



AMA JUNIOR DOCTOR TRAINING,
EDUCATION AND SUPERVISION SURVEY

REPORT OF FINDINGS



AMA

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FOREWORD

We are pleased to present the results of the AMA junior doctor training, education and supervision survey. This report contains important data about the training environment in our public hospitals for prevocational and vocational doctors, the backbone of these institutions. We would like to thank those doctors who gave their valuable time to participate in the survey.

Australia's public hospitals are fundamental to the education and training of doctors. Public hospitals are where the vast majority of junior doctors spend their formative years and the part that they play in medical workforce training is essential to the delivery of high-quality patient care.

Tension between service delivery and training requirements has always existed in public hospitals. This situation appears to be worsening. The community needs our public hospitals to provide proper training facilities, adequate clinical supervision and protected time for education to enable a first-rate educational experience for the next generation of doctors. It expects public hospitals to safeguard a culture and environment that encourage a full and comprehensive medical education.

Senior doctors are under ever-increasing pressure from clinical service and administrative workloads and are often not supported to pass on their skills to junior colleagues. Similarly, junior doctors are finding it difficult to balance the delivery of clinical services with their right to a sound training experience.

The AMA's training, education and supervision survey, an initiative of the AMA Council of Doctors in Training, set out to document the views of those at the coalface – junior doctors – on the training environment in public hospitals.

It has shown that more resources are needed to ensure that the quality of medical training in our public hospitals is maintained and improved. The system is already under strain as hospitals attempt to cope with a surge in medical graduate numbers and the pressures of the increasing demand for service delivery.

Australia's medical workforce has an enviable reputation. Governments, health departments and the profession are obliged to ensure that our training system has the resources and support it needs to continue to deliver the best possible clinical experience to future generations of doctors – and maintain the high quality of care that Australians expect from their doctors.



Dr Andrew Pesce
AMA President



Dr Andrew Perry
Chair AMA Council of Doctors-in-Training

REPORT SUMMARY

This 2009 report presents the findings of the Australian Medical Association's survey of junior doctors across Australia on how they regard their public hospital training environment. It was conducted on-line between 19 June and 19 July 2009.

The aim of the survey was to obtain a picture of the quality of the education and training that junior doctors are receiving in our public hospitals. Participants were asked questions about the learning environment and the availability of supervision, assessment and feedback in the training hospital where they were working. The survey was initially piloted in Queensland and the Northern Territory in 2007. There were 912 respondents, representing each State and Territory.

KEY FINDINGS

Public hospitals are doing some things well.

- Junior doctors have a good level of access to learning resources.

The majority of respondents say that their hospital gives them easy access to educational and information tools such as web-based programs and contemporary medical journals for educational and clinical practice needs.

- Public hospitals are adopting important quality assurance mechanisms that enable learning.

Three-quarters of respondents report that they receive useful team and unit-based meetings on a regular basis at their hospital.

Nonetheless, the survey shows that public hospitals are struggling to meet their medical education obligations in an overloaded health system. It indicates that the need to teach and train the next generation of doctors is being outweighed by the demand for service delivery in public hospitals.

- The supervision of junior doctors in public hospitals is inadequate.

Nearly one-third of respondents believe that their training hospital does not provide them with adequate and appropriate supervision. While doctors work hard to ensure that this does not compromise patient safety, clearly this situation cannot continue.

- Service delivery requirements are impacting on junior doctor access to medical education and training

Nearly half of the junior doctors surveyed believe that their training hospital does not quarantine sufficient time from the pressures of immediate service delivery for education and training.

More than one-quarter of respondents report that their training hospital does not provide an environment for effective clinical practice-based teaching.

- The inadequate investment in staffing in our public hospitals is decreasing opportunities for education and training.

Nearly one-half of respondents believe that their hospital does not provide them with a fair and equitable distribution of workload.

- Many public hospitals do not have a culture or environment that encourages high-quality medical education.

More than one-third of the junior doctors surveyed do not believe that their hospital gives them timely and easy access to professional development leave for teaching and training.

One-third believe that their hospital does not support part-time or flexible working hours to assist with training and study.

More than 50% of registrars and 38% of senior registrars believe that their hospital does not have structured study programs to assist with their formal training requirements.

- Public hospitals are not sufficiently investing in the next generation of clinical teachers.

More than half of respondents believe their hospital does not have processes in place to develop the skills they need to teach and supervise their more junior colleagues, as well as medical students.

- Public hospitals are not providing sufficient space for junior doctors to undertake study and research.

