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The three-hour meeting: A socio-cultural approach to engage junior doctors in education

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Abstract

Background: Learning in a socio-cultural context, in contrast to an individual context, has been highlighted in recent years. The 3-hour meeting concept presents a socio-cultural framework for collaborative educational opportunities; it has run successfully for 6 years at 129 meetings for junior doctors (JDs) in an 850-bed Danish university hospital.

Aim: This concept improved the educational environment and activities by engaging JDs in educational initiatives.

Method: The concept began with annual meetings that featured self-reflection and plenary discussions regarding all aspects of education. The meetings concluded with the Top 3 of 'educational issues of concern' and an action plan for education initiated by junior doctors. This written material on educational matters from each department provided updated knowledge to department and hospital management and resulted in the development of 'blue prints for educational action'.

Results: The compiled actions resulted in the implementation of 76 educational initiatives in the first year, after just one 3-hour meeting and managerial follow-up.

Conclusion: The junior doctors' increased engagement in education reinforced educational relationships with senior doctors and management, and this collaboration markedly improved the educational environment and the number of educational activities. Therefore, the 3-hour meeting concept supported the socio-cultural perception of education in the hospital.

Introduction

Traditionally, doctors have many solitary working routines, which promotes learning in an individual context; junior doctors (JDs) are embedded into these working routines and, thereby, into individual learning approaches described in learning theories (Kolb 1984; Piaget 1970; Schon 1987). Individual learning approaches affect the interaction of JDs with their peers and supervisors, thus sustaining a certain educational environment as noted by Bleakley (2006), 'Where the need for teamwork learning is recognised, paradoxically this may still occur within a climate whose main tacit theoretical reference is individual, rather than distributed, cognition'. Distributed cognition (Hutchins 1995) is in the tradition of socio-cultural learning theories (Bateson 2000; Engeström & Middleton 1996; Lave & Wenger 1999; Vygotskij 1978) with a focus on learning communities, as stated by Hutchins '... the fact that human cognition is always situated in a complex socio-cultural world and cannot be unaffected by it' (Hutchins 1995).

This led us to focus on the educational environment of hospitals, where individual and socio-cultural learning approaches should coexist to provide the best educational opportunities, as these methods complement each other (Sfard 1998). In Denmark, JDs have protected time for education (e.g. one-to-one supervision/apprenticeship, skills lab and sessions on specific disorders) with great variation between departments and often performed from the view of individual learning.

Practice points

- The three-hour meeting concept supported the socio-cultural perception of education.
- Junior doctors engaged in important educational issues.
- Dialogue was facilitated by management and doctors.
- Educational activities increased markedly within departments.
- The three-hour meeting concept created a symbiosis of the effort of the doctors, the departments and the hospital management.

However, it is difficult to propose socio-cultural changes in well-established working routines. Especially as a newcomer, this tends to cause despondent attitudes or passive behaviour, thereby reducing the motivation to engage in educational improvements. According to cognitive science and learning theories, however, an active learning approach increases educational outcomes (Graffam 2007), and Bleakley shows 'temporary members of teams can bring a fresh eye to habitual practices' (Bleakley 2002). Hence, a corner stone of the *three-hour meeting* (3-hm) *concept* is to take advantage of JDs' fresh eyes and their engagement in improved educational opportunities.

The aim of this article is to describe the framework of and our experiences with the 3-*hm concept* as a socio-cultural approach improving the educational environment

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and education in general at all departments in a hospital simultaneously. We focused on: (1) how to engage JDs in and give ownership to the process of education (i.e., What can JDs do amongst peers to improve the educational environment and support potential educational situations?) and (2) how to stimulate dialogue and educational relations within the organization (i.e. how to learn from each other). To our knowledge, no prior work has described a similar concept; therefore, we will demonstrate how 3-hms are conducted, report findings from the 3-hm and discuss the findings in a socio-cultural context.

