant to leave and spent considerable time thanking the facilitator and the other group members. Although this reluctance to leave was partly due to observers seeing the end of a well functioning group, this reluctance to leave at the end of sessions was a comment often made in facilitators reflective accounts.
5.8. Discussion

This evaluation, conducted within a qualitative paradigm, collected a substantial amount of data via questionnaires, interviews, observation and written documents from a range of stakeholders with the aim of addressing a number of key evaluation questions identified at the outset of the project (see Appendix 5).

These key questions relate to different facets of the primary research question: **What do facilitated learning groups of doctors in training contribute to the development of professionalism in doctors, their working colleagues, and the organisation?**

These facets include: an indication of actual outcomes for participants; the value of the intervention to a range of stakeholders, including the host Trusts; the practicalities of involvement for a range of stakeholders and identifying improvements or developments that might be needed for any future iterations. These questions therefore form the framework to this discussion and the summary.

Due to the emergent design nature of the project, some of the questions originally posed in the design phase were not addressed in the eventual evaluation (such as those concerning the effect on career aspirations of participants) and some other important questions emerged during the project and became foregrounded (such as the role of facilitators in the success of the groups and identifying the more enduring outcomes of involvement on participants).

5.8.1. The effects of participation on individuals

- **What are the actual learning outcomes of participation in a Trust-based learning group?**
- **How well have the reported learning outcomes matched the anticipated objectives?**
- **How did participation in the group contribute to trainee learning?**
- **What professional beliefs and values are developed through group membership?**

There appeared to be a significant self selection bias in choosing to attend, and to continue to attend, these groups. Many participants declared a pre-existing interest in professionalism, a desire to reflect on and develop their own professionalism and to hear the stories of others. Some also wanted to extend beyond developing their own professionalism to influence the professionalism of others, by teaching, giving feedback or role modelling. Participants highlighted this fact; that they may not be representative, nor indeed the most in need of the intervention.

Notwithstanding this limitation, 47 junior doctors completed the programme (84% of those initially recruited) and for those individuals it is clear that this type of facilitated learning group contributed to an increased awareness of, and orientation to, professionalism issues.

The set up of the group meetings allowed for a useful revelation and exploration of different understandings and constructions of professionalism at the beginning of the start of project and it appears from the post participation questionnaire and participant
Interview data that participants’ understanding matured and became more nuanced during the six months of involvement in the groups. Notions of professionalism often changed from personal and patient-focussed: the more traditional descriptors of professionalism to those that described professionalism as a relational concept. Participants were more aware of the democratic nature of contemporary professionalism; including a more collective orientation towards the concept of professionalism as it concerns colleagues and to teams. This appeared to develop through the work of group discussion and story telling. Facilitators felt this helped professionalism to become a more concrete concept and whilst it relied on internal values and principles, participants had come to see it as something far more tangible when it was seen in operation. This moving from the abstract to the more concrete was further illustrated by facilitators being able to report practical measures that participants felt they could put in place at work which would foster the development of professionalism. Thus it seems an evolution of professional beliefs and values are developed through such group membership.

Facilitators felt that although participants were a self-motivated group, there was some mismatch between the initial expectations of what the groups would entail and the reality of the participants’ experiences. Facilitators felt participants had come to learn, in a formal sense, rather than to participate and to discuss cases arising from their own experience. Although this was initially described as a hurdle it did not appear to take too long before participants were happy to actively contribute. However there was some attrition from the groups and at least one non-attender gave this mismatch as the reason for her dropping out of the course.

Facilitators felt that the groups were highly effective for participants, they were able to articulate and rehear their own voice; enabling them to question and refine their views on professionalism. They were also able to hear alternative views from a variety of colleagues helping them see a bigger picture and alternative perspectives.

There were a range of other positive outcomes from involvement in the groups which extended beyond the area of fostering professionalism. In particular participants appreciated the opportunity to discuss issues with their colleagues that impacted on professionalism at an individual and at an organisational level and to create shared solutions to problems. This pedagogical space and a time to come together as a group seems to be key to the success of these groups. For participants, facilitators and the project lead this was generally felt to be the more important and more effective aspect of the groups rather than the specific method of AI that was used in the groups.

There is also a clearly declared wish to influence both working colleagues and the organisation as a result of participation. This wish appeared strongly in the pre intervention questionnaires and in the post questionnaire where alongside personal gains, participants highlighted their wish to influence others and their increased mindfulness of the professionalism of those working alongside them. The interviews however suggested that significant structural barriers existed that impacted on the agency and effectiveness of junior doctors to effect change in others or at an organisational level.

It is notable that not everyone involved felt the impact on individual was significant: some participants and some DMEs felt that the project’s benefits on individuals were
limited and may be somewhat transient but agreed that the very existence of a project targeted at professionalism in their Trust did raise awareness of professionalism more generally.

5.8.2. The value of involvement to the participating Trusts

- What additional value, if any, is brought both to the Trust and local foundation and speciality training programmes?

The interviews revealed a variety of views about the benefits of participation beyond those to the individuals involved. The DMEs felt that enhancing the professionalism of juniors was good for the delivery of the service and for the Trust as well as for the individuals. They also felt, like the participants, that being involved in the project had raised the issue of professionalism in their own minds. This had started them thinking about how to augment other training opportunities to provide ongoing discussion and learning about professionalism.

Many participants felt they had developed more of an understanding on the impact of the workplace and the organisation on their ability to be professional. In the questionnaires they suggested ways they would impact on others however in the interviews many questioned their ability to have a substantial impact at the level of the Trust. All four of the participants interviewed six months after taking part had moved on or were on extended periods of leave. Some felt that whilst the groups were important developmental processes for the individuals involved and should be continued, for more people to benefit from these interventions those at the top of the medical hierarchy would need to become more involved and more concerned. The project lead also highlighted the key role of the DME is creating any change at the level of the Trust. He, like some of the facilitators, was a little more optimistic about the ripple effects these participants might create.

Whilst the DMEs felt that explicit teaching about professionalism, such as involvement in professionalism groups, was a good thing, this needed to be supplemented with experiential learning supported by meaningful relationships with other juniors and senior doctors both informally and via role modelling as well as via supervision and mentoring. However, like the participants, the DMEs recognised that aspects of the contemporary medical workplace worked inhibited junior doctors from feeling professional and engaged. They particularly highlighted issues such as the lack of opportunity for juniors to feel part of a team or to mix informally with other doctors and being omitted from organisational structures that did not make them feel part of the Trust.

One of the planned outcomes of the groups was to create ‘Professionalism advocates’. Participants were not generally enthusiastic in interviews about the possibility of being a professionalism advocate, although the facilitators and DMEs were more hopeful that a cascading model might be possible.

Participants were able to talk about a range of opportunities that their clinical setting afforded them in which professionalism could be raised and discussed. Some suggested that having been part of a these groups they could be facilitators of some kind of learning sets. However none of the talk was about concrete planning. Some talk was
future orientated with the idea that when they were consultants and responsible for organising and fostering their junior colleagues that these sorts of issues would be the ones that they would choose to privilege. Perhaps sowing the seed at this stage, dreaming about the possibilities for implementation and identifying a career point at which that may be possible are encouraging signs.

5.8.3 Practical issues

- What practical issues have arisen for participants and Trusts as a result of the project? What ethical, employment and legal issues have arisen for participants and Trusts as a result of the project?

As alluded to above, junior doctors are highly mobile and they often take periods of extended leave from the workplace for family or career reasons. This was in some cases responsible for the lack of regular attendance and significant drop out from the groups. This mobility will also have an impact, as suggested by the participants, on sustaining momentum form such interventions. Of those who did attend it seemed that the more senior doctors could create time for themselves to be available whereas the juniors needed a supportive supervisor to help them to negotiate protected time to attend. We know that the groups comprised of individuals who were already interested in professionalism. It is likely that the groups also comprised of those who were most able to secure protected time to attend.

In the NHS staff mobility extends beyond junior doctors. The only members of this project that remained stable throughout were the project lead, the DMEs and the facilitators. The administrative staff at all five postgraduate centres changed to some extent and the administrative staff at the Deanery also changed more than once. This led to difficulties in fully understanding the practical issues involved in the project.

5.8.4. Recommendations for future iterations or developments

- What do stakeholders perceive would improve future iterations or developments of the pilot project?
- What additional activities if any do stakeholders consider are needed to address the aims of the professionalism programme?
- What can be learned from the pilot project as a whole to inform embedding the continuing development of professionalism in all its aspects across all training programmes?