Nearly two-thirds of respondents report that they do not have adequate office space for these purposes.

INTRODUCTION

The issue of sufficient resources and infrastructure for clinical training is a key area of focus for the AMA, particularly during the past five years since the Commonwealth significantly increased its investment in medical school places in order to meet growing medical workforce shortages.

The AMA has worked diligently to raise awareness of the medical training emergency that will arise if growing graduate numbers overwhelm existing resources and infrastructure for medical education. The AMA training, education and supervision survey is another step in this process. It focuses on the training environment in our public hospitals - where most medical education is delivered.

Though the number of junior doctor numbers is increasing rapidly, the number of supervisors in our public hospitals remains relatively static. There is a constant tension between the demand for service delivery and the need to teach and train junior doctors. There is also insufficient recognition of, and support for, the junior doctors who themselves deliver clinical education in the course of their work.

In its 2008 report, *Beyond the Blame Game*, the National Health and Hospitals Reform Commission acknowledged this problem and stated:

“Research, education and training are sometimes seen as an afterthought by health services which are focused on service delivery. Clinicians who have clinics and operating lists cancelled at short notice are denied their responsibility to teach. Trainees are expected to provide service while the commitment to their own training and that of students can be ignored in the interest of service provision”.

“Inadequate access to protected time for research, teaching and training and the supervisors to provide this, is short-sighted and must be remedied.”

Australia is fortunate that many clinicians choose to work in the public health sector to serve the community and to train the next generation of doctors. A significant amount of undergraduate and postgraduate teaching is undertaken by clinicians on a pro-bono basis. However, the system is at a tipping point. They can no longer go unsupported in their efforts to train more doctors. Public hospitals must foster an environment that enables more doctors to become involved in teaching and supervision.

The AMA Council of Doctors-in-Training (AMACDT) is specifically tasked by AMA Federal Council to provide feedback on the views of junior doctors in Australia, from interns to senior registrars. There has been overwhelming feedback from medical students and junior doctors across the country that access to a high-quality training environment and educational resources is an issue of great importance to them.

The AMACDT is acutely aware that junior doctors must be appropriately supported and supervised during their formative training years – and that the breadth of their experiences properly prepares them for independent medical practice.

Though this survey focuses on the views of junior doctors, the AMA will continue to consult with senior doctors to get their perspectives on how they can be supported as supervisors and teachers.

The AMA is planning to conduct the training, education and supervision survey every two years to assess trends in the quality of the training environment in public hospitals in each state and territory.

METHODOLOGY AND SAMPLE

METHOD

The AMA junior doctor training, education and supervision survey was conducted between 19 June and 19 July 2009.

The survey was a 20-item confidential, online, self-reporting questionnaire. Each question utilised a five-point Likert item. It covered five key areas:

- educational practices,
- balancing service and training,
- resources for clinical practice and medical education,
- teaching the teachers, and
- supervision, feedback and assessment.

The survey was hosted on the AMA Federal Secretariat's website and the link distributed electronically to approximately 5,700 junior doctor members. Respondents were presented with an explanatory statement on the aims and objectives of the survey. Participation was voluntary. Additional strategies to encourage participation by non-members were used in some States. Participants were asked to submit the name and postcode of their employing hospital.

PROFILE OF RESPONDENTS

There were 912 surveys completed by junior doctors working in hospitals across Australia.

SEX	TOTAL PERCENTAGE
Male	44%
Female	56%
CLASSIFICATION	
Intern	29%
Resident Medical Officer	29%
Registrar	33%
Senior Registrar	9%
LOCATION	
Australian Capital Territory	3%
New South Wales	21%
Northern Territory	1%
Queensland	19%
South Australia	10%
Tasmania	2%
Victoria	32%
Western Australia	13%

Figures are rounded.

EDUCATIONAL PRACTICES

STRUCTURED STUDY PROGRAMS

The breadth of contemporary medical knowledge demands that all vocational (specialist) training programs are based on formal curricula. Similarly, junior doctors undertaking prevocational medical education are guided by the Australian Curriculum Framework for Junior Doctors (ACFJD). It is the responsibility of hospitals to develop study programs based on the curricular requirements of the specialty colleges and the ACFJD, and link the delivery of patient care with explicit training objectives.