Description of the 3-hm concept

Our context was an 850-bed university hospital with 29–32 departments covering all specialities and an average of 250 JDs, in a country with more than 90% public hospitals that provide medical education. The number of total departments changed from 29 to 32 due to organizational changes from 2002 to 2006. The 3-hms were arranged in each department once annually, and the 3 h time frame was chosen to ensure time for the doctors to reflect, share and discuss appropriate action. In departments with less than four JDs, a modified 3-hm concept was performed. 3-hms were optional for the departments, however, to emphasize the importance of 3-hms, they were strongly promoted by the hospital management. A letter from the Hospital Medical Director was sent to department management teams to encourage (1) participation of all JDs, 2) meetings to be held within daytime working hours and 3) meetings to be held without staff pagers (the 'emergency beeper' was to be answered by a senior staff member during the meeting). This support, along with a coordinator and the availability of specific report forms enabled the large-scale establishment of the 3-hm concept.

The itinerary of the 3-hm concept is shown in Table 1.

A *facilitator* from each department attended an instructional session, became the leader of each departmental meeting and informed JDs about the specific meeting concept. The facilitator was preferably an experienced JD (specialist registrar) or a young staff specialist for two reasons. First, a general observation was made that JDs were more willing to speak freely and bring up ideas when senior staff were absent. Second, a part of the concept was for the JDs to take ownership of the process and responsibility for the result because no senior doctors were present to do this. To support this autonomous process the facilitator was instructed to keep a low-profile concerning discussions, but to keep track on task and time. *Self-reflection* was introduced before the 3-hm by sending written instructions to JDs to recall three positive and three less positive experiences within their educational environment. *Prioritization* of the experiences was accomplished using a 'snowball sum-up': Written self-reflection about positive and less positive educational experiences, followed by pairs of JDs discussing the experiences and prioritizing them into their Top 3 list, and then two pairs of JDs were teamed up. This process continued until all JDs were joined in one group with a united set of Top 3 issues. This procedure was chosen to develop a framework where everybody participated actively and could reach a common understanding of importance. Hereafter, the main focal point was to create an *action plan* with emphasis on what JDs could initiate at their own level. The action plan consisted of educational changes in the department with exact goals, deadlines and the JD responsible for completing each written down. While working on the action plan, three questions clarified the level at which JDs have influence and made them focus on issues they could change: (1) 'What can we do to improve the education?' (2) 'What action would we appreciate from the department?' and (3) 'What action would we appreciate from the hospital?'

To expand the *dialogue* on education at all levels in the organization, the Top 3 lists and action plans from the 3-hm in each department were sent uncensored to both the department and hospital management to illustrate JD engagement and capacity to generate solutions. A *blue print for action* was then developed by department management to reassess the educational resource allocation and improve education, on the basis of the thorough information provided by the JDs. The actions were mostly directed towards the doctors and occasionally involved multiprofessional team members. A '3-hm report' was published by hospital management to inform all departments on the results of the 3-hm concept, highlighting important issues and facilitating knowledge sharing between departments. At the next 3-hm, the JDs *assessed* whether last year's goals were met and whether these issues were still important if the goals were unmet. This ensured recognition of achievements, reflection and generation of new insights over time.

Table 1. The itinerary for the 3-hm concept.

	Activity	Material	Timing
1)	*Facilitators* were informed	Lecture with information on the concept, the structured questions and report forms	One hour, 2 weeks before the 3-hm
2)	*Self-reflection* among junior doctors	Letter and oral information	Prior to and at 3-hm
3)	*Prioritizing* and sharing experiences	Written *Top 3*	At 3-hm
4)	*Action plan* from junior doctors	Written *action plans*	At 3-hm
5)	*Dialogue*, Top 3 and action plans were sent to the department and hospital management and were then discussed	Letters, free text and conversation (not recorded)	After 3-hm
6)	*Blue print for action* from management	Written *blue-print for action*	After approx. 2–3 months
7)	*Synopsis* from hospital management	Written *3-hm report*	Annually
8)	*Assessment* of action	Conversation	At next 3-hm

Method of evaluation

Document analysis was performed on the basis of written material (Table 1) with an inductive approach using a modified grounded theory process in the coding procedure each year separately, due to the fact that new unknown issues emerged every year. The evaluation of the 3-hm concept was divided into three categories. (1) The *number of participating departments*, as this illustrated the usefulness and impact of the 3-hm concept. (2) The *3-hm reports*, where the Top 3 lists and JD action plans revealed internal dialogue on important educational issues and their own concrete action upon them. (3) The *blue print for action*, which was a result of the collective dialogue, including a case report on new educational activities that illustrated the combined effect of the 3-hm concept as a symbiosis between the effort of the JDs, senior doctors (SDs), the department and the hospital management.