From the outset the project lead identified his desire to create a confidential space for peers to talk about complex issues that were troubling them. The facilitators, participants and some DMEs saw the potential of enduring benefits from being part of a peer discussion/support and network group. This seemed to be an as important area to explore following the end of the project as any further activities specifically targeted at improving professionalism.

The participants who completed the course and the facilitators all felt that the Trust based groups were important activities that should be maintained if possible. There was widespread disappointment that there would be no funding for further iterations. There was acknowledgement from the facilitators, the participants and the project lead that
well trained facilitators were required to support these groups and thus any future iterations would be difficult without financial support. The DMEs, recognising the need to do more with less, had used involvement with the project as a springboard to begin to explore ways of enhancing learning of professionalism in their Trusts. It may be that some DMEs may develop local projects mindful of the local contexts.

The ability to take on an advocacy role was rarely a declared outcome for participants, particularly when explored more fully in interviews. The notion that a junior could become an advocate as a result of attendance as a short course was questioned and structural, hierarchical and organisational restrictions seemed to significantly impact on any desire or ability to act as an advocate. It may be that the course could be seen a catalyst towards developing advocates but that advocates would need considerably more ongoing support and supervision to be effective.

A potentially more enduring outcome was changes in self-conceptualisation and self-understanding of what it means to be professional in the modern NHS. Whether individuals involved in these groups as juniors would go on to develop their own way of encouraging professionalism by example and role modelling or by creating legitimate opportunities for others to talk about professionalism issues as they rose through to senior positions would be an interesting follow up study.

5.8.5. The central role of the facilitator

The data from all sources suggests that the facilitators played a key role in the success of the groups. It is clear that this is a role requiring considerable expertise and in this pilot facilitators were carefully selected, trained and supported.

There was a conscious attempt in the spirit of AI to focus on narratives and stories. The facilitators highlighted an interesting facet of these groups: that they provided a rehearsal ground whereby difficult and challenging issues could be talked through in safety and practised was highlighted. Hearing stories that others brought helped participants feel that these were shared concerns. These stories often revealed the vulnerability of the participants and participants appreciated that the facilitator was the same person every time and external to the Trust. What started out as Trust based groups (in the sense they were made up of participants from the same Trust) had evolved into trust-based groups by the end of the course: with participants sharing profound or troubling experiences and gaining support from peers. This process seemed to be dependant on the close relationship with the facilitator and the methodology of story telling that was expertly utilised.

Being part of these groups was clearly something special for the facilitators and it was marked by trepidation as well as a sense of achievement. Facilitator felt that this was quite a steep learning curve for them. Initial feelings of concern and sometimes frustration were common to all facilitators but this reported eased as the enjoyment of working in these groups overtook their initial feelings. This was clearly a rich learning experience for the facilitators, either in the utilisation of AI as a group facilitation method, or be being intimately involved with healthcare professionals or reaching a deeper understanding of what professionalism meant to them. Whilst some facilitators clearly
felt the facilitators group meetings were a vital aspect of learning others seem to have found the groups themselves the richest source of learning.

There were challenges to running the groups that the facilitators identified in their interviews and reflective accounts. Facilitators were very aware of trying to maintain cohesion despite the fact that participants had to sometimes leave early, arrived late or were interrupted by their bleeps during the session. Facilitators found some problems with over domineering group members who because of their relative seniority they found difficult to manage. Most facilitators had some reservations about working with AI at the outset of this project. This was mostly because of unfamiliarity with the concept as applied to group work and the notion that this was a slightly false, or forced, way of working with groups. Working around the four D’s stages cause problems for some where they felt clunky interchanges between one phase and another and that some stages were easier to be in than others. Observations and reflective accounts both highlighted the facilitators feeling the need to take control of the group at times to ensure they did not wander too far from the 4 Ds.

Although the initial utilisation of this methodology was most problematic, this did not mean that after this initial phase the problem resolved. Indeed facilitators reported some ongoing issues and learning needs regarding this methodology even as the groups progressed. There was an idea among some facilitators, that it was their own unfamiliarity with this approach that was causing their problems; despite this group being all very experienced facilitators.

There was general agreement amongst facilitators, as well as participants, that looking towards the positive is a helpful stance in personal development. Participants felt the facilitators were using AI in a sophisticated and nuanced way despite the facilitators having concerns over their ability. When discussing how to make the changes enduring participants questioned whether they could manage such a process. The implications therefore of using AI as a methodology in such groups would need careful consideration. Training and ongoing support, as well as practise, seem necessary in developing expertise in AI.

5.8.6. What lasting change occurs as a result of the groups?

In a study of a single pilot activity over a short time frame it is difficult to identify hat might be enduring changes as a result of the intervention. The project lead talked of ‘throwing pebbles in a pond and seeing the ripples extend out’ and to some extent these initial ripples have been captured in the evaluation. The more distal and long term ripples can only be speculation at this point in time.

For the individuals involved in the pilot the questionnaire and interview data suggested they were more confident in their understanding of professionalism and were able to see its effects and its importance in a more wide-ranging way. Their descriptors of the effect of participation suggested they were becoming more oriented to the workplace as a community of practice (Lave& Wenger 1998). The collateral learning and vertical and horizontal networks (identified as inhibited by contemporary workplace organisation) that resulted form the groups may also have some lasting impact.
There is a ‘shadow’ side to the reports from participants revealing how useful these sessions were and the heightened level of enthusiasm facilitators had seen in participants as they left the sessions. Whilst gratifying at the level of this project this may be considered more widely as concerning issue. If the success of this project was dependant on the opportunity for individuals to come together and openly discuss, their experience and examine the organisational culture why is this sort of initiative not happening already? It seems this learning would not have happened without this initiative. There should be a concern that NHS settings may represent a "knowledge poor" learning environment in terms of fundamental aspects of professional development.

For facilitators there were also gains. Although already experienced, they gained additional skills in AI in group work. As members of a small community of medical educators they may be more confident to utilise this methodology in other training and learning activities.

For Trusts lasting change is even more difficult to quantify and may be more tenuous. The DMEs felt the pilot project has left them with an increasing consciousness of professionalism. They described pursuing ways of augmenting existing activities so that explicit discussions about professionalism, as well as means of learning it experientially, are created in the Trust. Raising the profile of professionalism in the trust was not seen as an issue indeed it was seen as a positive attribute.

There was also a raised awareness of how to enhance the cohesiveness of the junior body and encourage them to engage with broader Trust issues. Following the course one participant had identified a niche (and Trust money to backfill her time) to work on a specific Trust tool to improve professionalism. An email from the postgraduate centre manager at a participating Trust almost four months after the course had ended revealed that one of the former participants has taken a slot in the new doctors induction programme to try to increase awareness of professionalism issues for doctors joining the Trust.

A significant inhibitor of lasting change, identified by all stakeholders, but emphasised particularly by the DMEs was that the modern NHS was not organised as a learning environment. Fragmentation of teams and changes to service delivery has lead to the lack of cohesive teams, and a peer group of professionals to learn from and with. This seemed to be an issue across all Trust in the pilot. If this fragmentation is so pervasive then a potential function of these groups is to simply bring doctors together to talk about their work: this may be a valuable attribute in itself: whether the talk was about professionalism or not.

The interviews with the DMEs revealed some issues that might inhibit the potential for change at the institutional level as a result of this project. If change at an institutional level requires leadership and vision the fact that DME’s found it challenging to construct a working definition of what it means to be professional will make it difficult for them to convey the notion of professionalism, their vision of what being professional in their Trust means, to their team of educators, the clinical and educational supervisors and the trainees. Some of the definitions used were as unsophisticated as those of the participants at the start of the programme. If the course helped to develop more contemporary and relational notions of professionalism for the trainees, perhaps it is the
DMEs that should be targeted for the intervention if lasting changed at an organisational level is desirable?

5.8.7 Learning from the project approach

- What can be learned from the interactions of the stakeholders (including the project team, facilitators and expert panel) in relation to the approach adopted, and any tensions or dilemmas that emerged as a result?
- What recommendations can be made for longer term follow-up?
- What ethical, employment and legal issues have arisen for participants and Trusts as a result of the project?