Results

Table 1. The hospital has structured study programs to assist with formal training requirements

	ALL	INTERN	RMO	REGISTRAR	SENIOR REGISTRAR
Strongly agree	5%	3%	6%	6%	5%
Agree	29%	20%	34%	30%	43%
Not sure	31%	57%	33%	12%	15%
Disagree	23%	15%	16%	36%	23%
Strongly disagree	11%	5%	11%	17%	15%

Figures are rounded.

Respondents were asked if their hospital had structured study programs to assist with their formal training requirements (Table 1). There was an evenly divided response to this question: more than 50% of registrars and 38% of senior registrars believed that their hospital did not have structured study programs. A large number of interns (57%) and RMOs (33%) were ambivalent in their responses.

Discussion

These results suggest that alignment of learning objectives with clinical duties is inadequate. This finding is concerning, given that the majority of registrars are likely to be enrolled in a formal specialist training program with a defined curriculum.

The ambivalent result from junior staff suggests that promotion of the ACFJD is suboptimal. These results suggest there is some way to go in rolling out a meaningful professional development program for junior doctors.

Overall, the findings from this question indicate that more work needs to be done by hospitals, in partnership with the postgraduate medical councils and specialty colleges, to develop appropriate study programs for trainees. Formalised teaching is a critical component of clinical training at every stage of the medical education continuum. Hospitals must be aware of external training commitments and support trainees to attend relevant courses and events.

EDUCATIONAL PRACTICES

EFFECTIVE CLINICAL PRACTICE-BASED TEACHING

Most medical training that is undertaken in the clinical environment is patient-focused and skills-based. The proportion of practical learning increases as junior doctors graduate from medical school to residency and then vocational training. It is essential that the hospital environment supports clinical training for junior doctors at all stages of the medical education continuum. In practice, this means integrating education with everyday clinical processes. An appropriate administrative framework and well-resourced infrastructure are both required.

Results

Table 2. The hospital provides an environment for effective clinical practice-based teaching

	ALL	INTERN	RMO	REGISTRAR	SENIOR REGISTRAR
Strongly agree	9%	8%	8%	11%	11%
Agree	49%	49%	53%	47%	43%
Not sure	15%	15%	13%	17%	12%
Disagree	21%	22%	22%	20%	21%
Strongly disagree	6%	5%	4%	5%	13%

Figures are rounded.

Respondents were asked if their hospital provided an environment for effective clinical practice-based teaching (Table 2). Though 58% of respondents believed their hospital did so, a significant number (27%) disagreed. These results were consistent across training levels.

Discussion

It is disturbing that a significant number of respondents felt that their workplace did not support sound clinical-based education.

This result may reflect heavier service delivery demands in public hospitals. The 2009 AMA Public Hospital Report Card has confirmed that public hospitals are under increasing pressure to deliver more care with fewer resources.¹ A recent study showed that, despite growing numbers of medical school students and graduates, the total time spent on medical teaching by clinicians fell between 2005 and 2006.²

To improve clinical practice-based teaching, education needs to be integrated with the delivery of patient care. The two cannot be separated and both must be resourced adequately.

Hospital structures should reflect the needs of learners and the supervisory model of Australian public hospital practice. A whole-of-organisation approach is required to integrate learning with everyday tasks and responsibilities. For example, hospitals must factor in dedicated teaching time when allocating and rostering clinical duties.

Hospitals must be adequately funded to ensure that human resources and physical infrastructure are available to enable doctors to combine high-quality clinical teaching with high-quality patient care.

¹ AMA Public Hospital Report Card 2009, Australian Medical Association

² Joyce C, Piterman L, Wesselingh S. The widening gap between clinical, teaching and research work. *Medical Journal of Australia* 2009; 191 (3), p 170

EDUCATIONAL PRACTICES

QUARANTINED TIME FOR EDUCATION AND TRAINING

Education and training come in various forms for junior doctors. Though much can be learned in the course of everyday tasks and activities, it is essential that time is allocated for learning activities. Training opportunities are often sacrificed for service delivery requirements. Without guaranteed teaching time, the educational value of a hospital rotation can be quickly undermined.

The emergence of a curriculum framework for prevocational doctors requires that teaching hospitals adopt structured education programs. The full set of learning objectives cannot be met without dedicated teaching time. Similarly, vocational training programs have core curricular requirements that require formal teaching – both inside and outside of the hospital.

Results

Table 3. The hospital allocates sufficient quarantined time exclusively for education and training on a regular basis

	ALL	INTERN	RMO	REGISTRAR	SENIOR REGISTRAR
Strongly agree	9%	12%	6%	9%	7%
Agree	31%	42%	24%	28%	35%
Not sure	11%	13%	13%	8%	13%
Disagree	30%	23%	36%	33%	26%
Strongly disagree	18%	10%	21%	22%	18%

Figures are rounded.

