2011 Australasian Directors of Clinical Training (ADCTs) Forum

16th Australasian Prevocational Forum

6 November, 2011

Auckland, New Zealand

A. Background

On Sunday, 6 November 2011, the Australasian Directors of Clinical Training Committee (ADCTC) of the Confederation of Postgraduate Medical Education Councils (CPMEC) convened a workshop in Auckland, New Zealand on 6 November, 2011 for DCTs[1] as part of the 16th Annual Prevocational Medical Conference. The workshop was structured around the following three topics:

- *Professional development for DCTs*
- *Promoting interactions between DCTs and junior doctors*
- *Internship and the prevocational years*

The ADCTC had prepared an outline to guide discussions on the three topics (attached as Appendix 1). Each of the topics was co-facilitated by an Australian and New Zealand DCT to ensure a trans-Tasman perspective on each of the topics. This report provides a Summary of the key discussions on each of the three topics and the Recommendations of the 2011 ADCT Workshop.

[1] The term DCT is used generically to refer to those responsible for the training and supervision of prevocational doctors (including interns). They may be referred to as Directors of Prevocational Training, Intern Supervisors, etc.

B. Summary of Discussions

1. Professional Development for Directors of Clinical Training

This session was facilitated by Dr Stephen Childs (NZ) and Dr Barbara Bauert (Australia). The group noted the need for DCTs to have the same access to professional development as other clinical supervisors. The issue of professional development for DCTs was then considered in terms of knowledge and skills requirements, possible contents and the preferred delivery mode of a program. The following summarises the views expressed at the workshop:

a. What knowledge and skills do DCTs require?

- Leadership skills, both for an individual and for leadership within a system
- Counselling skills for pastoral care and career counselling
- Advanced communication skills both in written, verbal and non-verbal communication
- Role modelling support for individual professionalism
- Training regarding the ability to find resources and advocacy for training
- Skills in developing supervisory capacity

b. What contents should be in a Professional Development Programme for DCTs?

- Information regarding career counselling and career pathway advice
- Ability to act as advocates on behalf of individuals and systems
- Advanced assessment, feedback and appraisal skills
- A basic understanding of human resources law with regards to supervision and feedback
- Principles of remediation training
- Welfare of doctor in distress and support for doctors in difficulty
- Advanced leadership skills
- Advanced education skills on how to engage the mature learner
- Advanced skills in conflict resolution
- A strong understanding of the infrastructure of education that exists in the relevant jurisdiction including the responsibilities of the DCT
- An understanding of how Postgraduate Medical Councils and individual colleges function

c. How should the programme be delivered?

- The participants essential nature of a face-to-face meeting for both; practical tips, brainstorming and protected time to assist DCTs in this capacity
- There is an important opportunity to join existing electronic platforms which would minimise the need to duplicate infrastructure
- The necessity to capitalise on existing resources with regards to training

The workshop also explored the level of development required for DCTs and suggested the creation of four levels of teaching and supervision as follows:

- ***Level 1*** involves basic teaching skills that could be taught at the undergraduate level to all doctors.
- ***Level 2*** is more advanced teaching skills required by postgraduate students in their roles of supervising undergraduates as well as working within a team. Examples of this form of training exist with the current '*Teaching on the Run*' series, which is already well established throughout Australia as well as the TIPS programme developed within Canada.
- ***Level 3*** teaching skills would include those required by a clinical run supervisor in which the evaluations could include summative as well as formative evaluations and increased emphasis therefore on assessment and feedback would be required at this level.
- ***Level 4*** education skills are those required of an individual who is supervising supervisors. It is at this level that the workshop proposed the development of a PDP for DCTs. Current work in this area includes CPMEC's Professional Development Program for Registrars (PDPR), intern supervisors' manual published by the MCNZ, the NSW Health Education & Training Institute supervisors guide and the Royal College of Physicians Supervisors workshops and teaching programme developed by the Royal College of Physicians in the United Kingdom.

