# Persuading Foundation Doctors to become Psychiatrists

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## Introduction

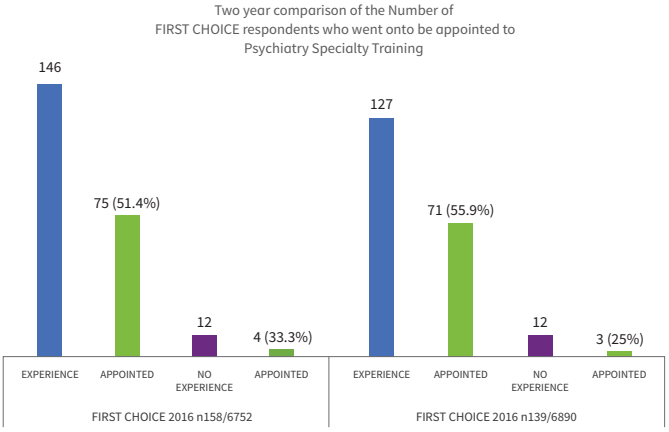
One of the four stated aims of the UK Foundation Training Curriculum in 2016 was to provide foundation doctors with a variety of hospital, community and academic workplace experience. In particular regard to this aim it is also stated that all foundation doctors must have opportunities in a community setting and that by 2017 45% of trainees will have a placement in psychiatry. The data from the 2017 UK Career Destination survey tracks the trainees perspective for achieving this aim, and considers the effectiveness of 'experience' (rotations and tasters) during foundation in increasing recruitment to this specialty.

| UK Foundation Programme Psychiatry Rotations 2010 to 2017 | | | | |
|---|---|---|---|---|
| YEAR | General Psychiatry | Old Age Psychiatry | Other Psychiatry Specialties | Total |
| 2010 | 5.1% | 0.4% | 0.0% | 5.5% |
| 2011 | 14.2% | 1.3% | 0.8% | 16.3% |
| 2012 | 4.0% | 1.7% | 0.3% | 6.0% |
| 2013 | 15.4% | 1.7% | 0.3% | 17.4% |
| 2014 | 21.4% | 1.9% | 0.6% | 23.9% |
| 2015 | 26.8% | 2.4% | 0.5% | 29.7% |
| 2016 | 30.6% | 3.2% | 0.7% | 34.5% |
| 2017 | 29.8% | 3.5% | 1.2% | 34.5% |
| Source: UKFPO Annual Report Data | | | | |

Table 1: Rotations comparison from 2010 to 2017,
"The Number of Rotations in Psychiatry are increasing, and when added to Tasters will meet the target of 45% for placements during Foundation".

## Methods

The Destination Survey is a UK national F2 Career Destination survey which annually collects data from outgoing F2 doctors. This Poster study considered the Survey data from 2010 to 2017. The study focuses mainly on the 2017 data. In 2017 a total of n6890 Foundation Trainees were asked to state; their First Choice Specialty at F1, whether they 'experienced' Psychiatry during Foundation Training, and eventual appointment to specialty. We compared the stated First Choices, and reported 'experience' in an attempt to identify the influence of this on appointment levels to Psychiatry Specialty Training.




Graph 1 : For the past two years around half of those who's First Choice was Psychiatry maintained this choice following Experience during Foundation Training


## Results

At the start of F1 n139/6890 (2%) stated that entry to Psychiatry was their First Choice for Specialty Training. 91% of this group had experience of this Specialty during Foundation compared to 41% of those whose First Choice was NOT Psychiatry. The differential for being appointed to Psychiatry, when it was a First Choice, is 31% (neither in favour of experience or no experience). Around 51% maintained this First Choice regardless of whether they had experience during Foundation. The differential for being appointed to Psychiatry when it was NOT First Choice was 3% (in favour of experience). This suggests that although experience during Foundation can have a small benefit in persuading doctors to apply to this specialty, there are other factors which influence specialty choice. Career choices and decision making are based on a number of factors.

## Discussion

This research provides an insight into the influence of experience of specialties during Foundation and the choices new doctors make. Good progress has been made to reach the target of 45% of trainees experiencing a placement in Psychiatry. However this study supports the idea that other activities in addition to providing experience during foundation training are needed to increase recruitment to this and perhaps other shortage specialties.



V4 16/04/18

# Peer-led Mentoring Pilot Scheme

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NHS Grampian

## Why?


**FY2 trainees experience...**

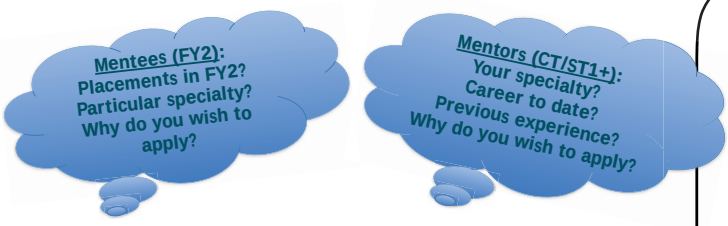
**Good evidence to support mentoring, especially at transitioning stages[1]:**

- Improved working relationships
- Personal development
- Better stress management
- Confidential environment for discussion
- Increased job satisfaction
- Better work-life balance

**... making them the ideal pilot group.**

## How?

**August 2017: pilot opened, which asked applicants for:**




**Mentors and mentees matched according to career aspirations and interests**

**Introductory leaflet for mentee**

**Mentor training workshop**

**September 2017 - January 2018**
**Mentoring meetings (20 pairs)**

**Post-scheme feedback survey**

**Being mentored and invested in career development are deep needs amongst medical trainees that can easily go unnoticed... (JN)**

**There are different perceptions amongst medical trainees as to what mentoring actually is... (GL)**

## What have we learnt?

**Future plans:**

**Two streams have emerged from the pilot.**

1. **A purely career support stream introducing career choices and tasters to foundation year one trainees by near-peers; and**
2. **A generic mentoring stream focusing on building mentoring capacity among trainees across the health board and supporting those engaged in mentoring on an informal basis.**

## What did we find?

**Mentors:**
**13 male, 12 female**
**15 CT/ST1-2, 10 ST3+**

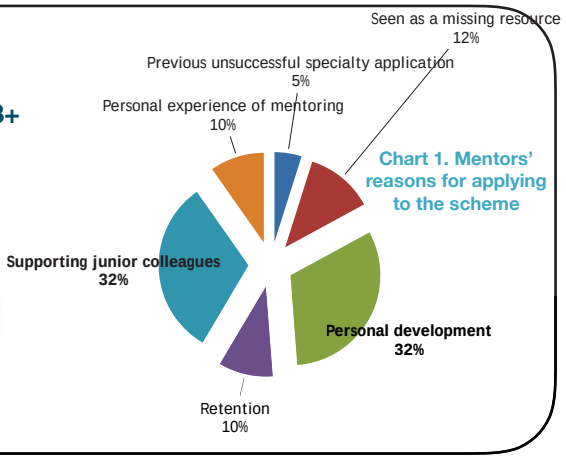




Chart 1. Mentors' reasons for applying to the scheme

**Mentees:**
**8 male, 12 female**

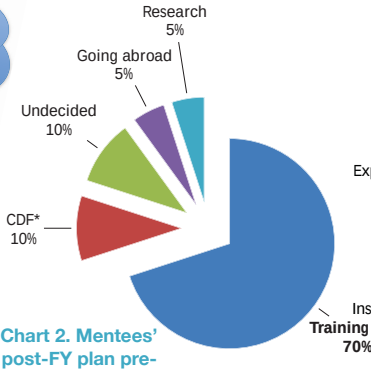



Chart 2. Mentees' post-FY plan pre-scheme

*Clinical Development Fellowship

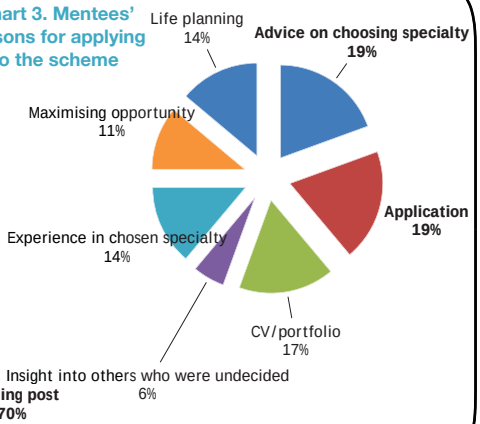
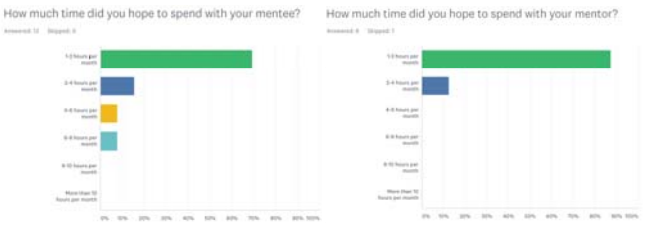
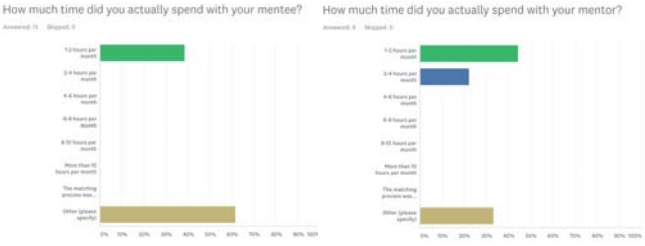