Nearly half (48%) of respondents believed that their hospital did not quarantine time exclusively for education and training on a regular basis (Table 3). These results were relatively consistent across all training levels. Interns were more likely to have access to dedicated teaching time and residents had the greatest concerns with respect to quarantined education time.

Discussion

Quarantined time for learning is essential for junior doctors, who often face significant clinical pressures; learning opportunities are easily foregone in the face of service delivery requirements. Education time needs to be protected from the competing pressures of immediate clinical service delivery to ensure that the quality and effectiveness of learning are not compromised. Resident Medical Officers in particular appear to be an at-risk group.

Protected teaching time is a key component of clinical support time provisions in most State and Territory industrial agreements. Hospital administration and senior staff must be diligent in ensuring that their employees have quarantined time for professional development – especially if contractual obligations exist. The provision of learning opportunities should be seen as core business and incorporated into the rosters for junior and senior medical staff.

EDUCATIONAL PRACTICES

CLINICAL MEETINGS

Clinical meetings are a vital component of education and training for junior doctors. Key benefits include the:

- opportunity for patient-centred clinical discussion,
- integration of research and best-practice literature with contemporary clinical cases,
- demonstration of clinical leadership, and
- delivery of formal education.

Clinical meetings are one of the few occasions when time is allocated for clinical discussion, which is a good medium for the delivery of medical education. They are critical for learning evidenced-based care and multi-disciplinary clinical management.

Results

Table 4. The hospital provides useful team/unit-based meetings such as case presentations/reviews and multidisciplinary meetings on a regular basis

	ALL	INTERN	RMO	REGISTRAR	SENIOR REGISTRAR
Strongly agree	15%	12%	12%	20%	17%
Agree	59%	58%	57%	62%	61%
Not sure	9%	10%	11%	5%	10%
Disagree	14%	17%	16%	9%	10%
Strongly disagree	3%	2%	3%	4%	2%

Figures are rounded.

Three-quarters of respondents believed that they received useful team-and unit-based meetings on a regular basis at their hospital (Table 4).

Discussion

This is an encouraging finding and suggests that team-based care, clinical audit activities and evidenced-based practice have been adopted widely. These are all important quality assurance mechanisms. As the number of medical graduates entering the health system grows, it will be important that hospitals ensure that clinical meetings remain a priority. Clinical meetings should be conducted at dedicated times that are protected from other clinical and non-clinical duties.

BALANCING SERVICE AND TRAINING

DISTRIBUTION OF WORKLOAD

Learning objectives in medical education can only be met when junior doctors have an appropriate workload. The delivery of a high-quality teaching program relies on appropriate rostering and allocation of clinical duties to both junior and senior staff.

Results

Table 5. The hospital provides junior doctors with a fair and equitable distribution of workload while maximising educational and training opportunities

	ALL	INTERN	RMO	REGISTRAR	SENIOR REGISTRAR
Strongly agree	4%	5%	4%	4%	2%
Agree	32%	34%	29%	30%	37%
Not sure	17%	18%	15%	16%	22%
Disagree	33%	31%	35%	35%	23%
Strongly disagree	15%	12%	17%	15%	16%

Figures are rounded.

Table 5 shows that only one-third (36%) of respondents believed that their hospital provided them with a fair and equitable distribution of workload. Nearly one-half (47%) believed that it did not. There was consistency across the training groups.

Discussion

This is a worrying finding and is probably indicative of the increasing pressures on the public hospital system. Higher patient volumes and accelerated turnover have impacted significantly on the workload of junior doctors, and escalating service demands inevitably decrease opportunities for education and training. It is critical that hospitals support junior doctors to deliver quality clinical care within a learning context.

Hospitals must be supported to employ a quantum of staff that is commensurate with workload. Rostering must reflect the fact that the junior doctors are learners as well as service providers. Achieving a balance between work, study and life more broadly is critical for maintaining a skilled and motivated workforce.

BALANCING SERVICE AND TRAINING

ACCESS TO PROFESSIONAL DEVELOPMENT LEAVE

Medical knowledge is constantly evolving and it is essential that doctors working on the front-line can gain access to the latest advances in medical science and technology. This requires attendance at forums and conferences.

In addition, most vocational training programs require their trainees to attend specialised programs and events. It is incumbent on hospitals to support their employees to participate in these activities – and it is in their best interests as well.