2 - Enhancing interaction between DCTs and Junior Medical Officers (JMOs)

This segment was facilitated by Prof Louis Irving (Australia) and Dr Wayne De Beer (NZ). Discussions centred on the ideal level of interaction between DCTs and JMOs examples of good practices, gaps that could be identified, and innovations to promote this interaction.

a. *Ideal Level and Format of Interactions*

- Most agreed that 6-monthly meetings (preferably one-on-one) were the current best practice, with the first meeting including goal setting and the subsequent meetings being focused on performance feedback and career planning.
- In the case of IMGs, the initial meeting also provided an opportunity to understand the working environment that they had come from and resultant adjustment issues.
- It was noted that there are other opportunities for DCT/JMO interaction, including casual contact in the workplace, group teaching sessions, contact through committees such as the JMO Forum committees and social functions. Feedback can also come from third parties such as MEOs and clinical supervisors.
- JMOs who have been identified as not progressing well, or who have specific problems, will need to have additional time with the DCT.

b. Examples of Good Practices

- One General Practice supervisor of other supervisors and trainees, described a model where he directly observed the interaction between the supervisor and the GP trainee, and gave feedback to both. The group considered this to be an excellent model, but would be difficult to adopt for more widespread use. If resources (including time) permitted, it could be used in special situations.
- DCTs indicted a clear preference for an approach that provided flexibility and allowed DCTs to tailor "individualised" approaches to fit their workplace situations.
- There was unanimous agreement that structured 6 monthly meetings were important. This is combined with a combination of a carefully planned orientation program, and a myriad of other strategies including regular "walkabouts" in the workplace to ensure DCT "visibility", informal contact at teaching sessions, an open door policy, end-of-term meeting of JMOs with senior medical leaders in the hospital, engagement of senior registrars, incentives such as coffee cards, etc.

c. Gaps and frustrations for DCTs

- Lack of time was identified by the group as the key constraint to interacting adequately with JMOs. This was particularly as most DCTs were fractional part-time appointments.
- Other frustrations identified included: particular issues associated with some IMGs, slow responses from the Medical Board of Australia about JMO issues, and the small percentage of 'recalcitrant' interns.

d. Examples of Innovations

- Discussions highlighted a variety of site-specific initiatives to improve contact and
- interaction including orientation leadership breakfast; clinical training record which ensures contact with the DCT; coffee cards as an incentive to contact; buddy system with a slightly more senior JMO; involvement of JMOs with planning rosters; JMO of the month award; social functions, mentor schemes, etc.

3 Internship and the PGY2 Year – Perspective of DCTs

This topic was co-chaired by Dr Ros Crampton (Australia) and Dr John Thwaites (New Zealand. Topics covered included access to undifferentiated patients as a cornerstone of medical education and training; the importance of emergency rotation in prevocational training; and embedding the Australian Curriculum Framework for Junior Doctors (ACF).

a. Access to undifferentiated patients and the Importance of emergency training for JMOs

The consensus from the attending DCTs was that having access to undifferentiated patients is a very important and valuable way for junior doctors to learn and develop clinical skills and should be encouraged wherever possible. In essence the process should allow the JMO to have "supervised autonomy" with clear lines of responsibility. The workshop also noted that emergency medicine added the following to the internship year:

- Excellent learning opportunities
- Supervised, graded autonomy in the evaluation of undifferentiated patients
- Synthesis with formulation of patient assessment investigation and management plan. This is key because an intern otherwise can be registered before they have ever seen a patient *de novo*. This task should involve some mandatory clerking.
    - Assessment of, and exposure to, a range of acuity of patients
    - Protected dedicated training time
    - Close supervision by ED consultants and access to Senior Medical Staff to assist and guide the JMOs and provide role modelling
    - Clinical and procedural skills
    - Inter-professional learning and teamwork
    - Identifies poor performance
    - Access to undifferentiated patients and at the interface of community care
    - Supervision is the key to ensure safety for both the patient and the practitioner.
    - Supernumerary is preferable
    - Modelling behaviour and practice is key
    - The settings for seeing undifferentiated patients include ward calls after hours, the emergency department, general practice and community care. In some situations it may be that the JMO is supernumerary such as perhaps in ED.