Chart 3. Mentees' reasons for applying to the scheme

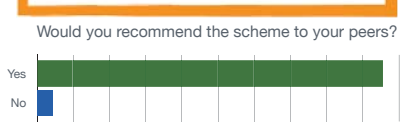




**Perceived obstacles**

- "Mentee was very stressed with work and felt mentoring scheme was too much time"
- "I think that our meetings were at a helpful time for the mentee but geography was the biggest barrier as we were working in different hospitals and cities"
- "Rotas and finding the time. Could this be arranged so that both received study leave to do this in work time?"
- "We were geographically separated so we communicated via email and managed to meet on occasion but yes it was successful and I felt we met an appropriate amount"
- "It's mentee led, they're busy and they're not sure of the value or what to bring to a mentoring relationship"
- "Busy rotas/workload for both of us, difficulty finding time that suited both of us"




**Ideas for improvement**

- "Could meeting time be part of study leave/protected time?"
- "I think the initial pairing-up is the most important aspect. Beyond that, I don't think much more input is required."
- "More training at midpoint"
- "Extend the scheme to peripheral placements eg Elgin"
- "Improve content of training. Run training on more than one occasion"
- "Encourage wider participation by opening it up to trainees who have no idea what they want to do"
- "Open to all trainees not just FY2s"
- "Spread it farther and farther into the Hospital"

**With thanks to Organisational Development and the Medical Education Team at NHS Grampian, as well as our mentors and mentees for sharing this journey with us.**

[1]Wilson G. *et al*, Exploring the relationship between mentoring and doctors' health and wellbeing: a narrative review, Journal of the Royal Society of Medicine 2017 May; 110(5):188-197

# Gateway to Medicine: Widening access to students from remote and rural backgrounds

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## Introduction

The Gateway to Medicine programme (G2M) is a joint venture between the University of Aberdeen and North East Scotland College (NESCOL). The programme, funded by the Scottish Government and supported by NHS Grampian, aims to widen access to students from conventional (e.g. SIMD20) and other (e.g. remote and rural) under-represented backgrounds.

## Methods

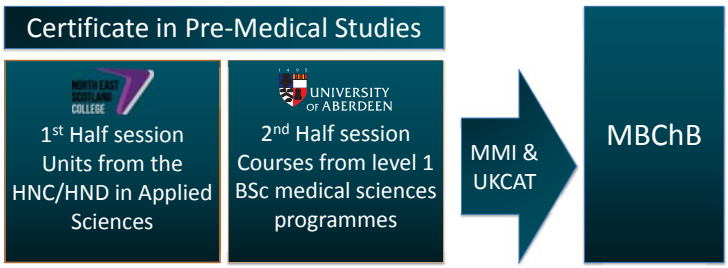
G2M Entry Requirements:

**Academic criteria**
4 Highers at AABB over one *or two* sittings – including any two from Chemistry, Maths, Biology/Human Biology, Physics

**Eligibility criteria**
Resident in an SIMD20 postcode
or is a young person in care/care leaver
or meets a minimum of three from:

- Applicant comes from one Scotland's REACH schools
- First generation applicant to higher education
- Applicant is formally classed as a carer
- Applicant is eligible for free school meals
- Applicant lives in an area that is remote or very remote by the Scottish Government 8 fold Urban Rural Classification
- Applicant is estranged from their family
- Applicant is eligible for the Education Maintenance Award (EMA)
- Applicant can provide verifiable evidence of severe hardship
- Applicant did not speak English when starting secondary school

The G2M Programme:

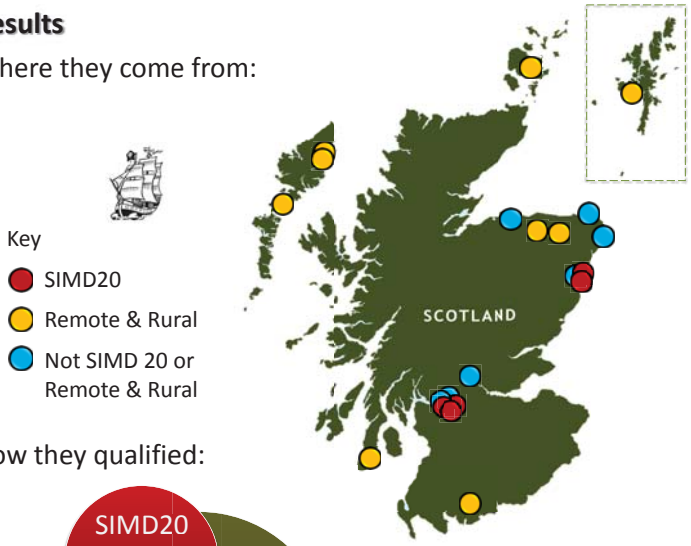



All students

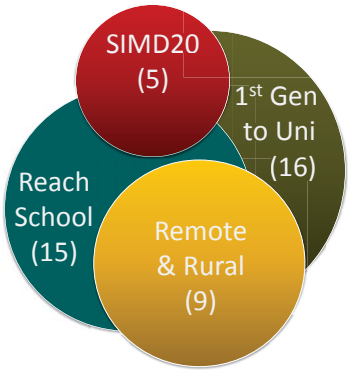
- Are guaranteed a £2000 bursary
- Are supported throughout by a G2M tutor
- Can get work experience via Healthcare Support Worker paid employment supported by NHS Grampian
- Take a course in Health and Health Care in the UK
- Are given training for MMI and UKCAT

## Results

Where they come from:




How they qualified:




21 students were recruited

- 6 qualified outright through SIMD20 and/or leaving care
- 16 were first generation applicants
- 14 came from REACH schools
- 9 were remote & rural
- 12 were eligible for the EMA
- 4 had English as their 2nd language

## Conclusions

The establishment of the programme has resulted in a cohort of students, of which a significant proportion are from remote and rural areas who would not have qualified under the conventional SIMD20 index. Courses of this nature have been running in various locations throughout the UK over the last decade or so, but they have been very poorly evaluated, and evidence of their effectiveness is lacking (Nicholson and Cleland, 2015). We are therefore carrying out a comprehensive programme of evaluation of G2M, to address this gap in the literature and provide useful intelligence to inform the next phase of G2M. This includes qualitative work with all G2M stakeholders, and following up this cohort to explore their experience of medical school, influences on career intentions and ultimate careers destinations. This kind of evaluation is vital in building an evidence base that informs policy and practice.

Nicholson S, Cleland JA. Reframing research on widening participation in medical education: using theory to inform practice. In Cleland JA and Durning S. 2015. Researching Medical Education. Wiley: Oxford, p.231-243.

COME HERE. GO ANYWHERE

# TiMe: Supporting Foundation Trainees to Thrive in Medicine

Dr Lesley Curry, Scottish Clinical Leadership Fellow, 2017-18 NES. Professor Clare McKenzie, Postgraduate Dean NES
Email: Lesley.curry@nhs.net

## Why do we need to make a change?

*'Our shifts are relentless. The medical registrar can't even sit down for 10 mins at lunch without several bleeps.' 'If you're always being pushed beyond your limit your health suffers, your patient care suffers'* *'Being a Junior Doctor', Royal College of Physicians Report, 2016*

Training and working as a doctor in the UK is becoming increasingly challenging. Research highlights multiple problems including workloads, feeling forced to cope, lack of team structures, support and feedback, and difficulty maintaining work/life balance and wellbeing. There is a strong link between patient safety and better staff engagement.

Scotland Deanery established a working group to look at how to equip trainees through challenging experiences, and consider resources to benefit future cohorts of trainees across Scotland.