The project was set up with a very clear ontological perspective on professionalism and how it might be developed. This required considerable negotiation and discussion amongst the expert panel and project group. Declaring the ontological positioning up front and accepting that ‘professionalism’ does not lend itself to simple, tangible, measurable outcomes is useful; and is a less common approach in medical education research and evaluation. This led to a particular type of intervention and a particular type of evaluation: one that was holistic and full of ‘thick’ data. Such a focused look at the particular, privileges idiographic research over large-scale studies and this makes the simple capture of hard outcomes and recommendations to stakeholders problematic. However, together with the use of emergent design this approach allowed flexibility and negotiation of what was evaluated and when, and eventually gave richer information that was able to contribute to theory building in the domain as well as create empirical data for funders and stakeholders.

The intervention devised was novel in its approach and there is merit in scrutinising the process and the outcomes to provide meaningful information for a range of stakeholders. There was undoubted benefit from involving a wide range of experts in the initial design phase; their experience contributed greatly to the design of the study. However early collaboration between the design team and the evaluation team would have produced additional benefits in getting the research underway in a more effective manner.

The project involved a very brief intervention followed by a relatively short evaluation period and this was always destined to be problematic with regard capturing measurable effects. Emergent design allowed for an extension of the evaluation period to follow-up at six months but this had its limitations due to the highly mobile group of participants involved. The nature of the intervention and the complexity inherent in studies involving professionalism also meant that hard objective evaluation outcomes were neither particularly desirable nor achievable. Thus whilst this project added richness to the understanding of participants views of professionalism and the utility of small groups to foster professionalism, some commentators may be more critical: preferring an evaluation approach with hard quantitative outcomes.

The interview data from all sources contributed to a rich understanding of the intervention but these represented a single lens through which individuals provided a personal construction of reality. The observations mainly concurred with reflective
accounts of the sessions but did reveal a subtle interesting difference between what was seen of facilitator behaviour and what was reported by facilitators. Perhaps more developed observations or indeed video recording of these unique groups would have provided another rich source of understanding both of how AI was practiced in these groups as well as how people developed their notions of professionalism through narrative.

AI was a fundamental aspect of this initiative. In this well funded pilot project very experienced facilitators were recruited and were provided with training and ongoing support. If AI, as a group method, were to be rolled out in a future iteration in a climate that is more financially restricted, the ability to recruit and support this level of facilitation becomes questionable. It would be likely that less experienced facilitators, such as past group participants, who may have been keen or encouraged to take the groups forward would have struggled without significant ongoing coaching in the methodology as well as with group facilitation.

There are undoubtedly barriers to adopting AI, with its conceptualisation as being somewhat ‘American’ and the application of the four stages, somewhat restrictive and formulaic. However a fundamental strength of AI is of the focus on the positive and the emphasis on language and its ability to regenerative metaphor to construct individual learning. If AI is to be a viable methodology these benefits would need to be highlighted and the concerns would need to be addressed at the outset of either training or implementation.

Only one significant ethical issue arose during this project. This concerned the confidentiality within the group and the sharing of group experiences and stores outside of the project participants and team. It became clear that although the extent to which experiences within the group could be shared with outsiders was extensively considered at the outset and during group meetings the extent to which facilitators could share their experiences with others in the education community was not so carefully considered and a single potential accidental breach of participants’ confidentiality occurred. During the course of this project which clearly involved talking about sensitive issues involving clinical care no significant events affecting patient safety were disclosed that required further action by the project team.

The evaluation team, and in particular the principal investigator, worked closely with the project team and facilitators to gain a quality understanding of the purpose of the intervention, the processes involved and the experiences of all involved in the endeavour. This allowed a shared lens through which to view the intervention and its effects. The ‘added value’ the extensive external evaluation afforded the overall purpose and process of the pilot project included: independence from the project funders and expertise in the field of education intervention research; an opportunity to collect data not just from participants but from a range of stakeholders often lost to an evaluation process; the use of mixed methods and triangulation to provide rich and multi-perspective data; the ability to provide longer term follow up of participants to access information about possible enduring aspects of participation.
5.9. Summary and conclusions

Professionalism
It appears professionalism, and attempts to foster professionalism, are seen as important to junior doctors and their education leads. There remains some difficulty defining what professionalism is, identifying how professionalism develops and thus what role education and training has in this trajectory. Interventions such as these Trust-based groups have given us an opportunity to explore their potential in encouraging professional development. The evaluation created the legitimate space to explore with a range of stakeholders not just the impact of participation but the personal and contextual factors that impact on professional identity and the enactment of professional practice.

Learning professionalism
The language used by participants to describe professionalism shifted from a series of somewhat hackneyed and inward facing signifiers to ones which showed an increasing awareness of the complexity of professionalism. This sophistication was fuelled by a greater receptiveness to the professional actions happening around them. Their broader definition of professionalism which encompasses the role of others has led, arguably, to a fuller understanding of the notion and one that can be articulated more clearly and meaningfully. This changing language may signify a conceptual shift in understanding of professionalism: not as an act of the individual, but as a construct which is socially mediated within the workplace. Through being able to discuss real-world experiences and their individual thoughts and feelings, acknowledging the importance of context and other agents, new meanings have come forward and become internalised as part of their new understanding.

However, one needs to consider whether shifting the discourse and the understanding of professionalism is a valued outcome? Whilst participants and facilitators felt that significant learning occurred, the impetus for the project arose partly from an expressed need by Directors of Foundation Schools and Heads of Specialty Schools for Trust-based ‘training’ addressing the generic curriculum and professionalism is still caught in the reductionist model of postgraduate training and aligned to a competency framework. There remains considerable work for educators in the field to shift the paradigm of workplace-based learning away from the notion of acquisition of measurable competencies and knowing towards a model more aligned to what is already known about how professional learning occurs. Work such as this has impacts beyond the empirical: and should be celebrated and utilised for its contribution to understanding the field.

Trust Based Groups
These Trust-based groups that created pedagogical spaces to discuss professionalism and afforded legitimacy to its exploration and had a meaningful effect on participants. Through conversation and shared story telling participants gained a heightened awareness of professionalism as it is acted out in their work settings, and for some, this created a growing confidence to explore situations that they would have previously ignored. Perhaps the participation in the group can be viewed as a dress rehearsal: a space in which to practice favourable responses to challenges to professionalism, a place to benchmark one’s own unique perspectives, and opportunity to hear the stories of others and create a shared understanding.
Pedagogical spaces
At the inception of this project he project leads dreamed:

‘I hoped the project would be a way of introducing into all Trusts in London the option for all their doctors in training of having a confidential space once a month or so to talk about complex issues that were troubling them.’

The benefits of joining and participating in these groups seems almost irrespective of the content. Sharing stories of the workplace was a productive activity in itself and one could argue that this is an example of the benefits on meaningful supervision, in its broadest sense, in healthcare education.

What happened in the groups: the freedom to speak, the flattening of hierarchies, professional socialisation, the opportunity to discuss important issues with a supportive peer group seems to be one of this projects great merits. Whilst clinical conversations are likely to happen naturally every day, talk about professionalism, the feelings that are evoked and issues around working with colleagues, are more problematic in the working day environment and do not always have a legitimate place to be addressed.

Sharing professionalism stories from individuals acted as the impetus to explore the effects of actions and inactions, perceived influencing behaviours on and from others, contextual factors and exploring alternative perspectives were at the heart of these groups. These together with a chance to explore possible alternative outcomes became the mechanisms by which professionalism was developed. This method could be used alongside more explicit ways in which professional learning and development occurs in the training environment, such as case-based discussion groups and educational supervision. It would deepen the development of professionalism and at the same time create a sense of positive relationships with others within the Trust.

AI as a facilitation method
AI was used as both a method in the groups and as an organising framework for the project and its evaluation. Its relatively novel use in the facilitation of learning groups in medical education, as well as a guiding methodology added to the project’s unique and innovative profile. Understandings of AI remains unsophisticated post participation and most groups still needed active support to function in an AI mode even by the final session. However participants valued the focus on the positive, the way in which it prevented discussions from descending into group moans and the validity it gave to story telling.

Facilitators needed expert training and ongoing support to provide group facilitation using AI and so the use of AI in a broader or more extensive way in medical education needs further investigation.

Barriers to professionalism
Both junior doctors and leads for education see the pressure of service delivery and the way it which it is currently organised acting as a barrier to behaving and developing professionalism. The transient nature of Trust allegiance, magnified by multiple ways in which Trusts create barriers to developing a sense of belonging is problematic in professional development. The fragmentation of the workplace and delivery teams also inhibits the opportunities to learn professionalism with and through relationships with
fellow professionals. This suggests that educational interventions like these, no matter how successful, with create only limited change.

