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ENGAGE, ENERGISE, ENRICH, EVALUATE – a practical guide to medical education

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DEDICATION

This book is dedicated to all the many medical educators who spend so much time trying to help others learn. Theirs is an act of great generosity; even professional educators spend far more hours than they are paid for preparing pondering and evaluating. Those who educate as an "add on" to their main job, often do so for no pay at all, yet may spend hours at weekends or in the evening preparing educational sessions for their learners. In that same spirit I offer this modest contribution; a recipe book of tried and tested methods that can be used to improve the effectiveness and value of education in health care settings.

ACKNOWLEDGEMENTS

I would like to thank Rebecca Baron for her encouragement to embark on this project and Bob Kirk for supporting it at HEENW. I would like to thank Sally Howorth for helping to disseminate it, make it available to all North West Educators, and for all the meticulous work she has put in behind the scenes to enable us to work effectively as educators.

I would also like to thank my family for encouragement and for tolerating my absence to write and for their cheerful interest in what I am doing.

Finally, but most importantly I would like to thank two groups of people.

Firstly, my fellow GP educators who have taught me so much about how to be an effective educator in many contexts, from one to one in tutorials, through to small group and large group sessions and even helped me understand how to present in very large groups. At every encounter with another educator I have learned something valuable. This makes you as a group far too numerous to name; please know I have learned from you all.

Secondly, I would like to thank the participants who I have worked with over many years, who probably now number hundreds if not thousands. You have tolerated my experiments, given positive (and brutally negative) feedback, which has helped me learn so much. You have been a delight to get to know as individuals, as well as participants in groups. Nothing makes me happier than to see previous participants becoming effective educators themselves, or to hear that other educators are developing techniques even further.

To all of you, MANY THANKS and HAPPY EDUCATING!

INTRODUCTION

This manual came about because I am interested in the development of the next generation of medical educators, especially those training in the context of General Practice.

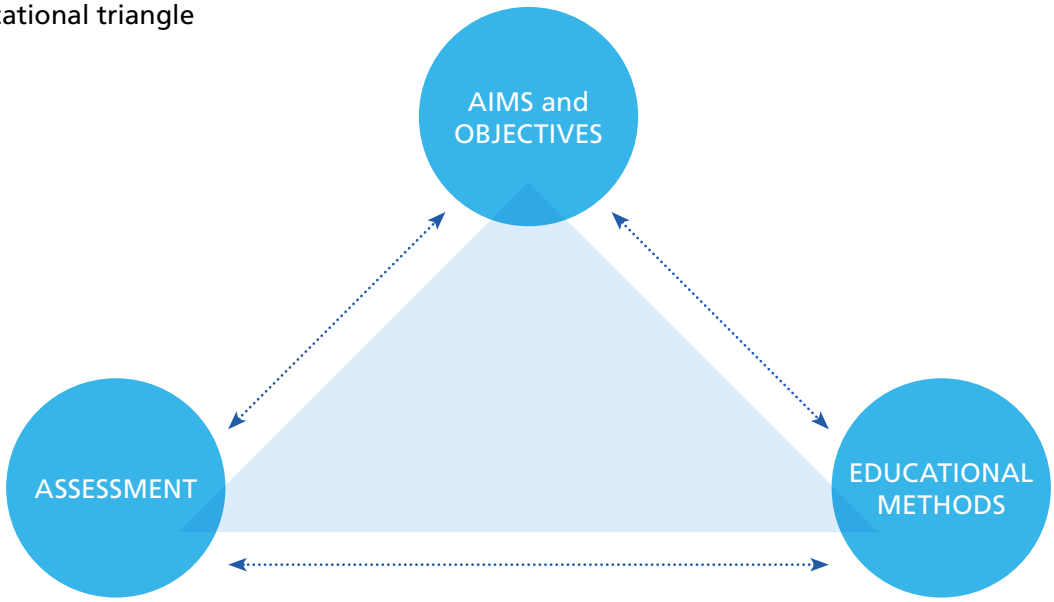
While new educators are better trained than ever, there is the potential for good ideas and techniques to be "reinvented" and useful techniques and ideas to be lost when older educators hand over to new ones.