## How did we approach transformation?

- Scotland Deanery **working group**, led by PG Dean
- **Evidence** search to identify relevant approach by SCLF
- **Co-Design** of course with Foundation trainees and experienced facilitators.
- **Implementation** group led by SCLF.
- Forward planning for future implementation; **faculty development**

→ TiMe Pilot course 2017

→ Supporting website and resources

## Objective of TiMe

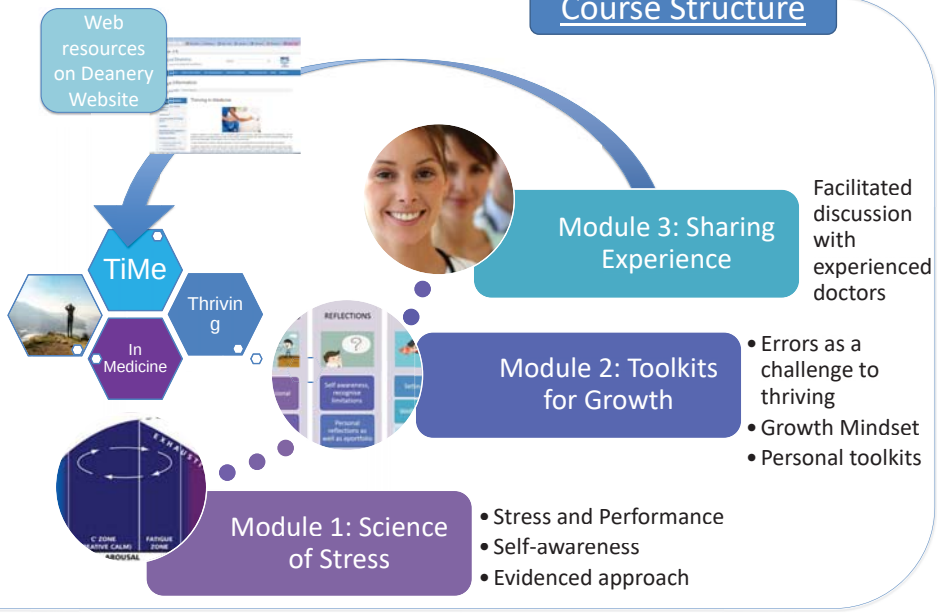
*To improve the skills needed for thriving in a life in medicine*

The structure of TiMe builds from a research basis through to skill enhancement and open reflection. It looks at the relevant stresses and strains in a medical career and their impact on performance. Personal, psychological, emotional and reflective skills for thriving at work are developed, with time for building supportive networks.

Objectives are assessed by:

- Brief Resilience Scale score change (validated scale)
- Course Evaluation (Likert and Free text)
- Qualitative interviews at completion

## Course Structure




## What do trainees think of the course?

Qualitative Interviews

Trainees highlighted the positive aspects they had found:

- Small group size
- Stress management
- Personal stories and strategies from senior colleagues
- Peer sharing of experiences

*'It was nice how honest we could all be and I did not feel judged at all when I was explaining how I felt…I think a lot of it was to do with the senior doctors that were there'*
(Participants 2017)

*'I enjoyed the science behind the suggestions, and appreciate the chance for open discussions.'*

| | Module 1 or 2 Attenders (n=18) | Attenders to Module 3 (n=6) | % Change | Non-attenders to module 3 (n=12, 50% response rate) | % Change |
|---|---|---|---|---|---|
| BRCS (4-20) | 12.45 | 17.2 | ⇑ 38% | 14.5 | ⇑ 16% |
| BRS (1-6) | 2.975 | 3.76 | ⇑ 29% | 3.2 | ⇑ 7.5% |

All attenders increased resilience scores; the biggest increase was seen in those who attended two or more module

## Where next?

- TiMe is now going to be further evaluated in NHS Lanarkshire, NHS Lothian and NHS Tayside using various delivery models, which support the positive features and content.

Acknowledgements: East of Scotland Research Ethics Service; NHS Tayside; NES Resilience Group and Facilitators (Dr Fiona Cameron, Dr Moya Kelly, Dr Alistair Leckie, Dr Liz Murphy, Dr Jerry O'Rourke, Dr Vicky Tallentire, Dr Kim Walker); Dr Judy Wakeling, NES Researcher

# Enhancing opportunities to work in integrated care for general practitioners in Scotland at an early stage in their careers - Setting up the educational framework

## Background

UK population demographics and healthcare requirements are changing, with an increasing population of frail elderly patients and those with multiple long-term conditions.
This requires more care in the community, to provide personalised and comprehensive continuity of care nearer to the patient's home.
Care needs to be coordinated with specialists, primary care, carers and other relevant professionals working in integrated care models with suitably trained teams.

GPs working in this area in the community may need additional skills to work across the interface between primary and secondary care, where boundaries become blurred.
Intermediate care models also need to develop - the proposed model builds upon existing community hospital experience in Scotland, the intention being that transfer of activity results from acute hospitals towards appropriately resourced extended-role community hospitals or "hubs".

## Rationale and Method

New Community Hub Fellowships were set up in late 2015 to enhance the skills of GPs early in their careers as GPs. The focus was to be urgent and acute care at the interface between hospital and community. Two Health Boards in Scotland were involved in the pilot for the first year. The programme comprises a one year GP post-CCT Fellowship year followed by a two year Health Board funded position in a role as a "community physician" in newly developed community hubs.

A stakeholder group from both primary and secondary care met to develop a **curriculum** that included care of acutely ill patients, frail and elderly care and acute psychiatric care, linked to the RCGP curriculum. This is organised in sections, the first being the core curriculum statement, *Being a General Practitioner*, in turn defining five broad Areas of Capability.

Clinical **competency areas** defined by the stakeholder group were linked to **intended learning outcomes** (ILOs) for the fellowship. A framework of educational components was drawn up in a guidance document, designed to address the competency areas and ILOs. Structure to the framework was provided by appointing mentors and scheduling in meetings between fellow and mentor at the beginning, mid-point and end of the fellowship.

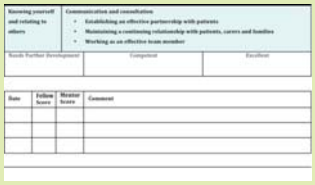
## Intended learning outcomes

On completion, the fellow should be able to:

- Recognise the limits of an individual's ability to recover from illness
- Recognise and manage the escalation of care for patients when required
- Perform capability assessments when required for individual patients
- Effectively manage the appropriate use and interpretation of investigations in primary and secondary care in the Community Hub setting
- Recognise when patients are dying and be able to have conversations around their palliative care with individuals and their relatives
- Manage the appropriate and timely assessment and follow-up of patients in a multi-patient, complex environment
- Effectively lead the multi-disciplinary team (MDT) in discharge planning.

## NHS Education For Scotland Educational Review Logbook

(example of one Area of Capability entry template)




A confidence rating scale would prompt discussion on areas of learning to be prioritised, whilst the mentor meetings would be documented in the educational review logbook. Here self-ratings from the fellow could be compared with mentor ratings, and provide opportunity for formative feedback.

**Evaluation** of the programme was carried out using surveys, interviews, and focus group work, involving all fellows and a variety of stakeholders.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## Confidence Rating Scale for the Community Hub Fellowship

| Common Medical Presentations<br>Be able to provide assessment, initial management and after-care as appropriate | | | |
|---|---|---|---|
| Acute kidney injury and chronic kidney disease – be able to assess a patient presenting with oliguria/impaired renal function, distinguish acute kidney injury from chronic kidney disease, and producing a valid differential diagnosis, plan for investigation, and formulating and implementing an appropriate management plan. Be aware of the methods for delivering renal replacement therapy (RRT) and be able to assess and manage a patient receiving RRT who presents acutely. | | | |
| Aggressive / Disturbed Behaviour – be competent in predicting and preventing aggressive and disturbed behaviour; using safe physical intervention and tranquillisation; investigating appropriately and liaising with the mental health team. | | | |
| Confusion/delirium: assess patients presenting both acutely and sub-acutely with confusion/delirium in the community and hospital setting, formulate a valid differential diagnosis, investigate appropriately, formulate and implement a management plan. | | | |
| Continence – To have the knowledge and skills required to assess and manage urinary and faecal incontinence across health care settings; To know how and when to refer for further specialist advice. | | | |
| Dementia – To be able to assess and manage patients who present with dementia and also to assess and manage patients with dementia who present with other illnesses in acute and intermediate care. To include appropriate referral and liaison with other clinical teams and agencies. | | | |
| Falls – be able to assess a patient presenting with a fall and produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan. | | | |
| Management of Patients Requiring Palliative and End of Life Care – To be able to work and liaise with a multi-disciplinary team in the management of patients requiring palliative and terminal care. To be able to recognise the dying phase of a terminal illness, assess and care for a patient who is dying and be able to prepare the patient and family. To facilitate advance care planning, the establishment of aims of care. | | | |
| Palliative Care – To have the knowledge and skills required to assess and manage patients with life-limiting diseases (malignant and non-malignant) across all health care settings, in conjunction with other health care professionals. | | | |
| Poor Mobility/Unsteadiness / Balance Disturbance – be able to assess a patient presenting with poor mobility, unsteadiness or a disturbance of balance to produce a valid list of differential diagnoses, investigate appropriately, formulate and implement a management plan. | | | |
| **Emergency Presentations** | | | |
| Shocked Patient - be able to identify a shocked patient, assess their clinical state, produce a list of appropriate differential diagnoses and initiate immediate management. | | | |
| **Additional Skills** | | | |
| Ambulatory Care and Hospital@Home settings - Within the training programme acquire the defined knowledge base that defines ambulatory care including the conditions that may be safely treated in this manner. | | | |
| Community Practice Including Continuing, Respite and Intermediate Care - To have the knowledge and skills required to assess a patient's suitability for and deliver | | | |

A **typical working week** would be split between GP and clinical experience in a secondary care setting, with one day of protected time for CPD, academic and leadership work. The academic day would include clinical teaching days, quality improvement project work, a programme to develop leadership skills (integrating with other healthcare professionals), workshops on integrated care, a university-led academic programme, and reflective case-history writing and sharing with peers.

| | | |
|---|---|---|
| Clinical experience in hospital setting | CPD, academic and leadership | General practice, including out of hours |

## Results and discussion

12 posts were available in the two Health Boards (NHS Forth Valley and NHS Fife), and 8 of these were recruited in the first phase.
Less than full time working was an option taken up by two of the fellows.
Protected time was essential for the success of the programme, and flexibility was needed to accommodate the needs of fellows and secondary care clinicians.
Fellows welcomed the educational aspect of the programme and engaged with it well.
A blended learning approach using contrasting methodologies appealed to a variety of learners, and addressed the competencies relevant to the fellowship.