**Professionalism Advocacy**

The concept of a professional advocacy, a role gained through involvement in the programme, was something that concerned many informants. Whilst some facilitators and DMEs were hopeful of the influencing effect on others following participation, if only in an informal way, most participants did not share these hopes. Engagement with the group validated participants’ notions of professionalism and this created a greater sense of responsibility on a personal level. However, very few felt empowered to take on the role of professionalism advocate. Being an advocate was not seen as an easy role nor one to be done effectively without support and mentoring. Heirarchies and a lack of influencing power were seen as barriers by some, others considered the notion that attendance at a course could affect their influencing behaviour as flawed.

This questioning of the possibility of advocacy can be seen as a positive outcome of a group process that aimed to enhanced understanding of the complexities of professionalism, including its relational and contextual nature. If professionalism is seen as a question of judgement, or *phronesis*, by participants and not a measurable competency then advocacy cannot be seen as something you can ‘train for’, nor be prepared to have the ‘right answers’ to professionalism issues but needs ongoing support and mentoring.

The transient nature of a junior doctors association with a Trust and the looseness of their allegiance to it highlighted in this study also calls into question whose role is professionalism advocacy within a Trust? Who is responsible, as juniors come and go, for maintaining the institutional conscience? Perhaps it is the DME, who acts as an advocate to ensure the best learning for trainees, who should be targeted in further learning opportunities in the domain of professionalism if ongoing advocacy is a desired outcome.

**5.10 Limitations of study and further questions**

This small scale study provided a rich source of useful information about how professionalism can be fostered and the advantages of addressing professionalism issues in Trust based learning groups. The generalisability of this study is somewhat limited because of the scale of the study, the way in which Trusts were recruited to the project, the relative expertise of the facilitators and the self selection of participants. The uniqueness of each group, the configuration of their group members and the contexts in which those participants learned and worked also limits what can be said of the potential for success in different organisations, with different facilitators and different group members.

We have illuminated what happens in well motivated groups with well motivated participants and external expert facilitators but what can we say of ordinary people participating and facilitating? What happens if you make participation mandatory?

The very early change in circumstances of the project from that of a pilot to allow recommendations for further iterations of the intervention to be established to a one off
event means that the nature and purpose of the evaluation needed to be recalibrated after the evaluation had commenced. An orientation to theory building became necessary: otherwise who would the outcomes and recommendations of the evaluation be useful for?

This evaluation allowed us to make meaningful statements concerning observed or perceived effects of participation for a range of stakeholders and allows some speculation regarding the potential of such group activities. The finding that everyone involved became more mindful of professionalism is encouraging. Longer term follow up for enduring effects or involvement would be informative. The collateral benefits of involvement and the creation of communities of practice are also worth exploring in more depth and over a longer time frame. The discovery that professionalism does not have a legitimate venue for discussion and that story telling is a powerful tool in professional growth, both have the potential to influence ways in which the education community might address the teaching and learning of professionalism.
6. References


7. Acknowledgements

This pilot project could not have taken place without the tenacity and vision of Dr John Launer and Professor Time Swannick at the London Deanery.

The success of the pilot groups were the result of the expert academic inputs of: Chris Oliver, Bryan Cunningham, Tony Garellick, David Guile, David Halpin, Sean Hilton, Michael Maier, and Trudie Roberts.

The facilitated groups could not have taken place without the hard work of the Directors of Medical education and the postgraduate centre managers in the participating Trusts and of course the group facilitators.

Our thanks also go to Dr Judith Stanton who conducted the DME interviews and who provided many useful comments on all drafts of the evaluation.

Many thanks to Heather Mitchell, Debbie Lucas Georgiou and Marica Rigby at ACME for their administrative and research support and the participants, facilitators, and DMEs who all gave up their time graciously to assist in the evaluation.
8. Appendices

Appendix 1: Ethics, consent, information for participants, data protection

Academic Centre for Medical Education, UCL

Title: Evaluation of the London Deanery pilot education project: Trust-based learning groups to foster professionalism.
NRES exemption 22.1.10

Participant Information and Consent

Thank you for considering participating in this evaluation. I hope the information below will help you decide whether or not to take part. If you would like to find out more about the evaluation or discuss areas of potential concern with me before reaching your decision, my email address is d.gill@medsch.ucl.ac.uk and my telephone number is 0207 288 3316

Background to the evaluation:
The London Deanery is currently exploring ways of fostering professionalism as part of their overall education endeavour and has been piloting Trust-based groups as one potential way of achieving this. They have commissioned the Academic Centre for Medical Education to carry out an evaluation of this initiative independently. The evaluation aims to discover the contribution of facilitated learning groups towards the development of professionalism in doctors in training, their working colleagues and the organisation in which they work.

Evaluation questions and nature of the evaluation:
1. What are the perceived contributions of facilitated learning groups to the development of professionalism in doctors in training?
2. What are the effects of participation on colleagues, patients and the organisation in which participants work from the perspective of participants, facilitators, the project lead and directors of medical education (DMEs)?

This is a qualitative study and will mainly consist of interviews with a sample of participants, facilitators and DMEs. The interviews will be supplemented with a small number of observations of groups in action.

Consent
If you decide to be part of the evaluation described, you will be asked to consent to take part in an interview in which you will be asked about your experiences. The interview will be conducted by me or one of the research team. Your participation is completely voluntary and you can withdraw at any point without consequence to yourself. If, at any point, you decide you no longer wish to take part in the study, you will be able to withdraw consent and any data already collected will not be used.

Confidentiality
Interviews will be audio-recorded and fully transcribed. The interviewer will take field notes during the interview. Excerpts from these transcriptions and field notes will be used in the evaluation report of the research. The identity of individual participants and the will be obscured by removing all
names and identifying features to the best of my ability in both the submitted report and in publications arising from the work.

Reporting of findings
This work is being undertaken for the purpose of an external evaluation of an education intervention on behalf of the London Deanery. The will be presented as a report of about 10,000 words. It is anticipated that some aspects of the evaluation will also be written up for publication in the form of journal articles and presentations. Again, identifying information will be concealed to the best of my ability.

It is hoped that the findings might inform those involved in postgraduate medical education with regard to the benefit of such interventions to professional development.

Dr Deborah Gill, on behalf of the Academic Centre for Medical Education, UCL.

March 2010

Dr Deborah Gill, on behalf of the Academic Centre for Medical Education, UCL.
Title: Evaluation of the London Deanery pilot education project: Trust-based learning groups to foster professionalism.
NRES exemption 22.1.10

Research Participant Consent Form

I have read the participant information associated with this study.

I understand that the interview will be conducted by a member of the research team from UCL, will last approximately 45-60 minutes, that the interview will be audio-recorded and fully transcribed and that excerpts from these transcriptions and field notes will be used in the report of the evaluation.

I understand that at any point I may decide to withdraw consent and any data already collected will not be used.

Signed……………………………………………………

Date …………………………………………………
DATA PROTECTION REGISTRATION
form 2

APPLICATION FOR INCLUSION OF A RESEARCH PROJECT

This form should be used to Register Research Projects that will be supported by UCL facilities. It should be completed in full and returned to the UCL Data Protection Officer before Data Collection commences.
If the Data has been collected from an organisation outside UCL then the Patient, or Subject, of the Data must have given their consent to both the collection of the Data and the transfer of the Data to UCL. A copy of the Patient Consent Form must be attached to this application. If you are not obtaining Patient Consent then an explanation must be attached.

DEPARTMENT
Division of Medical Education (DoME)
Academic Centre for Medical Education (ACME)

Please return this form to: The UCL Data Protection Officer, The Records Office. South Junction, Wilkins Building, Gower Street London WC1E 6BT Or Email to: data-protection@ucl.ac.uk

Please allow five working days in which to receive your Data Protection Registration No.

| Name of Principal Investigator (Student Supervisor)? | Dr Deborah Gill |
| Name of Data Collector and User: Dr Deborah Gill, Dr Ann Griffin, Dr Kath Woolf, Dr Alison Sturrock |
| Please state here the Title of your research Project? | London Deanery Professionalism Project |
| Address for correspondence regarding this application: | Whittington Campus, 4th Level, Holborn Union Building, 2-10 Highgate Hill, London N19 5LW |

Email Address: h.mitchell@medsch.ucl.ac.uk
### What Security Checks do you have in place? (Password on Electronic Database, Locked Filing Cabinets?)