Results

Table 6. The hospital provides timely and easy access to professional development leave

	ALL	INTERN	RMO	REGISTRAR	SENIOR REGISTRAR
Strongly agree	5%	3%	4%	7%	10%
Agree	28%	17%	23%	39%	37%
Not sure	30%	47%	33%	17%	15%
Disagree	24%	21%	25%	27%	23%
Strongly disagree	13%	12%	16%	11%	16%

Figures are rounded.

More than one-third (37%) of respondents did not believe that their hospital provided timely and easy access to professional development leave (Table 6). Senior trainees reported fewer issues and a large proportion of junior doctors were unaware of their entitlements.

Discussion

The response to this question aligns with anecdotal evidence that trainees face hurdles in securing professional development leave. Many junior doctors find getting access to their entitlements is cumbersome and bureaucratic. The large ambivalent result (30%) may suggest that communication processes in hospitals are inadequate. In many hospitals, a major barrier is the hospital administration's willingness and capacity to arrange appropriate cover arrangements.

Under State and Territory industrial agreements, junior doctors are entitled to professional development leave. Local institutional preference should not compromise access to clinical courses, conferences and training programs. These types of activities are essential in maintaining a skilled and talented workforce that is abreast of the latest advances in medical science and technology. Ultimately, limiting access to professional development opportunities will come at a cost to patient care.

These findings suggest that many junior doctors are not aware of their entitlements, and it is possible that their access to professional development leave activities is compromised. It is encouraging that registrars appear to be able to get access to leave for educational activities in accordance with the goals and objectives of their training program.

BALANCING SERVICE AND TRAINING

PART-TIME AND FLEXIBLE WORKING HOURS

A significant amount of research has established that junior doctors are in favour of flexible work arrangements. The 2007 AMA work-life flexibility survey of public hospital doctors showed that junior doctors had the greatest demand for flexible rostering and flexible working hours.³ It also showed that flexible working practices were important issues for junior doctors when choosing which medical specialty to pursue. More responsive rostering is essential if the public hospital sector is to engage and retain the current generation of medical trainees.

Results

Table 7. The hospital supports part-time/flexible working hours to assist with training and study

	ALL	INTERN	RMO	REGISTRAR	SENIOR REGISTRAR
Strongly agree	3%	1%	3%	4%	2%
Agree	17%	17%	15%	18%	26%
Not sure	43%	58%	46%	30%	35%
Disagree	21%	16%	21%	28%	16%
Strongly disagree	15%	8%	15%	20%	21%

Figures are rounded.

More than one-third (36%) of respondents believed that their hospital did not support part-time or flexible working hours to assist with training and study (Table 7). Registrars were particularly affected and a large proportion of junior trainees (58% of interns and 46% of residents) were unaware of the options available to them.

Discussion

These findings may reflect training demands, but employer attitudes may also contribute. It is often difficult to get access to flexible working arrangements in hospitals and, where they are available, the policies are not always publicised widely.

Recent jurisdictional reports have established that low morale and professional dissatisfaction are major issues for public hospital employees – with significant flow-on effects to patient care. Part of the solution is to encourage hospitals to offer flexible work arrangements to their staff, which will help motivate doctors to deliver high-quality care.

³ AMA Work-life flexibility survey: report of findings, Canberra, Australian Medical Association 2007.

RESOURCES FOR CLINICAL PRACTICE AND MEDICAL EDUCATION

EDUCATIONAL AND INFORMATION RESOURCES

The evolving nature of medical knowledge, as well as an increasing emphasis on evidence-based care, demand that all doctors have access to up-to-date clinical resources. This includes web-based programs, soft and hard-copy texts and contemporary medical journals.

Results

Table 8. The hospital provides you with easy access to a range of educational and information resources appropriate to your educational and clinical practice needs

	ALL	INTERN	RMO	REGISTRAR	SENIOR REGISTRAR
Strongly agree	26%	28%	27%	25%	21%
Agree	57%	55%	61%	57%	52%
Not sure	4%	6%	2%	4%	4%
Disagree	11%	9%	8%	12%	18%
Strongly disagree	2%	2%	1%	2%	5%

Figures are rounded.

The majority of respondents (83%) agreed that their hospital provided them with easy access to a range of educational and information resources (Table 8). This is a very positive finding, and hospitals should be commended for investing in this area. A well-stocked resource bank is essential for the delivery of high-quality patient care and medical education.