Challenges included

- successful integration of all elements of the fellowship, most of which were developed independent of each other.
- communication between NES and the various stakeholders, where split sites and multiple educators made it more difficult
- delivery of feedback, designed to be formative, could be variable and unstructured
- operationalising the educational framework, as not everyone involved with the fellows were clear as to their respective roles.

## Take home message

The community GP fellowship created considerable interest in an additional career path for GPs and of a new patient care pathway.
Secondary care consultants and colleagues need time for the preparation and teaching of the fellows

www.smerc.org.uk

# Perceived Organizational Support and Career Intentions: The Stories Shared by Early Career Doctors

**Gillian Scanlan[1], Jennifer Cleland[1], Kim Walker[2,3], Peter Johnston[2]**

[1] Centre for Healthcare Education Research and Innovation, University of Aberdeen, UK [2] NHS Education for Scotland, Scotland Deanery, UK [3] Scotland Foundation School Director, UK

## Introduction

In the UK around 50% of those graduates completing the Foundation Programme (FP: a generic two-year training programme between medical school and being eligible to apply for a training [residency] post) did not apply for a training post at the standard point in time[1]. Instead, they opted to take a break from training. The wish to take time out of medical training may be related, at least in part, to a wish for supportive working and learning environments. This in turn appears to be related, at least in part, to a strong desire for supportive working and learning environments[2,3].

However, the nature of this previous research - predominantly survey-based or descriptive qualitative inquiry– means we do not have a good understanding of what a supportive culture means to early career doctors. Nor do we know how their perceptions of support or sources of dissatisfaction may impact their future career intentions. **Our aim was to explore this in UK Foundation doctors.**

## Methods

This was a qualitative study using semi-structured interviews incorporating a narrative inquiry approach for data collection. Interview questions were informed by the literature as well as data from two focus groups. Interviews were carried out in two UK locations. Initial data coding and analysis were inductive, using thematic analysis. We then used the lens of **Perceived Organizational Support (POS)**[4,5] to group themes and aid conceptual generalizability. POS results from the reciprocal exchanges between an employee and the organisation. POS relates to an individual's perception of whether the organization values their work contributions and cares about their well-being[4,5]. An overview of POS and its components is presented below.

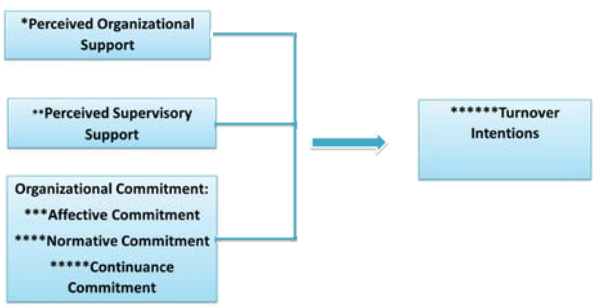


**Figure 1: The theory of Perceived Organisational Support (POS) and its underlying components.**

*** The Perception of support an organization has for their employees. ** The Perception of how much senior support an employee has within an organization. *** The emotional investment and dedication/attachment an individual has towards an organization. **** This component considers the morale conscious of employees particularly their obligation to stay working in the organization. ***** The advantages and disadvantages of leaving an organization. ****** Whether an employee will stay or leave an organization.**

## Results

Twenty-one interviews were carried out. Eleven interviewees had applied for specialty training, while 10 had not. **Support from senior staff and colleagues influenced participants' job satisfaction and engagement. Positive relationships with senior staff and colleagues seemed to act as buffer, helping participants cope with challenging situations. Feeling valued (acknowledgement of efforts, and respect) was important. Conversely, perceiving a poor level of support from the organization and its representatives (supervisors, colleagues) had a detrimental impact on participants' intentions to stay working within the NHS**. These quotes illustrate different experiences (can you guess who applied for a training post, and who did not apply?).

***'I've had a supervisor that has been enthusiastic, and that makes a hell of a difference … She even creates opportunities for you…. And then that leads into feeling valued'***

***'And I have never in my life felt so overwhelmed, and I just… I hated it, I absolutely hated it. I didn't get support; I'd phone the registrar to come in, they came in in the morning for an hour, did a ward round and just left'.***

***'Yeah, so as a whole, I found the foundation experience really disappointing. I've not enjoyed it all as a profession, or as a job. I felt that you're extremely undervalued as an individual, and as a professional'.***

## Conclusion

This is the first study to explore directly how experiences in early postgraduate training have a critical impact on the career intentions of trainee/resident doctors**. We found perceived support in the early stages of postgraduate training - particularly support from supervisors/senior colleagues and team members - was critical to whether doctors applied for higher training and/or intended to stay working in the NHS.** These findings have will provide useful intelligence to those involved in delivering and managing postgraduate training, particularly in contexts that are struggling to recruit and retain doctors.

## Funding and Acknowledgements

This project is funded by the Scottish Medical Education Research Consortium (SMERC). Ethics permission was granted for this project.

**References**

1 UK foundation Programme Office. F2 Career Destination Report 2015. http://www.foundationprogramme.nhs.uk/pages/home/keydocs

2 Cleland et al. What do UK doctors in training value in a post? A discrete choice experiment. Med Educ. 2016; 50: 189-202.

3 Scanlan et al. What factors are critical to attracting. NHS foundation doctors into specialty or core training? A discrete choice experiment. BMJ Open 2018;8:e019911. doi:10.1136/bmjopen-2017-019911. Open Access.

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SCOTTISH MEDICAL EDUCATION RESEARCH CONSORTIUM

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# What Factors Are Critical to Attracting NHS Foundation Doctors into Speciality or Core Training: A Discrete Choice Experiment

**Gillian Scanlan[1], Jennifer Cleland[1], Peter Johnston[2], Kim Walker[2,3], Nicolas Krucien[4], Diane Skåtun[4]**

[1] Centre for Healthcare Education Research and Innovation, University of Aberdeen, UK [2] NHS Education for Scotland, Scotland Deanery, UK [3] Scotland Foundation School Director, UK [4] Health Economics Research Unit (HERU), University of Aberdeen, UK

## Introduction

In the UK context, medical graduates are choosing not to progress through training as predicted. In 2016, nearly 50% of those graduates completing the Foundation Programme (FP: a generic two-year training programme which bridges the gap between medical school and being eligible to apply for a training [residency] post) did not apply for a specialty or general practice training post at the standard point in time[1]. Instead, they opted to take a break from training.

Previous research shows that multiple personal and work-related factors influence medical trainee careers decision making[2]. However, the relative value of these diverse factors is under-researched, yet this intelligence is crucially important for informing medical workforce planning, and retention and recruitment policies. **Our aim was to investigate the relative value of UK doctors' preferences for different training post characteristics during the time period when they either apply for speciality/core training, or take time out of the training pathway.**

## Methods

We used our knowledge of the literature and interviews to develop a discrete choice experiment (DCE)[3,4] specifically for this population. The DCE had six characteristics, each containing between two-four levels within the model. These were:

- **Geographical Locality (see Table 1 for an example)**
- **Familiarity With Specialty**
- **Culture of Working and Learning Environment**
- **Opportunities for Professional Development**
- **Working Conditions**
- **Potential Earnings**

**Table 1.** Example: characteristics of training positions and the range of possible levels presented within the choice scenario of geographical locality.

| Characteristic | Description | Possible Levels |
|---|---|---|
| Geographical Locality | This refers to the geographical location of the training position including amenities on offer, and the proximity to your family and friends, and/or spouse/partner employment opportunities. | Desirable Location<br>Undesirable Location |

**The DCE was distributed to all second year Foundation Programme doctors (F2s) across Scotland as part of a national Career Destination Survey, in June 2016.** The survey explained the DCE task and described each attribute and its levels before the 13 choice sets were presented. The F2s doctors were asked to choose their preferred training position between two available (**see Figure**). The main outcome measure was the monetary value of training-post characteristics, based on willingness to forgo and willingness to accept additional potential income for a change in each job characteristic calculated from regression coefficients.

In this section of the survey we are interested in the factors that have influenced your career decision making in your FY2 year and what characteristics are the most important when making a decision on whether to apply for specialty training, core training or GP training programmes. This section of the survey will ask you a series of choices on what post FY2 training place you would prefer based on characteristics of training places.

Now you will be given a series of 13 choices to make that are all slightly different. For each choice you will be asked two separate questions. One will be to select which option you **prefer** between the 2 training positions on offer. You may not like either post but we would like you to state which one you think is better!