Evaluation results

Participating departments

The number of participating departments is shown in Figure 1. In 2004, changes in hospital management staff meant that the follow-up was not as coherent as usual.

3-hm reports

Three examples of 'educational issues of concern' from the 129 meetings performed between 2002 and 2006 were chosen to (1) show recurrent issues in the majority of departments during the time frame and the type of narrative information obtained ('Introduction'), (2) show the ability of JDs to incorporate organizational needs ('Access to education') and (3) show the impact of external influences on the meetings ('Assessment').

The first issue concerning 'Introduction' was reported to be important for JDs to feel welcome and be recognized as a competent person, which gave them confidence in daily problem solving. The preferred introduction included the presentation of all staff members and an introduction to the doctors' community of practice and workplace values, not merely a presentation of locations within the workplace. When this level of introduction was conducted, the JDs felt more confident in contacting SDs and pursuing clinical solutions themselves, which facilitated learning in their opinion. With this awareness, JDs started to introduce new colleagues to the hospital in a different way, and this awareness was passed on to the hospital management, which incorporated it into the educational strategy for central introduction.

Concerning the second issue, 'Access to education', JDs implemented new work routines to make time available for supervision and more close cooperation with SDs. The JDs were very aware of the dilemma 'work *or* education' and tried to look for 'work *and* education' solutions, such as teaching by peers and better use of scheduled conferences. In relation to 'access to education', a desire for more continuity in patient care had two facets, one of education (by following patients for a longer period) and a professional facet related to the benefit to patients from continuous care. These approaches illustrated the engagement of JDs and their ability to look beyond educational needs and into the world of administering a workplace, which was recognized by management.

A third issue concerning 'assessment' in relation to the new national specialist training programme revealed difficulties in finding time and space for new activities in a busy workday and also the lack of appropriate assessment tools. This information resulted in new educational strategies and created awareness of the need to prioritize education in department work planning.

Blue prints for action from management

The JDs Top 3 list and action plan provided a kick-start for dialogue with management and resulted in new educational initiatives. This was revealed in a case report from the first year, where 76 definite educational initiatives in 29 departments were directly related to the 3-hm. Different department managements naturally had different educational prioritizations, but there were similarities in high and low initiative prioritization (Table 2).

The dialogue between departments and hospital management was very informative and productive. An example of this is shown by the disclosure of educational initiatives with low priority (Table 2). As an explanation for low prioritization, in general, the department management mentioned challenging areas (Table 3), which had an influence on the prioritization and highlighted where efforts could lead to better educational opportunities.

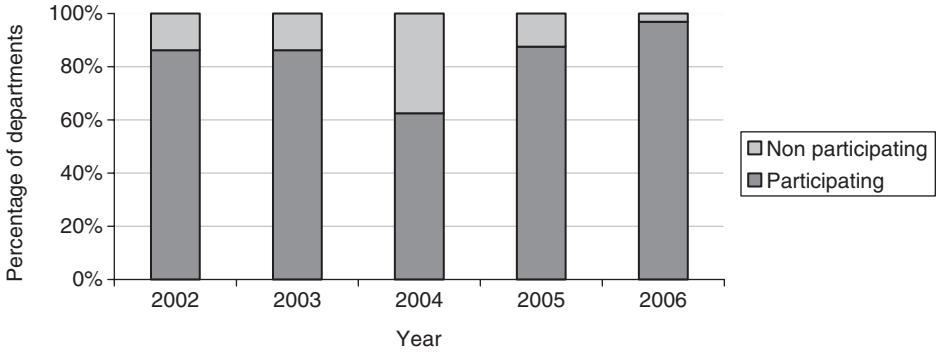

Figure 1. Departments involved in 3-hms from 2002 to 2006 ($n = 29$–32).

Table 2. Prioritization of educational initiatives by department management teams.

Educational initiative prioritization
High priority
• Supervision
• Work planning (some departments)
• Formalised educational events (e.g. Regularly scheduled conferences,lectures and staff meetings)
Low priority
• Guidelines
• Work planning (some departments)
• Introduction of junior doctors
• Feedback
• Reallocation of tasks and 'non-medical work'

Table 3. Challenging areas to implement educational initiatives.