RESOURCES FOR CLINICAL PRACTICE AND MEDICAL EDUCATION

ACCESS TO OFFICE SPACE

Junior doctors need proper physical infrastructure to deliver professional services. The provision of adequate office space is a good example of how hospitals can support their junior doctors.

Results

Table 9. The hospital provides you with easy access to office space

	ALL	INTERN	RMO	REGISTRAR	SENIOR REGISTRAR
Strongly agree	5%	3%	2%	9%	10%
Agree	25%	23%	21%	29%	30%
Not sure	10%	11%	11%	8%	6%
Disagree	39%	42%	48%	32%	28%
Strongly disagree	21%	21%	18%	22%	26%

Figures are rounded.

Nearly two-thirds (60%) of respondents disagreed or strongly disagreed with this statement (Table 9).

Discussion

Poor access to office space is a common complaint among junior doctors. Work-spaces (if available) are frequently shared with other professionals and students and are often small, under-resourced and badly positioned.

Adequate office space is critical to the efficiency of the workplace. It also helps to maintain patient privacy and enable better communication between health professionals. Hospitals are lively and busy places, and doctors need the necessary space to complete paperwork, transcribe communications and participate in sensitive and privileged clinical discussions. Much of a junior doctor's day is spent working alongside medical and allied health staff. Though it is important for colleagues to interact and communicate when delivering everyday patient care, some duties require a more discreet environment afforded by offices.

Office space is also an important factor in ensuring a quality training experience. Doctors need the physical space to undertake independent study and research.

The response to this question suggests that the provision of office space is not a priority area for hospitals. Addressing this situation will improve the capacity and productivity of hospitals and assist junior doctors to meet their learning objectives.

TEACHING THE TEACHERS

DEVELOPING JUNIOR DOCTORS' TEACHING SKILLS

The burgeoning number of medical trainees entering the public hospital system will require more doctors to become educators. Junior doctors already make a significant contribution to the provision of medical services as well as the teaching of more junior staff and medical students. Indeed, in many institutions all junior medical staff are obliged to provide education and supervision to their less-experienced colleagues.

There is a strong case for better equipping junior doctors and vocational trainees with the skills and knowledge to deliver high-quality clinical teaching in formal and informal training environments.

Results

Table 10. The hospital has processes to develop the teaching skills for junior doctors who provide training, eg, to medical students

	ALL	INTERN	RMO	REGISTRAR	SENIOR REGISTRAR
Strongly agree	4%	3%	3%	5%	2%
Agree	20%	21%	23%	18%	16%
Not sure	22%	23%	23%	19%	22%
Disagree	42%	43%	40%	43%	45%
Strongly disagree	12%	9%	11%	16%	15%

Figures are rounded.

More than half (54%) of respondents believed that their hospital did not have processes in place to develop the teaching skills of junior doctors who themselves must provide training, for example, to medical students (Table 10). These results were similar across the training levels.

Discussion

This is a significant finding. There is a growing expectation that junior doctors will participate in teaching of medical students and their junior colleagues. Interns, residents and registrars therefore need to be supported in their roles as mentors, teachers and facilitators.

Teaching is a unique skill that requires specific training. Greater systemic investment by hospitals and State governments for teaching the teachers is required. Collaborative relationships should be built between clinical centres and medical schools, as well as vocational, prevocational and undergraduate educators.

Hospital rosters should reflect teaching commitments, and junior doctors should be rewarded for delivering education. Innovation in the teaching and training of educators should be encouraged.

Junior doctors must be equipped with the necessary knowledge and skills to ensure that the education they deliver is safe, effective and efficient. Though some excellent programs are available at present such as "Teaching on the Run", they are often under-resourced and difficult to access.

SUPERVISION, ASSESSMENT AND FEEDBACK

SUPERVISION

The public sector has long used established hierarchical structures to deliver clinical services. Hospitals rely heavily on junior doctors to staff emergency departments, manage and perform surgical processes and procedures and care for in-patients. For the purposes of safety and quality, as well as clinical education, it is essential that junior staff are supervised in their work. Importantly, different models of supervision apply to different settings and trainee standards.

Results

Table 11. The hospital provides you with adequate and appropriate clinical supervision in all work situations

	ALL	INTERN	RMO	REGISTRAR	SENIOR REGISTRAR
Strongly agree	7%	4%	7%	10%	10%
Agree	46%	43%	47%	49%	41%
Not sure	14%	17%	14%	12%	15%
Disagree	25%	27%	27%	23%	21%
Strongly disagree	7%	9%	5%	6%	13%

Figures are rounded.

