Training our prevocational doctors

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Education of our doctors needs to be a priority for the health services, not an add-on

Training of doctors is expensive and takes a long time, and so we need to make sure all parts count. It had been recognised for some time that the PGY1 and PGY2 years, sitting between undergraduate and vocational training, were a lost opportunity, with no defined outcomes and marked variation in experience and supervision.[1] Gaps in knowledge and skills were often likely after completion of this part of training. A significant number of junior medical officers (JMOs) feel unprepared to deal with, for example, medicolegal issues, emergencies or some procedures, which is unacceptable.[2] Worryingly, they receive varying degrees of feedback and often feel inundated with administrative tasks. Many states had started working on defining outcomes for the PGY1 and PGY2 years, and, with leadership from the Confederation of Postgraduate Medical Education Councils and funding from the Medical Training Review Panel of the Australian Government Department of Health and Ageing, they collaborated to develop the recently launched national Australian Curriculum Framework for Junior Doctors (http://www.cpmec.org.au/curriculum). They drew on previously published frameworks from Canada[3] and the United Kingdom,[4] and the Australian National Patient Safety Education[5] and Committee of Deans of Australian Medical Schools Indigenous Health Curriculum frameworks.[6] The Framework documents key areas that we all know are important (clinical management, therapeutics), but also makes explicit areas that are usually minimally addressed, such as patient safety, communication and cultural safety. The consensus is a significant achievement in terms of agreement and collaboration across states.

A *curriculum* can be viewed as a statement of the philosophy, content, learning methods and implementation of a course, which ideally would be linked with assessment. The Framework provides one part of a curriculum, namely the knowledge, skills and behaviours expected to be attained by PGY1 and PGY2 trainees, which they will carry forward into practice. However, will the Framework make any difference to the educational experience in those transitional years? This is a point of concern for JMOs, as discussed by Gleason et al in this issue (*page 114*).[7]

Two key aspects of training relate to how learning and assessment occur. Firstly, as regards learning, the curriculum framework working group recognised that learning will be progressive and opportunistic, and will occur in the work setting, and that effective supervision is important. Most learning still occurs in the work setting, and currently is unstructured and unlinked to any overall outcomes. The term "deliberate practice" has been used to define a model of learning characterised by good supervision and feedback, focusing on well defined tasks that can improve performance, and ensuring plenty of opportunity to practise these tasks.[8,9] This requires a teaching program, guided by the Framework, which runs alongside clinical work, including simulation, tutorials, debriefing and online learning. However, this is not enough. A recent study on communication skills taught in a simulated setting showed that a program to transfer those skills back to the clinical setting (through close clinical supervision and feedback) is required for simulation training to have any effect on practice in real life.[10]

Assessment may be even harder. Although the JMOs are not keen for assessment to be used for registration,[7] registration is a recognition of a level of competence and needs to involve some form of assessment. How can we be sure that doctors have reached a level of competence where they can be left to care for patients independently or are ready to move to the next stage of training? Currently, requirements vary from state to state, and may involve no more than completion of a form on overall impressions by supervising consultants in the PGY1 year. Although staff training has improved the amount of feedback JMOs receive, it is still lacking. The UK has moved down the pathway of having detailed determination of competence with multiple observed activities. Insufficient resources were provided for administration and training of staff, and this has led to both junior doctors and their supervisors developing innovative ways to subvert the system (Professor Janet Grant, Chair of the Curriculum Subcommittee, Postgraduate Medical Education and Training Board, UK. 11th National Prevocational Medical Education Forum, Adelaide 2006). Rather than moving straight to a complex system, at risk because of insufficient resources, we could continue to improve our current assessment of overall "global" competence of trainees, backed up by assessing essential areas in simulated settings (such as cardiopulmonary resuscitation). When a trainee's global competence appears inadequate, a second look, using assessments such as those used in the UK, could take place and more support be instigated. This may shift our assessment culture from punitive (blocking progress) to formative (helping progress), which presupposes that JMOs will all eventually be successful. JMOs may fear this aspect less.

All of this is a big ask in an overburdened health system. Without resources, little is likely to change. We need to define and run simulations and tutorials. We need to train clinicians to facilitate learning and give feedback (professional development for clinical teachers). We need to train clinicians to recognise who is struggling. For both teachers and learners, we need to make sure there is enough time to do all this. The health services need to make education a priority, rather than an add-on.[1,2]

We agree that JMOs should be involved in developing and implementing an assessment plan. They also need to understand their responsibility in this partnership of learning. It is of interest that JMOs mostly request more tutorials and simulation to support training and think they learn little in the work setting. Learners need to be taught to recognise and make the most of learning opportunities, in part through reflection (teach the learners[11]).

We cannot make all JMOs' experiences uniform. It is unnecessary and impossible. However, the Framework allows administrators, clinicians and junior doctors in different states and clinical settings to consider the best ways to implement a better learning and assessment system for JMOs. Rather than lose the momentum, let us share resources and ideas nationally, and evaluate implemen-

tation through education research to make sure outcomes are achieved. We need to lobby as a group to make sure our clinical sites (including hospitals, community settings and new models of interdisciplinary care) are best structured and resourced to optimally train and assess our junior doctors.

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