Challenging areas revealed in the dialogue
Administrative areas
• Writing guidelines
• Library facilities
• Introduction
• Work planning integrating more education
Collegial areas
• Interest in supervision and feedback
• JD commitment
• The educational environment
Resource areas
• Recruitment of doctors
• Change in workload
• Course budget
• Budget for temporary employees
• Amount of non-medical work

The kind of effort needed was seen in the case of 'Introduction' of junior doctors, which was later improved by hospital management by improving central introductions.

Discussion

The most notable result was the impact that the 3-hm had on the entire organization. Middleton referred to literature about ideas of collective intelligence and socio-cultural learning theories, where *talk* creates awareness;

> Talk by team members about their work is of interest because as 'situated action' it is used both to construct versions of what the team is currently doing and constitutes ways to act that respond to those versions. Accounts of past practice in the present become a resource in defining future practice (Engeström & Middleton 1996).

At all levels, from the youngest doctor via the management to the senior doctor, education was *talked about* on a regular basis, and new opinions were discussed or formed in different educational relationships. This *talk* has been a continuing process due to the annual meeting set-up, and the implementation of the action plans and the blue print for action were permanent processes that promoted awareness due to *talking* within the organization even though the meeting lasted only for 3 h on a single day each year. Talking begins in the first half of the 3-hm, when JDs talk about their educational experiences.

In the second half of the 3-hm, the JDs were given the opportunity to suggest 'future practice', and the suggestions were reported to management. In some organizations and countries, this may be a bold step to take because of the cultural distance and respect between ordinary employees and top management. In our context, it was possible to take this step, and the new relationships were beneficial and offered different perspectives on education to the managers. They became aware of new opportunities in work planning and educational activities. Guile argued that crossing organizational boundaries involves the capacity to think beyond the immediate situation in order to generate new knowledge (Guile & Young 1998). Many of the department management teams and the hospital management took this step and used the new knowledge to provide departments with blue prints for action, which created relationships and dialogue among all doctors in the department. An important aspect of the 3-hm was the collective talk in the departments, because it was there the relationships and work routines could improve in the local educational environment.

Another notable result was the actual educational activities that resulted due to suggestions from the 3-hm action plans and blue prints for action. A substantial number of changes were made in many departments over the years. One of the reasons for this success may be seen from the perspective of 'legitimate participation' (Wenger 1999) provided by hospital management; the JDs were officially obliged to engage in educational issues. The JDs were invited to participate in the meeting, and this gave them a solid foundation and motivation to take ownership of the process as shown by the Top 3 lists and the action plans. The department management accepted the participation and reflected on the suggestions from the JDs, as outlined in the blue print for action.

Other results to emerge from the study were the depth and variety of issues exposed by both JDs and management; these covered many aspects of the workplace even though the key matter was education. These results agree with the socio-cultural learning literature that states that learning cannot be, and is not seen as, an isolated individual process.

However, an essential question remains unanswered: Would the changes in the educational relationships and educational activities have happened without the 3-hm? During the same time that we were conducting our study, new national specialist training programmes based on CanMEDS roles (CanMEDS 2000) began in Denmark, and these processes created more awareness about postgraduate medical education in the health service arena. In our opinion, the specialist training programmes supported training at hospitals through guidelines and curricula development, whereas the distinct change in educational relationships and working environments at hospitals is a local process.

When we look at hospitals in our region, educational improvements in different departments have been led by inspired people. At our hospital, we tried to establish a robust educational organization and make more consistent changes instead of relying solely on driven people.

Further investigations may involve the estimation of the effect of more formally engaging the SDs in all departments or how to avoid the repetition of issues in Top 3. Sometimes repetition was necessary to implement new routines; otherwise, repetition may become boring and stop the effectiveness of the 3-hm. This was discussed in some departments with good educational traditions, as these departments did not see the benefit of the 3-hm. However, when the meetings were refocused with themes or when new JD arrived, the benefits were obvious, and engagement was renewed.

Conclusion

In our setting, the 3-hm concept supported educational and general relationships at all levels in the organization and increased the number of educational initiatives. Tentatively, this may have encouraged to more confident clinical decision-making and may have improved communicative skills, both of which would be beneficial for patients. The 3-hm reports also showed that JDs engaged in planning and participated in educational initiatives and that management supported the education by developing educational strategies based on the JDs' suggestions. We hope that this article has revealed the 3-hm concept as one way to implement socio-cultural thinking in a medical world of individualists.

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