Table 11 shows the respondents' perceptions on the level of supervision that they were receiving in their hospital. More than half (53%) of respondents believed that their hospital provided them with adequate and appropriate supervision in all work situations. Nearly one-third of respondents (32%) did not – a finding that was consistent across the trainee groups.

Discussion

It is disturbing that a high proportion of junior students felt that they were inadequately supervised and did not have access to the requisite amount of direction from senior colleagues. This finding has implications for education and training, as well as patient safety. Junior doctors should not practise in an environment where they are unable to get advice and assistance from senior staff when required.

Guidelines and policies are available from a wide variety of organisations, educational institutions and registration authorities to assist hospitals in developing their supervisory standards and structures. These data suggest that there is room to refine and revise the implementation of these programs for junior medical staff.

SUPERVISION, ASSESSMENT AND FEEDBACK

FEEDBACK

Feedback loops are essential for quality assurance, service improvement and process re-design. The sourcing of junior doctor feedback is a basic standard of most specialty colleges, and is explicitly required by the postgraduate medical education councils which, at a minimum, accredit intern training posts. Educational programs can only be improved if appropriate feedback and evaluation mechanisms are in place.

Results

Table 12. The hospital has a mechanism for consultation with, and feedback from, junior doctors regarding their work and training

	ALL	INTERN	RMO	REGISTRAR	SENIOR REGISTRAR
Strongly agree	8%	11%	8%	5%	9%
Agree	50%	55%	52%	45%	46%
Not sure	17%	15%	17%	20%	12%
Disagree	19%	17%	17%	20%	21%
Strongly disagree	6%	2%	6%	9%	12%

Figures are rounded.

More than half (58%) of the respondents believed that their hospital had a mechanism for consultation with, and feedback from, junior doctors regarding their work and training. (Table 12). One-quarter (25%) did not.

Discussion

It is critical that junior doctors can participate in the appraisal of clinical terms in respect of their educational value and workload. Feedback from those at the coalface should be valued by senior, administrative and educational staff. It should be confidential and privileged where required.

In practice, feedback and assessment processes need to be tailored to suit the learning and employment context. Any system should enable a two-way exchange whereby the learner or employee and the teacher or employer can reflect on training and service delivery.

SUPERVISION, ASSESSMENT AND FEEDBACK

SUPERVISOR ASSESSMENTS AND REPORTS

Feedback is a vital component of medical education at all stages of the medical education continuum. It is essential that junior doctors can get access to feedback and appraisal processes relevant to their level of practice. This might come in various forms, including:

- de-briefing following a discrete clinical event, intervention or procedure,
- reflection on the attainment of key learning objectives on the completion of a hospital rotation,
- mapping progress against a curriculum or learning framework, and
- professional appraisal as a part of a broader human resources process.

Results

Table 13. The hospital has a sound and effective process for supervisor assessments and reports, including rights of review

	ALL	INTERN	RMO	REGISTRAR	SENIOR REGISTRAR
Strongly agree	7%	9%	8%	6%	6%
Agree	46%	54%	46%	42%	35%
Not sure	27%	25%	25%	29%	29%
Disagree	15%	11%	16%	18%	13%
Strongly disagree	5%	2%	4%	6%	16%

Figures are rounded.

More than half of the respondents (53%) agreed that their hospital had a sound and effective process for supervisor assessments and reports, including rights of review (Table 13). More advanced trainees were much less likely to agree with this statement.

Discussion

The further development and use of assessment reports based on the Australian Curriculum Framework for Junior Doctors is a potential pathway for engendering a more consistent approach to formal assessment of junior doctors. This is an essential element in supporting junior doctors to meet their learning goals. It is also critical in ensuring the development of a skilled and capable national workforce.

Clinical assessment and feedback tools should not, however, be used for recruitment and employment purposes. This is a basic tenet of the AMA's position on the assessment of prevocational doctors.⁴

For vocational trainees, the provision of feedback is critical for learning, especially when acquiring more advanced clinical skills. The Australian Medical Council has defined standards to guide the specialist colleges, and in turn hospitals, in the attainment of supervisor assessments and reports, as well as rights of review. Hospital feedback processes must be in accordance with professional standards and the applicable industrial agreements.

⁴ AMA position statement, *Prevocational medical education and training 2005*.

CONCLUSIONS AND RECOMMENDATIONS

Australia's public hospitals will continue to be central to the education and training of doctors. The findings of the AMA's training, education and supervision survey have confirmed that tensions exist between the demand for service delivery and the need to teach and train the next generation of doctors. An equilibrium must be restored so that the public health system can continue to rely on a sustainable and highly-skilled medical workforce.