**There are no right or wrong answers to these questions, we are just interested in your opinion!**

**Choice 1 of 13: Which position would you prefer?**

| | Position "A" | Position "B" |
|---|---|---|
| Geographical Location | Undesirable Location | Desirable Location |
| Familiarity with specialty | Quite Familiar | Unfamiliar |
| Culture of working and Learning Environment. | Unsupportive Culture | Supportive Culture |
| Potential Earnings | 10% Above Average | 20% Above Average |
| Working Conditions | Excellent Conditions | Poor Conditions |
| Opportunities for Professional Development | Average Opportunities | Poor Opportunities |
| **Which position would you prefer? Please tick one box** | ☐ | ☐ |

## Results

We used STATA for data analysis. 677/798 F2 doctors provided usable DCE responses. **F2 doctors would need to be compensated over 45% of their expected potential income to move from a desirable to an undesirable training location. Additionally, to gain a supportive working culture and improved working conditions (move from poor to excellent working conditions) they were willing to sacrifice over 38% of their potential earnings. Doctors who applied for a training post placed less value on supportive culture and excellent working conditions than those who did not apply. Male F2s valued Location and a supportive culture less than their female counterparts.**

## Conclusion

This is the first study focusing on the decision making of UK doctors at a critical careers decision-making point. Both location and specific job-related attributes are highly valued by F2 doctors when deciding their future. **These findings have wide-ranging implications, particularly for policy makers, so that they can focus their efforts in making training posts more attractive and ultimately improve the retention of this group.** Future research could usefully look at associations between certain preferences and specialty preferences, assessed via applications to specific training programmes.

**Funding and Acknowledgements:** This project is funded by the Scottish Medical Education Research Consortium (SMERC). Ethics permission was granted for this project.

**References**

1 UK foundation Programme Office. F2 Career Destination Report 2015. http://www.foundationprogramme.nhs.uk/pages/home/keydocs

2 Cleland J, Johnston PW, Watson V, Krucien, N, Skatun D. What do UK doctors in training value in a post? A discrete choice experiment. Med Educ. 2016; 50: 189-202.

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# The University of Aberdeen Remote and Rural programme: A successful undergraduate approach to improving recruitment and retention.

Dr Jennifer McGowan[1] , Professor John Duncan[1], Dr Ken Oates[2]
[1]Institute of Education in Medical and Dental Sciences, University of Aberdeen
[2] NHS Highland

## Introduction

The recruitment and retention crisis in Scottish General Practice, particularly in remote and rural areas has been widely reported. The University of Aberdeen (UofA) Remote and Rural (R&R) Programme began in 2006 aiming to provide a positive undergraduate experience of rural medicine and encourage pursuit of careers based in remote and rural areas.
Previous work[1] has shown that students who completed the R&R programme were significantly more likely to become GPs than the remainder of their year group. We built on this data by exploring previous student's choice of specialty and location.

## Methods

Previous students from R&R cohorts over 7 years were identified and invited to participate in an online questionnaire. Information was gathered on specialty choice, training location and the location of their background.

## Results

106 students completed the R&R programme between 2008 and 2014. Of the 84 invited to participate, 63% responded.

- 26% of respondents have completed specialty training
    - 86% of these are GPs
- 66% of respondents are currently in specialty training
    - 31% of theses are in GP specialty training
- Overall 43% have either completed or are currently in GP specialty training (figure 1)

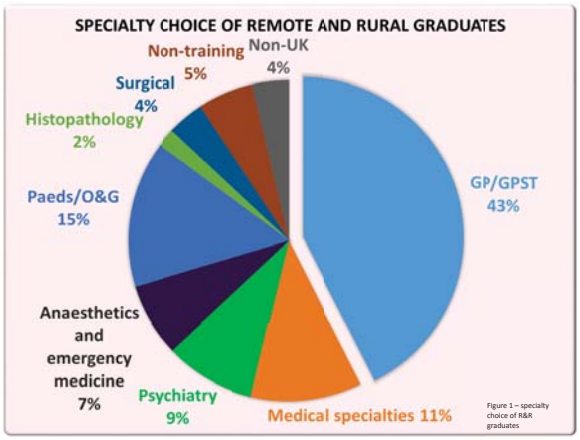

Figure 1 – specialty choice of R&R graduates

Throughout all medical training, the majority of respondents remained in Scotland with a high proportion staying the North of Scotland (36% for foundation training and 31% for specialty training – figures 2 and 3).

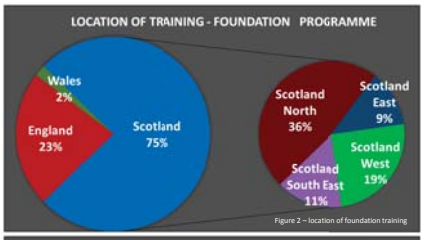

Figure 2 – location of foundation training

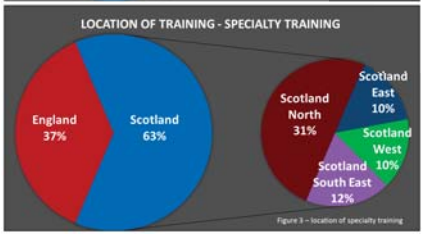

Figure 3 – location of specialty training

Comparison of postcode at point of entry to medical school to postcode of current job shows a similar geographical distribution (figures 4 and 5) with many working in areas classed as remote and/or rural on the Scottish Government urban rural classification map [2].

Figure 4 - postcode at point of entry to medical school

Figure 5- postcode of current job

9 respondents are GPs currently working in Scotland with 5 of these working in practices classified between very remote small town and very remote rural (figure 6).

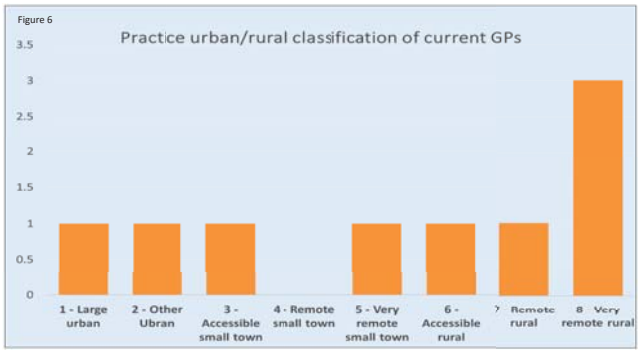

Figure 6

## Conclusions

The UofA R&R programme is successfully achieving its aims of encouraging careers in Primary Care in remote and rural areas. This is a positive approach to improving future recruitment and retention which could be expanded to increase the number of students completing this programme in forthcoming years.

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1. McGowan J, Oates K, Hogg M, Devendra A, Duncan J. The University of Aberdeen Remote and Rural Programme: A solution to the GP recruitment crisis? Presented at Scottish Medical Education Conference 4th and 5th May 2017
2. Scottish Government Urban Rural Classification http://www.gov.scot/Topics/Statistics/About/Methodology/UrbanRuralClassification
3. Recruitment and Retention RCGP Scotland http://www.parliament.scot/S5_Rural/Inquiries/201608-RR012_RCGP_Scotland.pdf