I would like to share some of the methods I have found most valuable, to make them easily available to anyone embarking on any kind of educational event in a health related context. This could be training professionals, such as doctors or nurses, it could be training staff in a general practice or Primary Care Team. There is no one size fits all, the techniques and methods are like the raw ingredients in a recipe. When cooking you need to know how ingredients work and what they are for. The methods in the ENGAGE, ENERGISE and ENRICH sections are like a cooks ingredients. The EXAMPLES and EVENTS sections give a few examples of how these "ingredients" are combined to make a nourishing educational "meals". Creative cooks/ educators can have free reign here!

My urge to write this all down emerged after reading several textbooks on medical education which said things like, "interactive methods are better for this" (Reference 3), without actually spelling out what such a method might actually consist of, or what skills would be necessary to carry it out successfully.

In medical education circles, Education 101 goes like this; there is a thing called the educational triangle and when planning education, you can basically start at any point and work round to help you ensure all bases are covered in your plan.

Educational triangle



The **AIMS and OBJECTIVES** of medical education are really defined by the curriculum for that area of work; for a given educational session or for an educational programme, the subject matter is likely to in some way derive from this curriculum. Of course a curriculum is a tricksy thing. The formal curriculum is usually clear and open to all to see. The website of any Royal College has a myriad of relevant documents. However, the aims and objectives of any training become less clear cut when two other curricula are considered; the informal curriculum and the hidden curriculum.

The **informal curriculum** includes all those things which are understood to be important to learn, but which are not necessarily written down formally. This includes all the behaviours that reinforce and transmit the attitudes, norms and beliefs about what being a clinician is all about, and how that should be demonstrated in how we speak, dress and behave.

For example, there may be no formal teaching or curriculum about what to wear or how to speak to fellow clinicians, especially in between formal events such as break times or in the canteen. This type of curriculum is *imbibed* rather than taught. Although the informal curriculum is not necessarily explicitly taught it may be transmitted by role modelling by seniors, via peer pressure, and via the implicit expectations that educators have of participants. For example, the manner in which a clinician speaks and works with fellow clinicians and team members will be observed by learners and the overall style and approach absorbed without much explicit instruction. Observing seniors responding to requests for help, or examining patients sensitively, are examples of where an informal curriculum is coming into play.

The **hidden curriculum** is not overtly stated, but expresses the priorities, deeper beliefs and practices of the environment or institution. The aims of the hidden curriculum are not explicitly articulated and yet are woven through all the practical and educational experiences that participants have during their training. For example, a hidden curriculum could include the expectation that learners strive for, and that they are capable of, excellence. In contrast, the expectation could be that clinical practice is too difficult to do well and that "getting by" is all that is reasonable.

It is obvious that those contrasting attitudes in the hidden curriculum will have very different effects on participants' views of themselves and what their training is *for*. The hidden curriculum is *felt* rather than expressed and can have a variety of effects. If participants do not have a sense of belonging or of being valued in their working environment, their commitment and learning will be adversely affected. This can happen without anyone needing to state anything openly. If women are groped in their medical school (yes it does happen) the implicit message is that "you do not matter much". If all informal events involve alcohol, the implicit message can be read as "you need to be like us to succeed", or "non-drinkers are not really welcome".

When we plan educational events, we take account of the formal curriculum requirements as a matter of course. When we choose our *learning methods*, (the subject of this book), we are often expressing the informal and hidden curricula, the priorities, attitudes, beliefs and values we are signing up to educationally. The subject matter we prioritise (clinical knowledge or skills development? Ethical understanding or regulatory compliance?), the educational methods we choose, (lecture or interactive small group work?) will both *imply* the curriculum and become part of the way in which it is delivered to participants. The formal curriculum of the Royal College of Surgeons includes aspects of communications skills, including the need to communicate effectively with relatives and other team members; if these matters do not appear on surgical training programmes the hidden curriculum is "this is not so important" and "you do not need training for this, you will pick it up somehow".

General Practitioners may have other "hidden curricula" such as "the main thing is to finish on time" or "patients do not really want shared decision making", or "we have to follow the guidelines all the time".

Thus, while the nature of what is to be taught is often very clear from the formal curriculum, how we teach and how we choose priorities, must take into account our desired and intended informal and hidden curricula when planning our educational events. In the main, this book does not cover the content of the education; that is outside my scope here. The methods can be mixed and matched to teach subjects as disparate as consultation skills, the surgical treatment of appendicitis, sepsis, professionalism, fitness to practice or the biochemistry of antihypertensive drugs. Having decided the content, the educator can then choose appropriate methods to enable effective learning.