Electronic data stored on shared drive which only those involved in the project have access to. All computers are password protected. The paper files are kept in locked filing cabinets in locked offices.

### Are you: Applying to the UCL Ethics Committee for Ethics Permission? (Yes/No)

No, exemption granted by NRES 22/1/10 as education evaluation and not research

### How will the Data be stored? (Electronic Database/ Paper Files)

- All demographic and contact details will be stored on paper in a locked cabinet in the PI's office at UCL.
- All other data will be stored electronically as word files on a password protected area of the UCL shred drive available only to PI and researchers.

---

**NB: Once the Research Project is completed, please contact the Records Office.**

**Email to:** records.office@ucl.ac.uk to arrange ongoing secure storage of your research records

http://www.ucl.ac.uk/efd/recordsoffice/policy/records-transfer/

**Unless you have made specific alternative arrangements with your dept or with your funder**

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<td>Representative? (Yes or No)</td>
<td>Please state where the data will be held?</td>
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<td>Have you informed your Department's Data Protection Coordinator about</td>
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<td>How long will your project last?</td>
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<tr>
<td>telephone number</td>
<td>020 7288 5209</td>
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Project? (Yes or No)  
NB: DP Officer will not be informing Dept DP Co-ordinator directly

The following are the standard Data Protection Registration Purposes and Descriptions. If your research is not covered by these please add the information at the end:

Please indicate using a (X) what is applicable to your research project

Personal Data will be collected from the following Data Subjects: (Who will you be collecting the data from)?

| Survey respondents, other persons assisting research |
| Patients |
| Patients families |
| Employees, trainees, voluntary workers |
| Employees of associated companies, organisations |
| Employees of other organisations |
| Recipients, customers or clients for goods or services (direct or indirect) |
| Suppliers of goods or services (direct or indirect) |
| Claimants, beneficiaries, payees |
| Account holders |
| Share and stock holders |
| Partners, directors, other senior officers |
| Employers |
| Competitors |
| Business or other contacts |
| Advisers, consultants, professional and other experts |
| Agents, other intermediaries |
| Trustees |
| Members, supporters a club, society, other institution |
| Assignees, guarantors, other parties with legitimate contractual or business interest |
| Donors and lenders |
| Witnesses |
| Complainants |
| Offenders and suspected offenders |
| Tenants |
| Landlords, owners of property |
| Correspondents and enquirers |
| Self-employed persons |
| Unemployed persons |
| Retired persons |
| Students |
| Minors (if you are collecting data from minors, please include the Parent or Guardian Information Sheet and Consent form with your application) |
| Applicants for permits, licences, registration |
| Taxpayers, ratepayers |
| Licence holders |
Vehicle Keepers
Elected representatives, other holders of public office
Authors, publishers, editors, artists, other creators
Immigrants, foreign nationals
Relatives, dependants, friends, neighbours, referees, associated, contacts of those ticked above

☑ Other: (specify): Doctors who have attended a specific educational event and the facilitators of those training events. The Directors of Medical Education in the NHS Trusts where the training took place.

Description of Personal Data to be collected: (What data will you be collecting)?

Identification data
☐ Personal identifiers
☐ Financial identifiers
☐ Identifiers issued by public bodies

Personal characteristics
☐ Personal details
☐ Physical description
☐ Habits
☐ Personality, character

Family circumstances
☐ Current marriage or partnership
☐ Marital history
☐ Details of other family, household members
☐ Other social contacts

Social circumstances
☐ Accommodation or housing
☐ Property, professions
☐ Immigration status
☐ Travel, movement details
☐ Leisure activities, interests
☐ Lifestyle
☐ Membership of voluntary, Charitable bodies
☐ Public offices held
☐ Licences, permits held
☐ Complaint, incident, accident details
☐ Court, tribunal, inquiry proceedings

Education, Skills, Profession
☐ Academic record
☐ Qualification and skills
☐ Membership of professional bodies
☐ Professional expertise
☐ Membership of committees
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<td>Work record, Health &amp; safety record, Trade union, staff association membership</td>
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<td>Financial details</td>
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<td>Allowances, benefits, grants, Insurance details, Pension's details</td>
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<td>Details of transactions, Goods, services provided to the data subject,</td>
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<td>Goods, services obtained from the data subject, Financial transactions,</td>
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<td>Business information</td>
<td>Business activities of the data subject, Agreements, contracts, Trading licences held</td>
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<td>Health and other classes</td>
<td>Physical health record, Mental Health Record, Disabilities, infirmities, Dietary and other special health requirements, Sexual life, Racial, ethnic origin, Motoring convictions, Other convictions, Criminal intelligence, Political opinions</td>
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### Political party membership

- Support for pressure groups
- Religious beliefs
- Other: data class (specify): Experiences of being involved in an educational event

#### The Results of the Research will be Disclosed to:

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<td>X The Data Subjects themselves</td>
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<td>Family, relatives, guardians, trustees</td>
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<td>Other members of their households, friends, neighbours</td>
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<td>Employers - past, current or prospective</td>
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<td>Employees, agents</td>
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<td>Colleagues, business associates</td>
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<td>Financial representatives</td>
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<td>Other professional advisers</td>
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<td>Ethics Committees</td>
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<td>Members, including shareholders</td>
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<td>Other companies in the same group</td>
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<td>Employees, agents</td>
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<td>Recipients, customers, clients for goods or services</td>
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<td>Claimants, beneficiaries, assignees, payees</td>
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<td>Suppliers, providers of goods or services</td>
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<td>Persons making any enquiry or complaint</td>
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<td>Tenants</td>
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<td>Other: (specify):</td>
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#### Organisation or individuals (general description)

**Central Government**
- Inland Revenue
- Customs & Excise
- Driver & Vehicle Licensing Centre (DVLC)
- Department of Education & Sciences (DES)
- Departments of Health and/or Social Security
- Department of Employment
- Home Office
- Ministry of Defence, including armed forces
- Department of Constitutional Affairs
- Other central government, including Scottish Welsh & Northern Ireland Offices
- Other (specify):

**Local Government**
- Education department
Housing department
Social Services department
Electoral registration, Assessment, Valuation departments

Other public bodies
Other public bodies not elsewhere specified
Foreign governments and authorities (specify):

Justice
Police forces
Prosecuting authorities
Other statutory law enforcement agencies,
Investigating bodies
The courts
Judges, magistrates
Prison service
Probation service

Health & Social welfare
Health authorities, family practitioners committees
or Family Health Service Authorities
Hospitals, nursing homes
Registered medical practitioners
Registered dental practitioners
Nurses, midwives, health visitors
Other health care agencies, practitioners (specify):
Social welfare agencies, practitioners (specify):

Other
Media
Public utilities
Banks
Building societies
Insurance companies
Other financial organisations (specify):
Accountants & auditors
Lawyers
Credit reference agencies
Debt collection, tracing agencies
Employment, recruitment agencies
Private detective agencies, security organisations
Trade, employers associations
Trade unions, staff associations
Professional bodies
Voluntary, charitable, religious organisations or associations
Political organisations

Education or training establishments, examining bodies
Survey or research organisations, workers
Providers of publicly available information, including public libraries, press and media
Providers of privately available information and databanks
Traders in personal data
Other organisation or individuals (specify):

Other: (specify):

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<th>Will the Results of your Research be published in an Academic Journal or other Publication? (Yes or No)</th>
<th>Yes</th>
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Please note that if you do publish the results of your Research they must not contain data by which an individual can be identified.

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<td>The Eighth Data Protection Principle. Personal data shall not be transferred to a country or territory outside the European Economic Area unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.</td>
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<th>Are you collecting the Data in a country outside of the EEA?</th>
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Please attach a copy of the Data Protection Registration in that country

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<th>Do you intend to transfer the Data to any other country or territory?</th>
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Please give details and attach a copy of your agreement with the recipient.

This form will be returned to you with the appropriate UCL Data Registration References, which you may quote on your Ethics Application Form, or any other related forms.

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<th>UCL Data Protection Registration Reference No:</th>
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SECTION:
From: NRES Queries Line [queries@nres.npsa.nhs.uk]

Sent: Fri 22/01/2010 11:04

Our leaflet “Defining Research”, which explains how we differentiate research from other activities, is published at:

http://www.nres.npsa.nhs.uk/rec-community/guidance/#researchoraudit

Based on the information you provided, our advice is that the project is not considered to be research according to this guidance. Therefore it does not require ethical review by a NHS Research Ethics Committee.