# MULTIPLE AND MULTI-DIMENSIONAL TRANSITIONS FROM TRAINEE TO TRAINED DOCTOR: A QUALITATIVE LONGITUDINAL STUDY

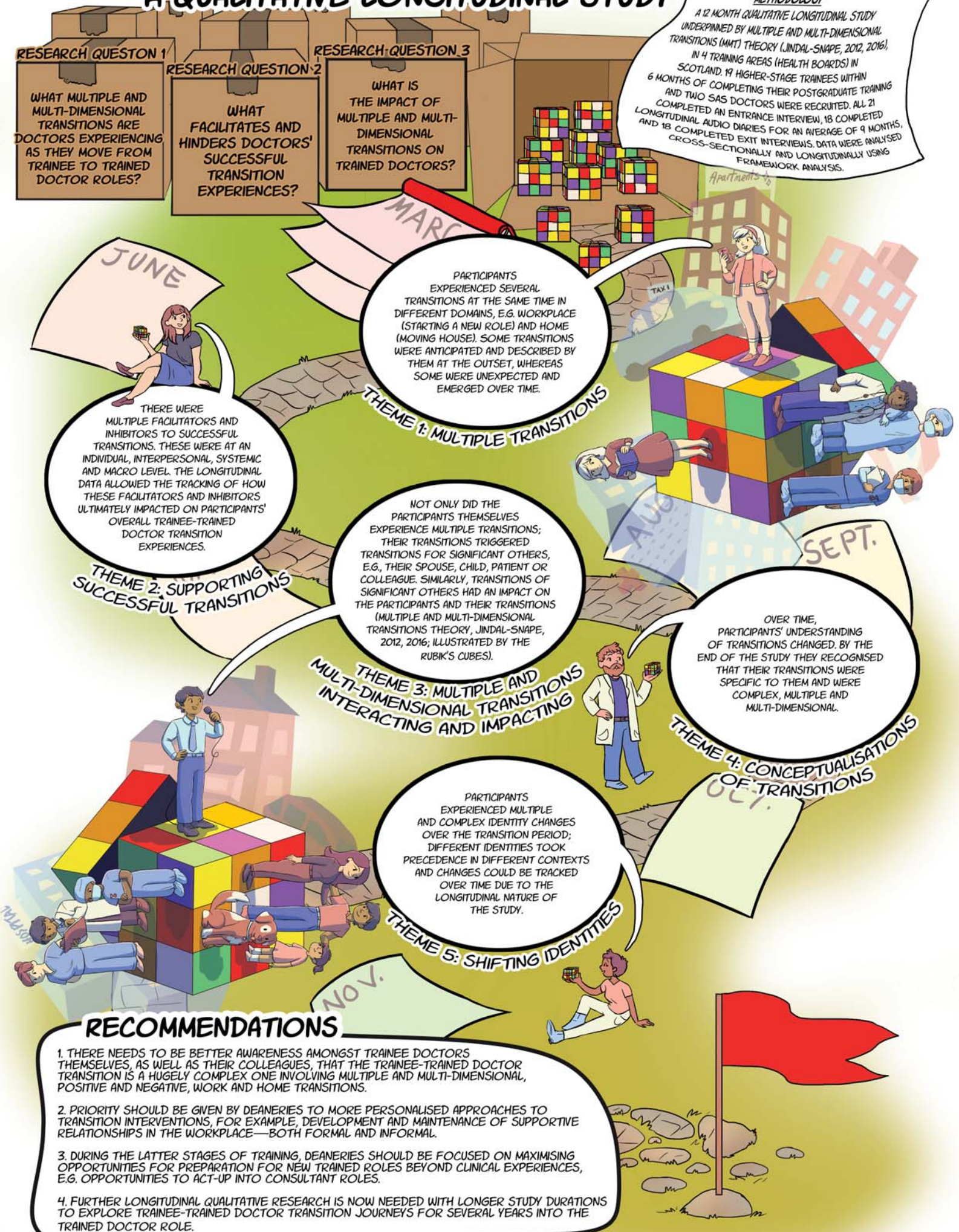
**RESEARCH QUESTON 1**
WHAT MULTIPLE AND MULTI-DIMENSIONAL TRANSITIONS ARE DOCTORS EXPERIENCING AS THEY MOVE FROM TRAINEE TO TRAINED DOCTOR ROLES?

**RESEARCH QUESTION 2**
WHAT FACILITATES AND HINDERS DOCTORS' SUCCESSFUL TRANSITION EXPERIENCES?

**RESEARCH QUESTION 3**
WHAT IS THE IMPACT OF MULTIPLE AND MULTI-DIMENSIONAL TRANSITIONS ON TRAINED DOCTORS?

## METHODOLOGY

A 12 MONTH QUALITATIVE LONGITUDINAL STUDY UNDERPINNED BY MULTIPLE AND MULTI-DIMENSIONAL TRANSITIONS (MMT) THEORY (JINDAL-SNAPE, 2012, 2016), IN 4 TRAINING AREAS (HEALTH BOARDS) IN SCOTLAND. 19 HIGHER-STAGE TRAINEES WITHIN 6 MONTHS OF COMPLETING THEIR POSTGRADUATE TRAINING AND TWO SAS DOCTORS WERE RECRUITED. ALL 21 COMPLETED AN ENTRANCE INTERVIEW, 18 COMPLETED LONGITUDINAL AUDIO DIARIES FOR AN AVERAGE OF 9 MONTHS, AND 18 COMPLETED EXIT INTERVIEWS. DATA WERE ANALYSED CROSS-SECTIONALLY AND LONGITUDINALLY USING FRAMEWORK ANALYSIS.




PARTICIPANTS EXPERIENCED SEVERAL TRANSITIONS AT THE SAME TIME IN DIFFERENT DOMAINS, E.G. WORKPLACE (STARTING A NEW ROLE) AND HOME (MOVING HOUSE). SOME TRANSITIONS WERE ANTICIPATED AND DESCRIBED BY THEM AT THE OUTSET, WHEREAS SOME WERE UNEXPECTED AND EMERGED OVER TIME.

### THEME 1: MULTIPLE TRANSITIONS

THERE WERE MULTIPLE FACILITATORS AND INHIBITORS TO SUCCESSFUL TRANSITIONS. THESE WERE AT AN INDIVIDUAL, INTERPERSONAL, SYSTEMIC AND MACRO LEVEL. THE LONGITUDINAL DATA ALLOWED THE TRACKING OF HOW THESE FACILITATORS AND INHIBITORS ULTIMATELY IMPACTED ON PARTICIPANTS' OVERALL TRAINEE-TRAINED DOCTOR TRANSITION EXPERIENCES.

### THEME 2: SUPPORTING SUCCESSFUL TRANSITIONS

NOT ONLY DID THE PARTICIPANTS THEMSELVES EXPERIENCE MULTIPLE TRANSITIONS; THEIR TRANSITIONS TRIGGERED TRANSITIONS FOR SIGNIFICANT OTHERS, E.G., THEIR SPOUSE, CHILD, PATIENT OR COLLEAGUE. SIMILARLY, TRANSITIONS OF SIGNIFICANT OTHERS HAD AN IMPACT ON THE PARTICIPANTS AND THEIR TRANSITIONS (MULTIPLE AND MULTI-DIMENSIONAL TRANSITIONS THEORY, JINDAL-SNAPE, 2012, 2016; ILLUSTRATED BY THE RUBIK'S CUBES).

### THEME 3: MULTIPLE AND MULTI-DIMENSIONAL TRANSITIONS INTERACTING AND IMPACTING

OVER TIME, PARTICIPANTS' UNDERSTANDING OF TRANSITIONS CHANGED. BY THE END OF THE STUDY THEY RECOGNISED THAT THEIR TRANSITIONS WERE SPECIFIC TO THEM AND WERE COMPLEX, MULTIPLE AND MULTI-DIMENSIONAL.

### THEME 4: CONCEPTUALISATIONS OF TRANSITIONS

PARTICIPANTS EXPERIENCED MULTIPLE AND COMPLEX IDENTITY CHANGES OVER THE TRANSITION PERIOD; DIFFERENT IDENTITIES TOOK PRECEDENCE IN DIFFERENT CONTEXTS AND CHANGES COULD BE TRACKED OVER TIME DUE TO THE LONGITUDINAL NATURE OF THE STUDY.

### THEME 5: SHIFTING IDENTITIES

## RECOMMENDATIONS

1. THERE NEEDS TO BE BETTER AWARENESS AMONGST TRAINEE DOCTORS THEMSELVES, AS WELL AS THEIR COLLEAGUES, THAT THE TRAINEE-TRAINED DOCTOR TRANSITION IS A HUGELY COMPLEX ONE INVOLVING MULTIPLE AND MULTI-DIMENSIONAL, POSITIVE AND NEGATIVE, WORK AND HOME TRANSITIONS.

2. PRIORITY SHOULD BE GIVEN BY DEANERIES TO MORE PERSONALISED APPROACHES TO TRANSITION INTERVENTIONS, FOR EXAMPLE, DEVELOPMENT AND MAINTENANCE OF SUPPORTIVE RELATIONSHIPS IN THE WORKPLACE—BOTH FORMAL AND INFORMAL.

3. DURING THE LATTER STAGES OF TRAINING, DEANERIES SHOULD BE FOCUSED ON MAXIMISING OPPORTUNITIES FOR PREPARATION FOR NEW TRAINED ROLES BEYOND CLINICAL EXPERIENCES, E.G. OPPORTUNITIES TO ACT-UP INTO CONSULTANT ROLES.

4. FURTHER LONGITUDINAL QUALITATIVE RESEARCH IS NOW NEEDED WITH LONGER STUDY DURATIONS TO EXPLORE TRAINEE-TRAINED DOCTOR TRANSITION JOURNEYS FOR SEVERAL YEARS INTO THE TRAINED DOCTOR ROLE.


CO-PIS: PROFESSORS DIVYA JINDAL-SNAPE + CHARLOTTE REES
CIS: DR LISI GORDON; PROFESSORS JILL MORRISON, GILLIAN NEEDHAM AND SABINA SIEBERT



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# Deep End GP Pioneer Scheme

*Supporting GP recruitment and retention in areas of deprivation*

Dr David Blane[1,2] Dr Noy Basu[3], Dr Katie Fleming[4], Dr Laura Johnston[5], Dr David McMahon[6], Dr Lisa Robins[6]

1) Academic Co-ordinator, Deep End Pioneer Scheme; 2) Academic GP, Pollokshaws Medical Centre and University of Glasgow; 3) Deep End Fellow, Glenmill Medical Practice; 4) Deep End Fellow, Lightburn Medical Centre; 5) Deep End Fellow, Easterhouse Health Centre; 6) Deep End Fellow, Possilpark Health and Care Centre

- The "crisis" in GP recruitment and retention is well-documented and has multiple causes, including increased demands with fewer resources. (1)
- The Deep End GP Pioneer Scheme started in 2016 with funding from the Scottish Government's GP Recruitment and Retention Fund.
- The aim was to develop and establish a change model for general practices serving very deprived areas. This included recruitment of early career GPs, retention of established GPs, and their joint engagement in strengthening the role of general practice as the natural hub of local health systems. (2)

## Methods

- GPs at the Deep End work in 100 general practices serving the **most socio-economically deprived** populations in Scotland.
- The Pioneer Scheme involves **five early career GP fellows** working in Deep End GP practices. The scheme is supported by a **overall lead GP** and an **academic coordinator** alongside a **lead GP from each practice.**
- The GP fellows provides **additional clinical capacity** for the practices (3 sessions) and backfill for established GPs to work on **service development** within their practices (3 sessions).
- One day a week the GP fellows alternate between **practice-based projects** and **day-release learning** with a curriculum based on identified learning needs for Deep End practitioners (Table 1).
- Since the scheme started in October 2016 there have been 10 meetings involving the lead GP and fellow from every practice to **share learning** and **provide support**.