In order to create effective education, **ASSESSMENT** clearly plays a large role. The level that any given teaching experience aims at is determined by assessment of the level of attainment the participants are *currently* achieving. Clearly, the approach for a medical student in their first week needs to be different to that used in providing education for a senior and highly qualified Advanced Nurse Practitioner. Deciding how to work out whether your learners have reached the right standard is covered by assessment processes specific to the context. In General Practice, for example, examinations (Applied Knowledge Test, Clinical Skills Assessment), competency based Work Place Based Assessments (using Consultation Observation Tools, Case Based Discussions) and portfolios which log learning and reflection, are all used for assessment. Many participants are also subject to other assessments such as 360 degree or multi-source feedback. If things go a bit pear shaped, patients are more willing than ever to make complaints and give feedback. Most educators should have a pretty good idea of the level to which training should be pitched.

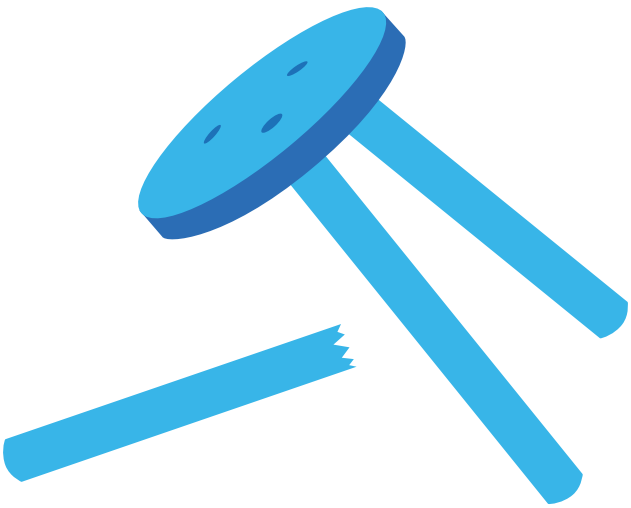
However, at Post Graduate level, participants often vary in their specific learning needs; a matter which seems easy for one participant (for example helping a person change their drinking habits), might seem daunting to another. For this reason, the techniques described in the ENGAGE section help educators assess the specific learning needs of the group of participants they expect to be working with.

If AIMS and OBJECTIVES and ASSESSMENTS are generally well covered and familiar, the choice of **EDUCATIONAL METHODS** can sometimes be given rather less attention. Instead of a robust educational triangle we sometimes experience something more like a broken three-legged stool, where the wobbly third leg represents the EDUCATIONAL METHODS most appropriate to the tasks of Assessment and delivery of educational objectives.

If the third leg, the METHODS leg is unstable, it will be hard to create robust education that delivers its objectives. Why does this matter? After all most trainees/learners pass their exams eventually and become employable in their professional role. I think the delivery of education, using the best and most appropriate educational methods, matters for the following reasons:

- **Training time is limited** – effective teaching methods make better use of this limited time, i.e. effective methods achieve larger effects.
- **Effective methods are quicker** to use than some conventional techniques such as the PowerPoint accompanied lecture.
- **Effective methods are easily acquired by learners themselves** – the result is that participants become more effective life-long learners. This can help to maintain professional development over their careers.
- **Effective techniques can be used across the board** – the effectiveness of learning in multidisciplinary teams, professional partnerships and working with patients groups van all benefit from the use of effective educational methods.
- **Effective methods deliver better informal and hidden curriculum objectives** – effective methods support rather than undermining desirable informal and hidden curricula.

Broken three-legged stool



The educational methods described in the sections of this manual have a close relationship to the skills that are used in the consultation. Building a rapport with a patient, listening and really hearing what a patient has to say, working with their agenda and using skills for explaining and helping patients retain information, have a lot in common with the skills of required for an educational encounter. Furthermore, many of the skills that make for effective education are the same skills that make for effective teamwork. This is another example of the synergy between educational skills and the skills needed in clinical practice.

Just as training for effective Consultation Skills draws on a systematic approach to teaching, learning and assessing skills, the techniques described here are presented in a systematic way. However, in this manual, the skills are those needed when a medical educator works with groups of participants. Many skills needed in consultations (listening, summarising, and being patient centred) are similar to the skills needed when running education for groups (and indeed individuals). Doctors with skills in the consultation will find that these skills are transferable to an educational context. This has the potential to make acquiring educational skills easier and quicker – a big bonus. The educator will also find that the skills acquired in education will be useful in their local teams.