The workshop further noted that there was a need to address safety concerns. Supervised autonomy needed to be matched with explicit responsibility for optimal patient and trainee experience. Furthermore, there needed to protected and dedicated teaching time to ensure the full value of such rotations.

c. *Embedding the Australian Curriculum Framework for Junior Doctors (ACF) in the prevocational years*

Comments from DCTs indicated variability in the incorporation of the ACF into the prevocational years and particularly for PGY2s in some jurisdictions. The difference was partly influenced by variable levels of resourcing. A link between the ACF and requirements for the vocational colleges was also recommended i.e. the ACF needed to synchronise with the colleges particularly where those colleges had aspects of basic training commencing in the PGY2 year.

d. *What are the minimum capabilities expected at the end of the internship year and at the end of PGY2?*

In determining this, the Workshop suggested that the following factors need to be taken into account:

- The driver is the requirements for PGY1: what is the skill set required for registration should be given as advice by the CPMEC to the credentialing body.
- PGY2 training and accreditation is less well-resourced in some jurisdictions
- As noted above, there was also a need to link to the vocational Colleges curricula and to synchronise with these
- The key issue was the need for the integration of all aspects of the education program which needed to be mapped to the curriculum, including e-learning.
- Log books and e – portfolios may be required to build in a process that recognised prior learning

C. 2011 ADCT Workshop Recommendations

The 2011 ADCT workshop unanimously supported the following recommendations:

1. *That 'minimum standard ratios' be published for "DCT equivalent tenths" for all teaching hospitals in Australasia.*

2. *That a Professional Development Programme (PDP) is created for all Training Supervisors in the following format:*
    a) *a six monthly one day workshop*
    b) *e-learning modules on a common e-learning platform to promote communication and collaboration amongst Australasian DCTs*

3. *That structured 6 monthly meetings between DCTs and their JMOs were important.*

4. *That the ACF should be further embedded in the first two years of postgraduate training. To accomplish this, the DCT Committee recommends completion of the following goals:*
    a) *To determine the minimum capabilities required for registration at the end of PGY1 and present as the recommendation of the CPMEC*
    b) *To fully articulate and synchronise with the skill set required by all vocational colleges at entry to vocational training on completion of PGY2*

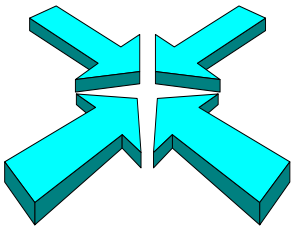
5. *That the experience of Emergency Medicine provides essential PGY1 training in the following respects:*
    a) *Supervised, graded autonomy in the evaluation of undifferentiated patients*
    b) *Synthesis of patient evaluation, and the formulation of investigation and management plans*
    c) *Exposure to a range of acuity of patients*
    d) *An environment that further ensures close supervision by Emergency Consultants; exposure to procedural skills; inter-professional learning and teamwork; and Identification of poor performance*
    e) *The workshop acknowledged that other settings may provide some of this experience but immersion in each of these workplace experiences had to be explicitly ensured and supervised.*

Compiled by Dr Jag Singh
CPMEC
5 April 2012

APPENDIX 1

Confederation of Postgraduate Medical Education Councils

ACT Health
Postgraduate Medical Council of Victoria
Postgraduate Medical Council of Tasmania
Postgraduate Medical Council of Queensland
NSW Clinical Education & Training Institute
Medical Council of NZ Education Committee
SA Institute of Medical Education and Training
Northern Territory Postgraduate Medical Council
Postgraduate Medical Council of Western Australia



Australasian DCT Committee

2011 Prevocational Forum DCT Workshop

AGENDA

Meeting Co-Chairs: Prof Lou Irving & Dr Stephen Child

1. ***Introductions & Apologies***
2. ***2011 Annual Prevocational Forum DCT Workshop Draft Agenda***

2011 DCT Workshop – Proposed Format

1.30pm – 1.45pm: Opening, Introductions and Outline for the Day

(L Irving & S Child)

1.45pm - 3.00pm: Topic 1: Professional Development Program for DCTs

(Session leaders: S Child & B Bauert)

Group Inputs and Presentations

3.00pm -3.30pm:	TEA BREAK
3.30pm – 4.05pm:	Topic 2: Promoting Interactions between DCTs and JMOs
	(Session leaders: L Irving & Wayne De Beer)
	Group inputs and presentation
4.05pm - 4.40pm:	Topic 3: Internship and the Prevocational Years
	(Session Leaders: Ros Crampton & John Thwaites)
	Group inputs and presentation
4.40pm – 4.55pm:	General discussions
4.55pm – 5.00pm:	Final Summation **(L Irving & S Child)**
	Next steps – Workshop Consensus Statement Writing Group
	Post-Forum follow up