I'd deem this an educational evaluation akin to service evaluation, hence would not require REC review.

If you are undertaking the project within the NHS, you should check with the relevant NHS care organisation(s) what other review arrangements or sources of advice apply to projects of this type. Guidance may be available from the clinical governance office.

Although ethical review by a NHS REC is not necessary in this case, all types of study involving human participants should be conducted in accordance with basic ethical principles such as informed consent and respect for the confidentiality of participants. When processing identifiable data there are also legal requirements under the Data Protection Act 2000. When undertaking an audit or service/therapy evaluation, the investigator and his/her team are responsible for considering the ethics of their project with advice from within their organisation. University projects may require approval by the university ethics committee.

This response should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.

However, if you, your sponsor/funder or any NHS organisation feel that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further.

Where NHS organisations have clarified that a project is not to be managed as research, the Research Governance Framework states that it should not be presented as research within the NHS.

Regards

********

Queries Line
National Research Ethics Service
National Patient Safety Agency
4-8 Maple Street
London
W1T 5HD
Website: www.nres.npsa.nhs.uk
Email: queries@nres.npsa.nhs.uk
Ref: 04/02 This reply may have been sourced in consultation with other members of the NRES team
Appendix 2: Interview Schedules

Professionalism Project Interview Schedules: general comments

- Interviews will be conducted using an agreed schedule of orienting questions. They will be semi-structured in nature to allow a subjective focus in the accounts.
- Interviews will be conducted in a relatively informal narrative-style to allow interviewees to explore areas which may often be tacit and unarticulated.
- They will be tape recorded and field notes should be taken.
- The spirit of Appreciative enquiry will be utilised

1. Group Participants

Introductions, outline of the interview and reconfirm verbal consent

This evaluation is being conducted on behalf of the London Deanery and aims to discover the contribution of facilitated learning groups towards the development of professionalism in doctors in training, their working colleagues and the organisation in which they work.

In this interview I will ask you about your experiences as part of a professionalism group and ask you to think about how your practice and the practice of those around you might benefit from a group taking place in this Trust.

The interview will last approximately 45-60 minutes.

Your participation is completely voluntary and you can withdraw at any point without consequence to yourself. If, at any point, you decide you no longer wish to take part in the study let me know.

With your permission the interview will be audio-recorded and fully transcribed and I will be jotting down some notes during the interview. Excerpts from these transcriptions and field notes will be used in the evaluation report of the research however your identity will be obscured by removing all names and identifying features to the best of my ability in both the submitted report and in any publications arising from the work.

Start tape: Name of interviewer and time and venue

Interview questions – Group Participants

1. What has been good about participating in this group?

2. Tell me about your experiences of being involved in these group sessions:
   - What have you learnt?
   - What was participating like?
   - How practical was it to get to sessions?

3. The group was conducted using a principle called Appreciative Inquiry:
   - How would you describe AI?
   - How was AI used in your group?
   - In what ways might you be able to utilise AI in your work as a doctor?

4. Now you have had an opportunity to reflect and share stories with colleagues:
   - What does professionalism mean to you?
   - What aspects of professionalism are important to you?
In what ways do you think being involved has affected your personal ‘professionalism’ or has altered your practice? – can you give an example?

What are the themes that your group discovered were important for fostering professionalism?

Can you tell me a story about professionalism that you think reflects this Trust’s attitude to professionalism?

5. You are now a professionalism advocate:
   - What does this mean to you?
   - What could be the benefits of your participation on others?
   - How can momentum for fostering professionalism be maintained?

6. Now you have had this experience, what else do you think can be done to foster professional development and growth within the Trust?

7. Is there anything else you would like to tell me that might help me to understand your experiences of this activity?

*Would you be happy to take part in a follow-up interview if necessary to identify ongoing ways in which you may have benefitted from being involved in this group? If so to complete the form*

2. Group Facilitators

**Introductions, outline of the interview and reconfirm verbal consent**

This evaluation is being conducted on behalf of the London Deanery and aims to discover the contribution of facilitated learning groups towards the development of professionalism in doctors in training, their working colleagues and the organisation in which they work.

In this interview I will ask you about your experiences in facilitating one of these groups. The interview will last approximately 45-60 minutes.

Your participation is completely voluntary and you can withdraw at any point without consequence to yourself. If, at any point, you decide you no longer wish to take part in the study let me know.

With your permission the interview will be audio-recorded and fully transcribed and I will be jotting down some notes during the interview.

Excerpts from these transcriptions and field notes will be used in the evaluation report of the research however your identity will be obscured by removing all names and identifying features to the best of my ability in both the submitted report and in any publications arising from the work.

Start tape: Name of interviewer and time and venue.

**Interview questions – Group Facilitators**

1. What has been good about being involved in this project?

2. What have been your experiences of running one of these groups:
   - What do you think participants have taken away?
3. As you know, the project has been based on the principles of Appreciative Inquiry:
   - What did you know about AI before the project began?
   - How would you describe AI now?
   - How was AI helpful to you as a group facilitator in this setting and dealing with this subject?
   - Do you think AI was successfully adopted in your group? - What made adoption easy or more difficult than you imagined?
   - In what ways might AI be applicable to other settings within this Trust

4. Now you have had an opportunity to work with a group for a significant period of time:
   - In what ways do you think this Trust helps to foster and develop professionalism in its staff?
   - Do you think what went on in your group might spill out into other aspects of working as a professional here?
   - How can momentum for fostering professionalism be maintained?

5. Is there anything else you would like to tell me that might help me to understand your experiences of this activity?

3. Directors of Medical Education

Start tape

Name of interviewer and time and venue

Introductions, outline of the interview and reconfirm verbal consent
This evaluation is being conducted on behalf of the London Deanery and aims to discover the contribution of facilitated learning groups towards the development of professionalism in doctors in training, their working colleagues and the organisation in which they work. It will also ask you about your personal views regarding professionalism in doctors in training.
The interview will last approximately 45-60 minutes. If, at any point, you decide you no longer wish to take part in the study let me know.
With your permission the interview will be audio-recorded and fully transcribed and I will be jotting down some notes during the interview.
Excerpts from these transcriptions and field notes will be used in the evaluation report of the research however your identity will be obscured by removing all names and identifying features to the best of my ability in both the submitted report and in any publications arising from the work.

1. Tell me a little bit about your role as DME.
   a. Professional background
   b. How long you have been in this post
   c. What the DME does in this Trust
2. Tell me about what you have heard or seen of the Trust based group to foster professionalism that has been running in this Trust
3. What has been good for the Trust about being involved in this project?
   a. Do you think that many people in the Trust know about this professionalism project?
   b. Do you think there has been an effect?
4. What led you to do medicine?
5. What led you to develop in the area of developing professionalism? Are those conditions still in place? If they have changed, how have they changed?
6. What do you believe to be the role of the DME of a Trust in developing and ensuring professionalism amongst doctors who work here?
7. What aspects of this Trust help to foster and develop professionalism?
8. How can you now support today's junior doctors in developing their concept of professionalism?
9. How do these fit with the service needs of the Trust?
10. In terms of a rounded professional understanding, (beyond the specialty curricula) do you feel that junior doctors are ready for their first consultant posts?
   a. Do you feel that there are some areas where they are well prepared for professional responsibility in their first consultant posts?
   b. Are there some areas where you feel that they are less well prepared for their first consultant posts?
11. If we were rethinking junior doctor training at the Deanery, what should we do differently?
   a. In general
   b. With regards to professional development in particular
12. Finally this was a brief intervention with a small group of doctors:
   a. How can the momentum initiated be maintained in the participating doctors
   b. How can the interest in professionalism be spread out to other doctors in the Trust

4. Project Lead

*Introductions, outline of the interview and reconfirm verbal consent*

This evaluation is being conducted on behalf of the London Deanery and aims to discover the contribution of facilitated learning groups towards the development of professionalism in doctors in training, their working colleagues and the organisation in which they work. In this interview I will ask you about your experiences as the project lead. I will also ask you about your personal views regarding professionalism in doctors in training.

The interview will last approximately 45-60 minutes. If, at any point, you decide you no longer wish to take part in the study let me know.

With your permission the interview will be audio-recorded and fully transcribed and I will be jotting down some notes during the interview.

Excerpts from these transcriptions and field notes will be used in the evaluation report of the research however your identity will be obscured by removing all names and identifying features to the best of my ability in both the submitted report and in any publications arising from the work.