How do the skills of the consultation relate to those used in education?

ENGAGE

In the consultation we need to establish rapport and understand why the patient has come to see us. In a similar process, at the start of any education session, we need to ENGAGE with the learners, developing a rapport with them, and assessing what it is they are able and willing to learn that day. These methods encourage participants and educators to work together, create interest and motivation for learning, via the exploration of common agendas.

ENERGISE

As a consultation develops we have to constantly be aware of what the patient is concerned about, so as to maintain and develop the relationship in an effective way. As education sessions develop we need to maintain interest and commitment by using techniques that ENERGISE participants. These techniques maintain motivation and interest throughout training sessions and present information in ways that generate energy (and even excitement). This keeps participants on track. The benefits of educational time are maximised if everyone is awake throughout, everyone participates and no one loses interest during the session.

ENRICH

As the relationship deepens with a patient, our understanding of their predicament becomes more complex and we need to explain things, exploring the realistic application of our proposed management plans. Similarly, as teaching sessions develop, we can use techniques to ENRICH the content, to enable it to go deeper and work at different levels. This is especially valuable when there are learners at different stages in a group (for example a Primary Health Care Team, or a learning group with participants at different stages of training). Identifying ways to engage with formal knowledge and attitudes and values, deepens the range of possible learning from a session. Using hierarchies of learning when planning, can engage learners at different levels, while still creating education that benefits all. Using a wider range of methods avoids death by PowerPoint. Enrichment techniques can also promote reflection on participant's experiences and reinforce learning.

EVALUATE

Finally, after every consultation there will be at least a moment of reflection ("that went well" or "that was not my best moment"). This corresponds to the EVALUATE process of education; there are many different ways to do this effectively. Going beyond the tick box "Did you have a good time?" or "Did they pass the exams?" can enable educators to make sure that their work is linked to the reality of clinical practice, is fully absorbed by participants and can lead to important improvements in subsequent training interventions.

There are two tasks that run throughout any educational session; developing **relationships** with participants and attending to the **structure** of the session.

Throughout consultations and throughout education sessions we are always creating inter-personal relationships. In a consultation it is the one to one relationship that is the key. In education sessions it is more complex, as there are two tasks; we are constantly developing and monitoring the relationships between the *educator and the participants*, and the *relationships amongst the participants themselves*.

These relationships are a key way to support and enrich the learning process. Healthy relationships create a sense of belonging, encourage commitment to learning and to the learning of others and can enable learning to go to higher and more complex levels. All educators need to develop relationships with participants of appropriate intensity, to build the attention, rapport and commitment necessary for effective learning. This includes role modelling, showing genuine interest in participants as individuals, and working to promote learning in all participants. Participants can tell if you don't really care; nothing puts them off more. Poor relationships in the training session results in poor educational outputs.

Tuckman described the stages of team or group work as being "Forming, Storming, Norming and Performing" (see Reference 5). Tuckman later added "Adjourning/Mourning "which is the stage when a team or group break up having completed their task, (see ENRICH Endings). Although the term "team" is used by Tuckman, the same processes occur in educational groups that meet over time. Successfully "Performing" educational groups pay greater attention to the relevant tasks and provide effective support to the learning of all participants. This creates the potential for greatly improved outcomes. Methods to improve group work in education can be very profitably used in practice and other teams too. This is another example of the synergy between professional skills used in clinical work and the educational skills acquired by educators.

In a consultation, we are constantly attending to timing and structure, using signposting and nudges to help us make best use of the time available, for example, saying, "before I examine you is there anything else I need to know?" or "before you go, can we just go over the plan?". Education sessions also benefit from having the structure overt and signalled to participants; this helps participants to:

- **anticipate** when new things are going to happen
- **understand** the purpose of any practical exercises
- **ensure** that the material will be covered in a timely way
- **experience** an atmosphere in which they are "held", with a clear sense of direction.

Educators need to be skilful in knowing when to spend time on an important issue raised unexpectedly, and when not to get bogged down. Dealing with difficult participants needs skill; if left unchecked the learning of others can be compromised.

I have summarised these processes in Table 1, see below.

Table 1

	Stage of the educational intervention	
↑ Develop the relationship with the participants ↓	ENGAGE at the start to get learners and teachers working together and to establish the relevant agenda for the process.	↑ Attend to the structure of the educational programme and make this explicit to participants ↓
	ENERGISE throughout the intervention using techniques that maintain interest.	
	ENRICH the experience by using varied techniques that enable working at different levels, exploring knowledge skills and attitudes.	
	EVALUATE effectiveness during the intervention and afterwards using techniques to promote reflection and improvement.	