3. *Topic 1: Professional Development for DCTs*

Convenors: Dr Stephen Child & Dr Barbara Bauert

The following represents an outline of topics for consideration in the section dealing with the professional development of DCTs:

1. *What knowledge, skills and behaviours do DCTs (or equivalent positions) need to function effectively in the role?*
2. *If a professional development program were developed for DCTs what would be the possible contents of such a program?*
3. *What mode(s) of delivery would be effective format in supporting the professional development of DCTs?*
4. *What other considerations need to be taken into account in relation to training in professionalism for DCTs?*

To generate discussions and provoke some pre-workshop reflections on the part of intending participants the following are suggested for consideration:

DCT Knowledge, skills and behaviours

- Managing the demands of the DCT role (or equivalent) given the part-time nature of the appointment
- Have self-awareness of personal strengths and weaknesses and impact on others
- Deal with a range of different conflict situations
- Understand and apply collaborative team working skills
- Undertake supervision and assessment of JMOs and give effective feedback
- Have a good grasp of the Medical Board of Australia's requirements for internship including the role of the Australian Curriculum Framework for Junior Doctors (or equivalent in NZ)
- Providing counselling, mentoring and support for doctors in difficulty
- Dealing with systems issues relating to JMO education and training

Possible Contents of Professional Development Program (PDP)

- Building self-awareness (including 360 feedback)
- Time management & prioritisation
- Medical Board of Australian Internship standards
- Assessment and calibration
- Adjusting supervision styles to trainee needs
- Managing conflict
- Dealing with doctors in distress
- Giving feedback
- Defining professional boundaries
- Mentoring
- Demonstrating leadership
- Teaching

Possible modes of delivering a PDP

- Should it be face-to-face, online or a blended approach?
- If face-to-face, what should be the recommended duration of the program (e.g. should be at least two days, etc.), in a residential or non-residential format, to maximise learning and provide the opportunity for DCTs to network with peers.
- Need for pilot programs – CPMEC to approach Health Workforce Australia or other agencies to secure funding to conduct pilot programs. Depending on the success of

the pilot programs, consideration to be given to rolling out the program nationally (and bi-nationally) through a Trainer Accreditation Program.

- Development of modules as an alternative or supplement to a face-to-face format?
- How to build on work already done through programs such as the Professional Development Program for Registrars?
- Should there be a credentialing system for DCTs? Where would a PDP fit into such a system?

4. ***Topic 2: Enhancing interactions between DCTs and JMOs***

Some topics for consideration under this section would include:

a. Is there an ideal level of formal and informal interaction between DCTs and JMOs?
b. What are DCTs doing now that seems to be working well?
c. What are some gaps that need to be addressed?
d. What are some innovations that could promote this interaction?
e. How do we ensure effective succession of DCTs and maintenance of 'corporate' knowledge (especially tacit knowledge acquired through years of experience)?
f. What support/resources would assist or promote the relationships between JMOs and DCTs?

5. ***Topic 3: Internship and the PGY2 year – the perspective of DCTs***

Some topics for consideration under this section would include:

a. Access to undifferentiated patients as a cornerstone of medical education and training
b. Access to community and primary care – alternatives?
c. Importance of the emergency rotation in prevocational training – what does it add?
d. Embedding the ACF in the prevocational years - what are the minimum capabilities expected at the end of the internship year and at the end of PGY2?

6. ***General Discussions***

This session will provide participants with an opportunity to raise any other issues not considered previously during the workshop.

7. ***Next steps***

This will involve agreement on the next steps to follow discussions and key resolutions agreed during the workshop. This will include the following:

a. Developing a consensus statement from the DCT Workshop on the key resolutions and outcomes through the establishment of a small Writing group to work with CPMEC.
b. Consideration of strategies for post-Forum follow up and communication with workshop attendees

Dr Jag Singh

Secretary

Australasian DCT Committee

3 November 2011