## Results

- **'Key ingredients'** of the scheme have been identified:
- 1) Early career and established GPs have benefitted from the **network of peer support**;
- 2) The academic programme has **expanded knowledge** of key topics relevant to working with deprived populations;
- 3) The **increased capacity** provided by the Pioneer Fellow has **reduced GP stress, improved job satisfaction** and motivation, and resulted in an **improved working environment** that benefits the **whole practice team**;
- 4) **Learning has been shared** within and between practices, via face-to-face meetings and an online platform.
- Examples of practice **quality improvement (QI) projects** led by experienced GPs include: **audits** (e.g. screening uptake, diabetes care); **system change** (e.g. access, registration forms); **engaging with others** (e.g. community resources); and **extended consultations** for complex patients.

**Table 1: Day-release learning for Deep End GP fellows**

| | |
|---|---|
| **2016 (started in October)** | • Assessing learning needs<br>• Preventing burnout<br>• Quality after QOF and Julian Tudor Hart |
| **2017** | • Violence reduction and domestic violence<br>• Financial inclusion<br>• Learning from the Links Worker Programme<br>• Complex consultations and trauma<br>• Multiple exclusion<br>• Palliative care in the Deep End<br>• Asylum Health Bridging Team<br>• Chronic pain<br>• Living with poverty<br>• Personality disorder<br>• Freedom from torture / working with interpreters<br>• Child protection in the Deep End<br>• QI tools for GP leadership<br>• Adult support and protection<br>• Addiction in older adults<br>• Social model of disability<br>• LGBTQ health inequalities<br>• Glasgow Asylum Destitution Action Network<br>• Female Genital Mutilation |
| **2018 (to April)** | • Prisoner health<br>• Working with others<br>• Obesity in the Deep End<br>• Educational psychology |

## Conclusion

- The Pioneer scheme has shown real promise as a new model for general practices serving very deprived areas, supporting early career GPs and experienced GPs alike.
- There is clear scope for GP clusters across Scotland to assimilate learning from this new way of working.

## References

1. Health Education England. (2016) By choice – not by chance: Supporting medical students towards future careers in general practice. London
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# Career Start GP Posts

## An exciting opportunity to enhance and develop a career in General Practice through an innovative and flexible scheme

Dr Shawkat Hasan[1] Dr Christopher Weatherburn[2] Dr David Shaw[3] Dr Michelle Watts[4]

1. Clinical Lead Career Start NHS Tayside 2. GP Lead Dundee Health and Social Care Partnership 3. Clinical Director Dundee Health and Social Care Partnership 4. Associate Medical Director NHS Tayside

### Background

The purpose of the scheme is to develop the skills and confidence of recently qualified GPs enabling them to become the best GPs of the future and fulfil the RCGP 2022 Vision.[1] Within supportive environments, we want to see the development of our GPs based upon the values and vision of NHS Tayside.[2] They will work as an integral member of a multi-disciplinary team supporting our population to live longer, healthier lives at home.

### Aims

- Retain high quality recently qualified GPs in Tayside
- Attract First5 GPs to work in Tayside from out with the area
- Increase the skill level of GPs in the community
- Support the development of GPs as leaders of the MDT
- Develop a sustainable recruitment and retention strategy

### Method

- Advertise posts through local and national outlets
- Identify local practices interested in hosting a Career Start GP
- Identify local specialty areas looking to host a Career Start GP
- Match applicants to practice and specialty

### Results from First Year of GP Career Start Posts

- 3 Career Start GPs appointed
- 18 local practices interested in hosting
- 3 Specialty areas interested in hosting
- 2 (66%)of Career Starts attracted from out with NHS Tayside
- Positive Feedback from GP Career Starts
- Positive Feedback from host specialties and host GP practices
- Project approved for second year

### Recruitment

- Advertised on the national SHOW website & local ST Careers Event.
- 4 applications were received;
  - 2 applicants from out with NHS Tayside who were willing to relocate to Tayside specifically for this post
  - 1 applicant who was working locally as a GPST3
  - 1 applicant who was working locally as a GP partner
- 3 applicants were appointed

- 3 specialties were keen to host a Career Start GP in their areas
  - Medical Education, Medicine for Elderly, OOH.
- At interview stage applicants were invited to give their preferences for the type and location of practice they would like to work in and they also ranked their preferred specialty areas
- The 3 appointed Career Starts were invited to visit a shortlist of their preferred style of practice and choose where they would like to work
- All 3 candidates were also able to be appointed to their 1st choice Specialty area and selected the practice they would work in.

### Current Career Start GPs Developments

- GP 1 : Full Time. Inner city practice. Medical Education - completed PG Cert in Medical Education
- GP 2 : Part Time. Rural practice. Medicine for the Elderly - completed first part of Diploma in Geriatrics. Also started working in local OOH Service
- GP 3 : Part Time. Deprived 2c practice. Medical Education - completed PG Cert in Medical Education and runs the CPD Program in practice

### Support and Mentoring

- Career Start GP has protected weekly CPD Time
- Peer support online and face to face
- CPD Programme
- Practice and Specialty Mentor
- Clinical Lead support
- Optional Personal Leadership Mentor

### End of Year 1 Feedback

Career Starts GP – unanimously positive feedback on both practice and specialty elements, all have continued into Year 2.

Practices – Delighted to have the opportunity to host a Career Start GP. The additional GP capacity in the practice has also taken pressure off existing GPs in practice although it was noted that the Career Start required more support and mentoring than a locum or salaried GP.

Specialty – Medical Education Career Start GPs are now integral to local undergraduate teaching program and an asset to the department. MFE GP is now working as part of the Acute Frailty Team locally and doing additional clinical sessions with this team.

### Funding and Contract

- Scottish Government Recruitment and Retention Fund
- Career Start GPs salaried at £70,000 FTE
- Practices and Specialty charged back £150 per worked session

### Year 2

- 7 applications received and 6 appointed (1 pending)
- Majority applied after hearing about post due to word of mouth
- 25 local practices signed up to host a Career Start GP
- 5 specialty areas signed up to host a Career Start GP
  - Medicine for Elderly, OOH, Paediatric OOH, Palliative Care, Musculoskeletal and Community Physiotherapy
- Interest from Prisoner Healthcare and Substance Misuse Service
- Support from LMC, HSCP and local GPs
- Interest from other Health Boards

### Quotes from Career Start GPs :

able to establish my own program

my ideal job

heard good things about it from colleagues

Opportunity to develop unique positions with specialist component

enjoyed the freedom and personalised opportunity

a unique opportunity in Scotland

trust the organising team

attracted from out with area solely due to programme

feel loved

the future of general practice

References

1. RCGP 2022 Vision http://www.rcgp.org.uk/policy/rcgp-policy-areas/general-practice-2022.aspx
2. NHS Tayside Vision http://www.nhstayside.scot.nhs.uk/WorkingWithUs/WhyWorkforNHSTayside/PROD_204621/index.htm

Career Start : Build your perfect job!

# Career Start GP Posts Evaluation

Dr Christopher Weatherburn [1] Dr Shawkat Hasan [2] Dr Michelle Watts [3] Dr David Shaw [4]

1 . GP Lead Dundee Health and Social Care Partnership 2. Clinical Lead Career Start NHS Tayside 3. Associate Medical Director NHS Tayside 4. Clinical Director Dundee Health and Social Care Partnership

## Background

- Recruitment difficulties in primary care
- Desire to attract GPs to NHS Tayside to develop links and ultimately work longer term in practice
- Opportunity to develop unique positions with specialist component

## Aims of Poster

- Assess reasons GPs applied for these positions
- Assess reasons GPs did not apply
- Ascertain how the positions are going and if anything could be done better to implement these posts