This manual is arranged in sections, each one with a brief introduction to the general principles, and then detailed descriptions of specific techniques to ENGAGE, and ENERGISE participants and to ENRICH and EVALUATE sessions. There are additional sections describing how to combine educational methods together to make whole sessions in the EXAMPLES AND EVENTS section. Finally, there is a list of handy resources.

The individual chapters in each section are laid out as below:

- Name of method
- What it is for?
- When to use it
- The set up: how to use this method
- Explanations/timings
- The debrief: maximising the benefits
- Equipment/resources needed
- Skills to make this work even better
- Pitfalls/when NOT to use this method
- Applications in other areas of the session
- How does this help to build relationships?
- How does this help to structure the education?

Part of the skill of effective postgraduate education is to be able to combine clear and structured aims, objectives and processes which still allow for unpredictable and spontaneous outcomes; the educator facilitating the group to work effectively towards clear educational goals. If this sounds a bit puzzling, all will become clear when you read about the potential activities in this manual and start trying them out for yourself.

Part of the art of education is developing a knowledge of different methods, knowing when to select a particular technique, how to vary it according to circumstances and when to avoid it. Preparation and planning are essential; on the day even the best laid plans may get waylaid by circumstances, such as participants distressed by a painful incident on their team, the imminence of exams, a change in official guidance that alters what you want to convey. In these situations the educator is like a musician – well prepared after practicing scales, technical exercises and also full musical pieces, who is also like a jazz musician, who is able to improvise within a formal and well prepared structure.

Style plays a part here too; some educators, like some musicians or some cooks, are more comfortable with pre prepared plans and scripts (like scores or recipes), which they bring to life with their own interpretation and input. Others can improvise from whatever material is available. The skills involved are the same but used differently. Educators can be very flexible about how they approach their work, as long as there is an underlying understanding of WHERE they want to go (the aims and objectives, the curriculum), HOW they are going to get there (the educational methods they will employ) and HOW they will know whether they have arrived (evaluation and assessment).

Does this matter? Do educators need all these special skills? Isn't enthusiasm and a passion for teaching enough?

Educational skills make education more effective for learners, and undoubtedly more interesting for educators, as they develop a range of educational methods. Using methods appropriately opens up educational riches, mobilising the energy and resources of the participants in ways that stay in the memory and enrich the experience of educator and learner alike.

One of the most gratifying things that a patient can say is "thank you for listening". As educators we could be aiming not simply for our participants to listen but also to remember, to be inspired and to acquire the tools to ensure their own continuing professional development. I hope these methods in a very small way will help to make education more interesting and more effective. The payback for this is sometimes long delayed, but nothing is more gratifying to an educator when someone says:

"I was in your sessions years ago when you got me thinking … and I have not stopped thinking ever since."

Glossary

Educator – the person responsible for planning, organising, supervising and facilitating educational events of any kind.

Participant – the people who come to the educational events.

Group – all the participants present.

Sub group – a smaller number of participants, when the main group is divided into smaller units.

Facilitate – what an educator does to promote learning in participants.

Time budget – the (strictly limited) time available for the education, whether in one session or over a period of training.

Session – a single educational event such as a one hour event, half or full day training event.

Programme – a series of educational sessions, combined over time to deliver a curriculum. For example, a Study Release Training Programme, or a postgraduate training programme delivered in several modules over time.

Resources and references

Formal, Informal and Hidden Curricula; some perspectives.

http://student.bmj.com/student/view-article.html?id=sbmj.j3287

The risks of following the informal and hidden curriculums

How following the unwritten rules of medicine can cause professionalism dilemmas and emotional distress. Marika Davies

http://website.aub.edu.lb/fm/shbpp/Documents/The-Not-so-hidden-curriculum.pdf
Thalia Arawi

Teaching Made Easy; Mohanna et al; Radcliffe, Oxford 2014

Skills for Communicating with Patients; Silverman et al; Radcliffe, Oxford 2005

There is a quick summary of Tuckman's ideas about Forming, Storming, Norming and Performing here:

https://www.mindtools.com/pages/article/newLDR_86.htm

and a useful Wikipedia section here:

https://en.wikipedia.org/wiki/Tuckman%27s_stages_of_group_development