In November 2008, the Council of Australian Governments announced a \$1.64 billion funding package to support clinical training across the whole of the health workforce. It was a strong package but had a significant focus on undergraduate clinical training. Though it includes additional private sector specialist training positions and GP training positions, it does not adequately address the immediate and growing need to support prevocational and vocational training better as graduate numbers continue to grow.

Governments will have to increase the resources allocated to hospitals if they are to provide quality supervision and maintain training standards. Infrastructure, resources and supervision will all need to be increased significantly and the use of alternative training settings, including private hospitals and community settings, considered. By ensuring that there are sufficient training places for the increase in medical graduates over the next few years, State and Territory governments will ensure that they can meet future medical workforce needs.

The AMA released its blueprint for health reform, the AMA *Priority Investment Plan for Australia's Health System*, in September 2009. The plan identifies key areas of the health system where urgent action will make a real difference for people seeking access to quality health services.

Guaranteeing the quality of medical education and training for the increasing numbers of medical graduates is a priority area selected by

the AMA for immediate significant investment in health. The AMA is calling for:

- 820 prevocational general practice training placements a year by 2012,
- 1,500 first-year GP vocational training positions a year by 2015,
- 3,400 guaranteed intern places by 2013 – with processes in which States are accountable to the Commonwealth for delivering on this, and an annual process of monitoring by the Commonwealth to ensure that these places are provided,
- commensurate increases in prevocational training places to meet the increasing number of junior doctors that complete their intern year,
- better access to protected teaching time for junior doctors, while senior clinicians should be guaranteed at least 30% of their ordinary working time to devote to clinical support activities such as teaching and training,
- the new Health Workforce Agency (HWA) – in close collaboration with the medical profession through the AMA – to undertake comprehensive and robust medical workforce modelling of supply and demand requirements for the next 10 years to determine the detailed number of vocational training places required in each discipline, and
- the Medical Training Review Panel to report annually on the availability of clinical training places for students at medical school, for doctors in training at prevocational and vocational levels, and to assess progress against the above targets established by the HWA.

Implementation of the AMA's plan will ensure that Australia maintains a world-class medical education system and a highly-skilled medical workforce. This is in the best interests of all Australians.

GLOSSARY

INTERN	A graduate of an Australian Medical Council (AMC) accredited medical school who is undertaking the year of supervised clinical training. The intern year, also known as the postgraduate year 1 (PGY1), is undertaken primarily in a public hospital.
JUNIOR DOCTOR	Also known as a doctor-in-training, a doctor undertaking postgraduate (prevocational or vocational) medical training.
MEDICAL EDUCATION CONTINUUM	The continuous process of medical education from undergraduate, prevocational and vocational training progressing through to continuing professional development throughout a doctor's career.
PREVOCATIONAL TRAINING	<p>Broadly the first two years of postgraduate training for junior doctors.</p> <p><i>Postgraduate year 1 (PGY 1):</i> the year of supervised clinical training completed by graduates of an AMC-accredited medical school. Also known as the intern year.</p> <p><i>Postgraduate year 2 (PGY 2):</i> the year of structured rotations through supervised clinical training placements, mostly in public hospitals, undertaken when medical practitioners have completed their internship, and gained general medical registration. Also known as the first-year Resident Medical Officer year or Hospital Medical Officer year.⁵</p>
REGISTRAR	<p>Also known as a trainee, a junior doctor undertaking vocational (medical specialist) training.</p> <p><i>Basic training:</i> a period of defined training required by some specialist medical colleges to be undertaken in order to meet eligibility criteria for entering an advanced training program.</p> <p><i>Advanced training:</i> a period of defined/structured education and training which, when successfully completed, will result in eligibility to apply for fellowship of a specialist medical college or to practise as a specialist, in some cases preceded by completion of basic training requirements.⁶</p>
RMO	Resident Medical Officer: a junior doctor undertaking structured rotations through supervised clinical training placements, mostly in public hospitals, following completion of the intern year.
SPECIALIST	A medical practitioner who has successfully completed vocational medical training and the other requirements of a specialist medical college and been awarded fellowship of the college.
VOCATIONAL TRAINING	The necessary training for a chosen medical specialty.

⁵ Eleventh Report of Medical Training Review Panel, Australian Government, 2008, p.113.

⁶ Ibid, p.113.







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