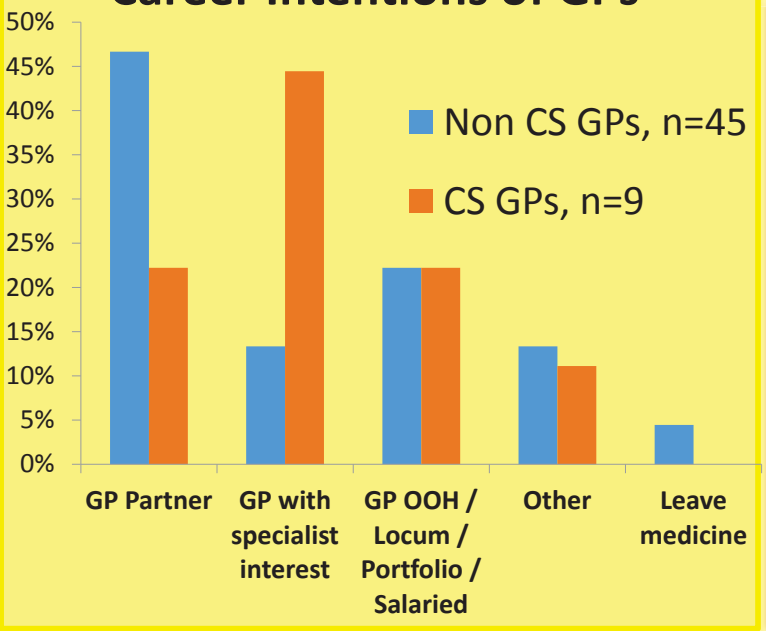
## Method

- Questionnaire sent electronically to appointed Career Start (CS) GPs via surveymonkey.com
- Different questionnaire to local early career GPs who did not apply to these positions via surveymonkey.com. Sent to local GP locum group, GPs who had recently obtained a CCT from East of Scotland, Tayside OOH GPs and RCGP First Five East of Scotland. This voluntary survey asked them to complete if they identified themselves early career GPs.
- Meeting took place on 29/11/17 with authors and six CS GPs to discuss positions, challenges and what could be improved

## Results

- All 9 appointed CS GPs completed questionnaire
- 45 non CS GPs completed questionnaire – 29 of these had heard of this job opportunity.

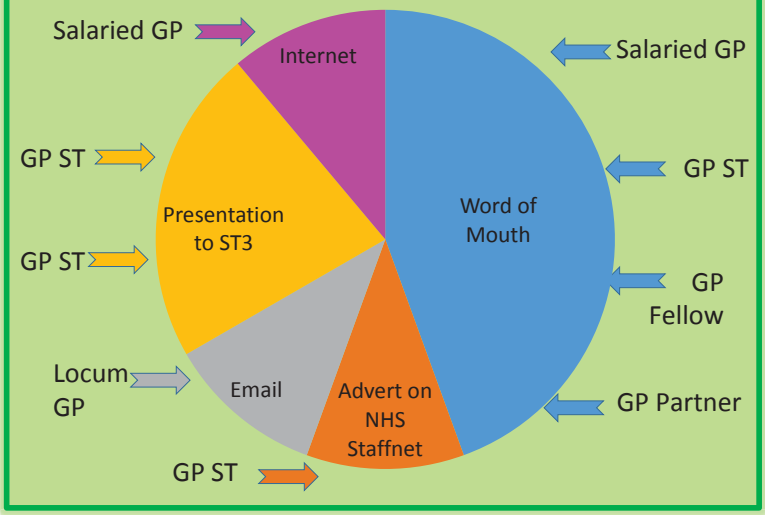
## Career Intentions of GPs




## Recruitment

- All CS GPs stated that being able to select specific work location across Tayside encouraged them to apply.
- Eight CS GPs stated that the location Tayside was most important, one CS GP stated the location Scotland was most important.

### Previous Role & Recruitment Method




## Nine CS GPs Appointed to Following Specialities

- Medicine for the Elderly : 2
- Medical Education : 2
- Musculoskeletal / Community Physiotherapy (MSK) : 3
- Paediatric OOH : 1
- Palliative Care : 1

- 8 remain in post, 1 has resigned (Paediatric OOH, previous GP locum). Demand from Prisoner Healthcare and Substance Misuse Service specialities to offer positions.

## Feedback

- Overall positive - the intention is to continue these positions
- The duration of a CS GP session (4 hours) differs from a GP partner session (5 hours) – this led to slight difficulties when some CS GP started in general practice. Therefore when a CS GP is just about to commence work the general practice will be reminded of the session duration.
- It was noted by practices that the CS GP requires more support from practice than a salaried or locum GP
- CS GPs working in MSK perceive useful skills gained to enhance their abilities as a GP but no subsequent clear career pathway.
- CS GPs working in Medicine for the Elderly and Medical Education perceive there is a strong clear career pathway for them to further pursue and develop their specialist interest. As a direct consequence of this position they will fulfil their career goals.

## Quotes from GP Career Start

"able to establish my own program" "enjoyed the freedom and personalised opportunity" "heard good things about it from colleagues" "attracted from out with area solely due to programme" "Opportunity to develop unique positions with specialist component" "my ideal job"

**Overall feedback has been very positive** from specialities, GP practices and CS GPs.

*Career Start : Build your perfect job!*

University of Dundee

# Impact of postgraduate health education qualifications on graduates' professional identity and career pathways

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## Aim

There are growing expectations of medical educators by the regulatory bodies, students / trainees and institutions[1]. This has led to increased interest in professionalisation of medical education, evidenced by a steady increase in award-bearing programmes (6 to 121 globally, 2 to 31 in the UK in the last two decades)[2].

Despite this, little evidence is available on the impact of such courses on the graduate themselves and those they teach[3].

This limited evidence about the benefits of qualifications in medical education has resulted in them being undervalued by many health professionals[4].

## Research questions

We sought to explore how two such qualifications, the Centre for Medical Education Dundee's Postgraduate Certificate & Masters, have impacted graduates' professional identity and career progression.

This led to two RQs:

1. How does attaining the qualification in medical education influence graduates' professional identity and practices?
2. What is the impact of attaining the qualification on the department or institution in which the graduate works?

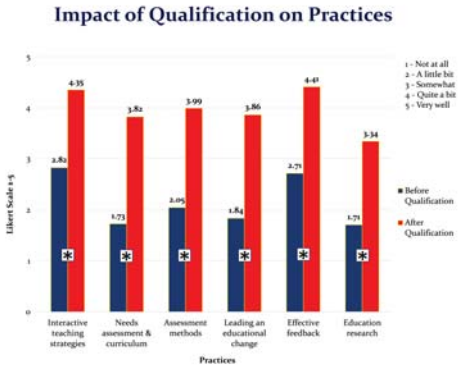
## Methods

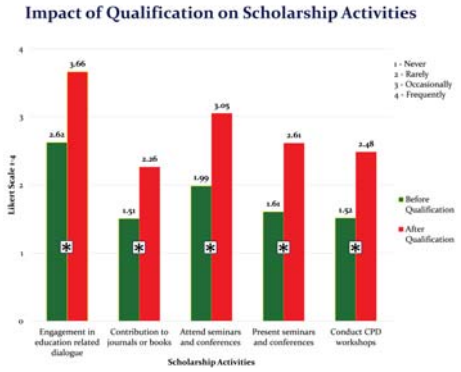
The 2-phase study design was mixed methods using the explanatory model[5].

- **Phase I**: The data was collected from the graduates (2008-2012) of the Centre for Medical Education, Dundee initially through a questionnaire using Bristol Online Survey and the quantitative data were analysed using non-parametric statistics on SPSS 21.
- **Phase II**: A diverse pool of purposively sampled (14 UK & 13 International) graduates were sequentially explored in more depth through semi-structured interviews (Telephone – Skype – Face to Face). Data were analysed using Framework analysis[6] in Atlas ti 7.

## Results: Phase 1

The response rate was 45% (224/504). The respondents reported a highly significant (P<0.001) improvement in educational competencies and involvement in scholarship activities after graduation.




## Results: Phase 2

The analysis revealed over-arching themes on:

**Educational Changes**: Participants developed as a change agent and led various educational changes in the workplace e.g. curriculum reforms, evaluations, assessment etc.

> Being asked to revamp the undergraduate programme for the years 1 to 3 … you have been given blank piece of paper and told well you can do what you want … so we are thinking about learning outcomes that all had to be mapped across in terms of curriculum … and then for each individual piece of module … moving down into lesson plans … there was loads of CME modules work

*Male medical doctor UK; Masters*

**Professional Identity**: Participants experienced transformational changes; they reported starting using evidence to inform their practices and developed as a teacher, leader, researcher and learner.

> I think probably my previous teaching being more didactic and less student led whereas now I try to really involve the audience and try to get them to lead the discussion

*Female medical doctor Australia; Certificate*

**Career Progress**: Many participants attributed their career progression and promotion into senior position to the qualification and this was associated with greater educational responsibilities.

> Had an opportunity to take on an extra role that's foundation programme director … and I also understand the fact that I had postgraduate medical education qualification helped me get that post. I have also become medical ethics and law lead for the medical school … I don't think previously I would have felt that I had the knowledge or experience even to put myself forward for some of these posts

*Male medical doctor UK; Masters*

## Discussion

Participants reported an increased sense of belonging to educational communities of practice[7] along with improved self-efficacy in educational competencies.

Graduates with a master's qualification reported more growth with research publications because of their greater commitment and having done their research with qualified supervisors.

The current study[8] is the first to look in-depth and report transformational changes among medical educators along with other benefits in terms of a rewarding career. As many graduates took 3-5 years in doing the qualification, it is hard to differentiate the effect of qualification from that of experience and other development activities.

Future research should follow the students longitudinally through the course to the workplace to establish the influences on development of professional identity.

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