Start tape: Name of interviewer and time and venue.
1. Tell me about what you hoped the project would achieve at the very outset.
2. What has been good about being involved in this project?
3. What do you think have been the outcomes:
   2. for you as project lead
   3. for you as facilitator
   4. for the other facilitators
   5. for the participants
   6. for the Trusts
4. What have been the positive experiences and the lessons learnt?
5. How do you think momentum can be maintained after the end of the project?
6. What do you think are the roles/influences of the DME on this sort of project?
7. What do you dream about the future? What will be the legacy?
8. What do you think the evaluation will say?
9. Anything else that you want to tell me that might help me to understand what this last 9 months, has been like

5. Participants who stopped attending

Introductions, outline of the interview and reconfirm verbal consent

Thank you for talking to me today. I am xxxxx and I work at UCL and we’ve been commissioned to do the evaluation of the London Deanery Professionalism Project. Our main research question is to find out about the ways in which these learning groups might contribute towards the development of professionalism to doctors in training. So we’re interviewing people that took part, people that facilitated the taking part, those who ran the project and also the people who took part and then for one reason or another didn’t take part. So that’s the purpose of this interview. I want to ask you some questions about the group in general, about your motivations for taking part and the reasons behind you not continuing in your group. I have been asking similar sorts of questions to all people who did take part, but obviously I have a few other questions for you. The interview will last approximately 30 minutes. If, at any point, you decide you no longer wish to take part in the study let me know.
With your permission the interview will be audio-recorded and fully transcribed and I will be jotting down some notes during the interview. Excerpts from these transcriptions and field notes will be used in the evaluation report of the research however your identity will be obscured by removing all names and identifying features to the best of my ability in both the submitted report and in any publications arising from the work. Is that all OK?
Start tape: Name of interviewer and time and venue.

Interview questions – non completing participants

1. What were your expectations when you decided to take part in this project?
2. Why you decided not to continue attending your group?
3. How many sessions did you attend before you made that decision/could no longer take part?
4. What did you get out of attending the group session?
5. One of the approaches used was something called appreciate enquiry. What were your feelings about that?
6. What was the composition of the group like? Did it work?
7. What does professionalism mean to you?
8. If you were to design an intervention yourself with regard to professionalism, what, if anything, would you have done differently?
9. What interventions do you think might affect professionalism?
10. Is there anything else you’d like to tell me that would help me to understand your experiences of this particular activity?

6. Follow up participant interviews

Introductions, outline of the interview and reconfirm verbal consent
Thank you for talking to me today. I am xxxxx and I work at UCL and we’ve been commissioned to do the evaluation of the London Deanery Professionalism Project. Our main research question is to find out about the ways in which these learning groups might contribute towards the development of professionalism to doctors in training and you kindly gave us an interview at the end of the sessions. So now we’re interviewing again some of the people that took part to look at the longer term impact and identify any enduring. The interview will last approximately 30 minutes. If, at any point, you decide you no longer wish to take part in the study let me know. With your permission the interview will be audio-recorded and fully transcribed and I will be jotting down some notes during the interview. Is that OK? Excerpts from these transcriptions and field notes will be used in the evaluation report of the research however your identity will be obscured by removing all names and identifying features to the best of my ability in both the submitted report and in any publications arising from the work. Is that all OK?

Start tape: Name of interviewer and time and venue.

Interview questions –
1. Please remind me about your experiences of being involved in the sessions in the -------: What are your abiding memories of that experience?
2. Over the last six months since the course have you encountered any issues concerning professionalism, either your own or the professionalism of others and though about or managed the situation differently?
3. In your first interview -------- you made some comments: I wonder if I could ask you about them now?
   a. you said -------------------------------
      ---------- about professionalism. do you think the same now? how has this affected your behaviour?
   b. you said -------------------------------
      ---------- Have you thought about or used AI since the course?
   c. you said -------------------------------
      ----------about being an advocate. Have you had any opportunities to do this?
4. (some of these questions may already have been answered in 3. if so just move onto the relevant unaddressed sections) I am interested in what you see might be the enduring effects of participation:
   a. how do you think it has affected you or the way you work?
   b. what effect if any does this have on your colleagues?
   c. on your patients?
   d. on the Trust in which they work?
5. One of the outcomes of attendance was becoming an advocate: what is the reality of that situation?
6. Now you have had time to reflect about your experiences: what can Trusts and the Deanery do to foster professionalism?

Appendix 3: Observation schedules

Observer Plan

Context:

- Non participant observer
- Sit outside the group
- Remain unobtrusive; try to deflect any comments or questions back to group/facilitator but may need to answer questions concerning observation, nature of notes, confidentiality/anonymity etc.

Activities:

1. Introductions and explanation of role in session
2. Verbal consent
3. Details of room and participants
4. Use checklist and detailed written notes with timings where appropriate
5. Overview of session: brief description of the session produced as session unfolded and completed at end of session
6. Record of key events and powerful comments with record of time and involving whom:
   a. Page 1: what
   b. Page 2: reflections in action
7. Completion of observation checklist
8. Reflections after action /any other comments
<table>
<thead>
<tr>
<th>103</th>
<th>AI Observation schedule</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
</tr>
<tr>
<td>DISCOVER</td>
<td>Active choice of the positive as a starting point for dialogue</td>
</tr>
<tr>
<td>DISCOVER</td>
<td>Use of positive questions</td>
</tr>
<tr>
<td>DISCOVER</td>
<td>Acceptance of unconditionally positive answers</td>
</tr>
<tr>
<td>DISCOVER</td>
<td>Positive narratives within the group</td>
</tr>
<tr>
<td>DISCOVER</td>
<td>Identification of factors that made for a positive story/ successful outcome</td>
</tr>
<tr>
<td>DREAM</td>
<td>Creation of a positive view of reality</td>
</tr>
<tr>
<td>DREAM</td>
<td>Imagining a preferred future</td>
</tr>
<tr>
<td>DREAM</td>
<td>Dreaming about what can make it even better</td>
</tr>
<tr>
<td>DREAM</td>
<td>Imagining positive outcomes</td>
</tr>
<tr>
<td>DESIGN</td>
<td>Identify common themes</td>
</tr>
<tr>
<td>DESIGN</td>
<td>Clarifying what should be</td>
</tr>
<tr>
<td>DESIGN</td>
<td>Move towards generative</td>
</tr>
<tr>
<td>DESTINY</td>
<td>Encouraging creativity to implement plans</td>
</tr>
<tr>
<td>DESTINY</td>
<td>Creating shared visions / things forwards</td>
</tr>
<tr>
<td>DESTINY</td>
<td>Innovative ideas to foster professionalism</td>
</tr>
</tbody>
</table>
Appendix 4: Pre and post intervention questionnaires

Questionnaire before pilot project on professionalism

Please complete this questionnaire before the first meeting and bring it with you to the meeting.

Name       Date

Please complete the following sentences

My current definition of professionalism in medicine would be....

My reasons for participating in this pilot project are ..... 

My hopes for the professionalism project include...

My previous learning on the topic of professionalism has included...
My understanding of appreciative inquiry is....

On a scale of 1 – 10 please score where you see yourself in relation to:

Understanding the nature of professionalism
1 2 3 4 5 6 7 8 9 10

Your desire to improve your own professionalism
1 2 3 4 5 6 7 8 9 10

Your need to develop your own professionalism
1 2 3 4 5 6 7 8 9 10

Your confidence that there will be positive change in your own professionalism in future
1 2 3 4 5 6 7 8 9 10

Your capacity to influence change in others’ professionalism
1 2 3 4 5 6 7 8 9 10

Any other comments (continue overleaf if you wish)
Questionnaire following participation in the pilot project on professionalism

Please complete this questionnaire during or after the final meeting and hand it into your facilitator.

Name (optional)      Date

Please complete the following sentences

My current definition of professionalism in medicine would be....

My understanding of appreciative inquiry is....

The things I gained from taking part in the professionalism project include....

The things that may change in my practice having taken part in the professionalism project include...

On a scale of 1 – 10 please score where you see yourself in relation to:

Understanding the nature of professionalism

Your desire to improve your own professionalism

Your confidence that there will be positive change in your own professionalism in future

Your capacity to influence change in others’ professionalism

Any other comments (continue overleaf if you wish)
Evaluation of London Deanery pilot project: Trust-based learning groups to foster professionalism

Bids to a maximum value of £20,000 are invited for research to evaluate a pilot project to foster professionalism in doctors in training through participation in Trust-based learning groups.

Background

Professionalism has become a central theme in postgraduate medical education. It has been a focus for a range of recent official documents including PMETB \textit{Standards for curricula and assessment systems}, the national curriculum for the Foundation Programme and the generic curriculum of the Academy of Medical Royal Colleges. These and other regulatory and official bodies take a broadly ‘competency based’ approach, generally relating this to standards set in guidance from the General Medical Council, especially \textit{Good Medical Practice}.

At the same time, many medical educators are challenging the competency-based model of professionalism, promoting instead a more ‘ecological’ and evolutionary approach, with an emphasis on the need for doctors to find meaning and value in their work, as well as the need for organisational and cultural change to go alongside positive support of trainee doctors in developing professional values.

In August 2009 the London Deanery appointed a lead associate director for professionalism, to work with the lead director for professional development (whose role covers leadership, organisation and generic learning). This appointment coincided with a request from the heads of speciality schools for the Deanery to deliver trainings in trusts to address professionalism. The appointment also coincided with the decision of NHS London to implement a strategy that will separate the current functions of the Deanery into commissioning and providing. An important part of the commissioning function will be to work with providers including acute and mental health trusts to develop their own capacity to offer postgraduate education and training in a way that reflects sound adult educational principles, particularly with regard to the ‘informal curriculum’ and effective supervision and support for trainees.

The aims of the professionalism programme are therefore as follows:

- To promote a fuller understanding of professionalism, reflective practice and patient centred care among doctors in training in London.
- To make a contribution to the London Deanery project ‘Leadership, Organisation and Generic Learning’.
- To meet the requirements of the Directors of Foundation Schools and Heads of Specialty Schools for trust-based trainings addressing the generic curriculum.

A project team has now been set up to pilot learning groups for doctors in training in five London trusts. The chosen intervention is based on concepts from the fields of Appreciative Inquiry, Complex Responsive Processes, and Emergent Design (see project description, attached with references).

The objectives of the pilot project are:

- To develop a method of training that helps trainees gain a fuller understanding of professionalism, reflective practice and patient centred care.
- To evaluate Trust-based learning groups as a contribution to the continuing development of professionalism in all its aspects among doctors in training.

Method
To establish learning groups in five London NHS trusts in order to foster and promote an understanding of professionalism in the workplace. Each group will include around twelve doctors from a range of specialities including foundation year doctors, speciality registrars and SAS grades. The groups will meet with a trained facilitator once a month for six months. They will provide an opportunity for participants to consider professionalism in all its aspects, reflect on their own professional practice in its context, to consider what gives meaning and value to medical work, and to explore how to make a difference to patients and their families, colleagues, teams, the organisation and local networks. Participants will receive a London Deanery certificate as ‘Advocates for Professionalism’ on completion of the pilot programme.

Research questions
The primary research question is:
- What do facilitated learning groups of doctors in training contribute to the development of professionalism in doctors, their working colleagues, and the organisation?
Subsidiary questions that it is hoped the research project will address will include:
- What are the actual learning outcomes of participation in a trust-based learning group?
- How well have the reported learning outcomes matched the anticipated objectives?
- How did participation in the group contribute to trainee learning?
- What professional beliefs and values are developed through group membership?
- What additional value, if any, is brought both to the Trust and local foundation and speciality training programmes?
- What effect if any has participation had on the career and personal aspirations of participants?
- What practical issues have arisen for participants and Trusts as a result of the project?
- What ethical, employment and legal issues have arisen for participants and Trusts as a result of the project?
- What do stakeholders perceive that would improve future iterations or developments of the pilot project?
- What additional activities if any do stakeholders consider are needed to address the aims of the professionalism programme?
- What can be learned from the interactions of the stakeholders (including the project team, facilitators and expert panel) in relation to the approach adopted, and any tensions or dilemmas that emerged as a result?
- What can be learned from the pilot project as a whole to inform embedding the continuing development of professionalism in all its aspects across all training programmes?
- What recommendations can be made for longer term follow-up?

Methodology
In view of the small numbers in the pilot project and nature of the research questions, a mainly qualitative methodology will be required. The research team will be expected to develop their design in partnership with the project team and other stakeholders including the group facilitators. They will need to have an understanding of different constructions of professionalism and how the interplay between these might be captured in an evaluation. Some quantitative data may be available including attendance figures, as well as qualitative data such as themes raised in the learning groups and reported at the facilitators’ meetings, and written feedback from participants at the end of the project. Bidding organisations should therefore propose how they might balance qualitative and quantitative measures, in a manner aligned with appreciative inquiry and emergent design. Bids should identify the ‘added value’ they would bring to the overall purpose and process of the pilot project.

Intended outcomes
We envisage that the outcome of the pilot will be a report of publishable quality that will be disseminated throughout NHS London and the UK to support future developments in postgraduate medical training. The report will be submitted to a peer reviewed journal for publication.

Time frame
In order to enable the gathering of data from this first cohort of participants, the final report should be gathered by July 2010.

Bids
Bids should be structured under the following headings:
- Principal researcher and team – brief biographical details
- Institution – brief outline of institutional support available
- Evaluation outline plan with timeline
- Method(s) – description of data collection methods to be used
- Analysis – description of data analysis methods to be used
- Ethics – description of how ethical requirements will be satisfied
Costings – full costs to be included

**Deadline**
Bids should be received by **Monday November 30th 2009**
Please send to:
Dr John Launer MA MRCGP
Associate Director and Lead for Professionalism
Faculty Development Unit
London Deanery
Stewart House
32 Russell Square
London WC1N 5DN
[John.launer@londondeanery.ac.uk](mailto:John.launer@londondeanery.ac.uk)
Appendix 6

Research outline and timescale

January 2010:
1. Meeting with the project team and group facilitators to discuss:
   issues concerning constructions of professionalism of the project and research teams
   the extent to which AI and emergent design will inform and shape data collection
   and analysis.
   the progress of the project so far (as it is expected that some facilitated groups will
   have already taken place).
   This will also be an opportunity to negotiate an understanding of these meetings as
   data, and the nature of any planned interviews with participants and education
   representatives within the Trusts.

2. Submit request for ethical approval in the five contribution Trusts.

3. Evaluation team meeting to construct proformas for evaluation, arrange interview
   schedules for participants, group facilitators and education leads at Trusts drafted
   and piloted.

February – May 2010
Data gathering stage 1

June –July 2010
1. Data analysis stage 1
2. Meeting with project team to discuss initial data analysis and emergent themes
   from both evaluation and from group meetings. Negotiation of next stage of data
   collection.

July-October 2010
1. Validate transcripts
2. Continue with data analysis
3. Complete project report and check with project lead on detail style etc.
4. Agreement of a proforma for follow up telephone interviews and selection of
   ‘telling cases’.
5. Collect administrator data where required
6. Start writing evaluation report

November 2010
Data collection stage 2: telephone interviews

December 2010
1. Data analysis stage 2
2. Validation of results with contributors
3. Completion of evaluation report
<table>
<thead>
<tr>
<th>Item</th>
<th>Price</th>
<th>Total</th>
</tr>
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</table>
| Academic attendance at development meetings    | 5 x ½ day @ £500 per day  
5 x ½ day @ £350 per day | £1,250  
£875       |
| Academic time –one to one interviews           | 10 x ½ day @ £350 per day  
10 x ½ day @ £500 per day | £1,750  
£2,500     |
| Academic time –observations                    | 5 x ½ day @ £500 per day                  | £1,250  |
| Academic time –follow up telephone interviews  | 10 x 2 hours @ £350 per day               | £1,000  |
| Academic time- analysis/report writing         | 42 hours @ £500 per day  
21 hours @ £350 per day                | £2,625  
£1,050     |
| Administrative support                         | 4 sessions per month for 6 months.        | £1,284  |
| Transcription of interviews                    | 80 hours @ £20 per hour                   | £1,600  |
| Transcription of focus groups                  | 28 hours @ £20 per hour                   | £560    |
| Transcription of telephone interviews          | 40 hours @£20 per hour                    | £800    |
| Refreshments for focus groups                  | 5x £25                                    | £125    |
| Travel expenses                                | £8.00 per interview, meeting or observation | £296    |
| Nvivo Software packages for 1 computer         | 1 x £138                                  | £138    |
| Sub total                                      |                                            | £16,448 |
| UCL levy (20%)                                 |                                            | £3,289.60 |
| Total cost of evaluation                       |                                            | £19,733.60 |