Prevocational medical training and the Australian Curriculum Framework for Junior Doctors: a junior doctor perspective

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ABSTRACT

- The current system of prevocational training does not meet the needs of junior doctors because of a high administrative workload, insufficient funding for education, and a lack of centralised guidance for trainees, teachers and hospitals.
- The Australian Curriculum Framework for Junior Doctors is designed to identify the training objectives for the prevocational years.
- The Framework has the potential to improve the quality of training of junior doctors, but this depends on how well it is implemented and resourced.
- It is imperative that any group responsible for implementing or assessing the Framework have a representative junior doctor, among others, on its decision-making committee.
- Stringent accreditation of training institutions is vital to the effective implementation of the Framework.
- The Framework should be used to promote teaching and learning, not as a barrier to vocational training or as a checklist to complete.

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In Australia, doctors must complete a 1-year internship and generally spend at least 1 additional year rotating through various terms before entering a specialty training program. These prevocational years should provide a bounty of opportunity for doctors to develop essential skills, but currently this process is impeded by several factors, including the lack of a formalised national prevocational training program, inadequate funding of education and skills training, and high service demands. To ensure a high quality medical workforce, the needs of doctors in training must be identified and met.

Here we discuss how the Australian Curriculum Framework for Junior Doctors, which was launched in 2006, could affect prevocational medical training, as well as important issues regarding implementation and resource allocation. Our conclusions represent a consensus of personal opinions of the Chairs of the Junior Medical Officer Forums of New South Wales, Queensland, South Australia, Victoria and Western Australia, who all contributed to the ideas expressed in this article.

The current situation

There is a common misconception that a medical graduate steps into a hospital and instantly becomes a doctor. In reality, the process of becoming a doctor is gradual, beginning at the undergraduate level, where one learns the principles of sound clinical practice, and continuing through the supervised hands-on experience of prevocational and vocational training. This process involves the acquisition of skills, knowledge, reasoning and experience, and is a vital foundation for later unsupervised practice. Although clinical experience during training is essential, it must be supplemented by on-the-job teaching from senior clinicians and structured education programs.

There are no published data documenting the amount of teaching available to prevocational doctors in Australia, so we make generalisations based on our experience. On a daily basis, doctors in training spend minimal time at work involved in dedicated education and training activities. As a vital cog in the day-to-day operation of the public health system, much of their time is occupied by repetitive administrative tasks. In many hospitals, the only structured education interns and residents receive is 1 hour of formal teaching a week. This teaching is of variable quality and relevance and, because of service demands, junior doctors are frequently too busy to attend these sessions. When they are able to attend, interruptions to answer pager calls often make effective learning virtually impossible (although some hospitals now have pager-free teaching time). Valuable teaching from consultants and registrars also takes place, but this is sporadic and impromptu. Teachers are left with the difficult task of determining what should be taught and how this should be done.[1] The systems that do exist for delivering education are inefficient, under-resourced, under pressure and unsustainable.[2] Ultimately, prevocational doctors have little time for learning, and little formal teaching is provided.

To illustrate these issues, a recent national survey, commissioned by the Australian Government Department of Health and Ageing, showed that 64% of prevocational doctors felt generally prepared for their job, 31% felt adequately prepared for clinical emergencies and 45% felt prepared for performing procedures.[3] Only 20% reported exposure to clinical skills training and 56% felt that they had adequate contact with consultants. More than 80% of these trainees wanted more formal instruction from their registrars and consultants, and increased exposure to high-fidelity simulation and to professional college tutorials.

1 The Australian Curriculum Framework for Junior Doctors[8]

- The Framework is an educational template that identifies the core competencies and capabilities necessary to provide quality health care. It will enable individual doctors to assess their education and training needs.
- It outlines the general knowledge, skills and behaviour that prevocational doctors should acquire, regardless of their planned specialisation or training location.
- It bridges undergraduate curricula and college training requirements, and is intended to assist education providers, clinical teachers and employers to provide a structured and planned program of education for junior doctors.
- It is built around three learning areas — Clinical Management, Communication, and Professionalism — which are divided into 11 categories.
- Each category comprises a number of learning topics, each of which details the associated capabilities expected.
- It is envisaged that learning and assessment resources will be made available to support each learning topic. ◆

2 Issues to address in adopting the Australian Curriculum Framework for Junior Doctors

General aspects

- The Framework should aid in the development of learning objectives that the junior doctor can achieve in each rotation, depending on the duration, case mix, and supervision provided.
- Responsibility for training should be a partnership between employing hospitals, training governance bodies and doctors, so that a disproportionate amount of work does not fall on the individual prevocational doctor.
- The curriculum and assessment should not replicate or replace learning that takes place at university. It should reinforce and revisit this learning, taking advantage of the benefits of the clinical training environment.
- Effective learning occurs through the integration of general medical knowledge, skills and attitudes in everyday clinical practice, supported by adequately resourced educational programs, supervision and time for learning.

The process of implementation

- Any consultation process discussing implementation must provide adequate time and resources to engage relevant parties, especially junior doctors, and allow comprehensive discussion of the issues.
- A robust and accountable process must be created to ensure any recommendations for implementation are followed.
- The responsibility for implementation should be well defined and shared among individual hospitals, postgraduate medical councils, and other relevant bodies.

Practical aspects of implementation

- Hospitals must meet their training responsibilities and should not continue to place service demands above the training needs of doctors.
- Teaching time needs to be a regular, protected, paid part of every junior doctor's day. The Australian Medical Association recommendation of 5 hours per week of pager-free quarantined education time for prevocational doctors is a reasonable goal.[15]
- Clinicians must be paid to teach, ensuring the provision of expert supervision.[16] Teaching responsibilities must be incorporated into job descriptions, and resources provided to allow time to fulfil this role. It is no longer possible to rely on pro-bono teaching by senior clinical staff, who are frequently too busy to prioritise teaching.[17]
- Innovative solutions to balancing service demands and training needs must be sought, and the efficacy of these solutions should be adequately evaluated.

The assessment process

- Assessment should aim to demonstrate a high standard of clinical ability, not just serve a certification role or as a hurdle to career progression.
- Although assessment is necessary to ensure that teaching methods are effective, the process should not be unnecessarily onerous.
- Assessment should provide effective feedback for the learning and development of the doctor. It should not be adapted to a tick-box form that has little meaning or relevance.
- Assessment should provide feedback to the hospital about the resources for and quality of their training environment.
- Assessment should be used by bodies such as the Postgraduate Medical Councils to accredit hospitals on their ability to provide training and experience. Hospitals that are unable to provide adequate training should not be accredited to receive prevocational doctors.
- Assessment should not be used as a criterion for obtaining prevocational or vocational positions or registration.
- Assessment should begin through meetings with supervisors to discuss agreed goals and objectives.
- Learning objectives should be reviewed periodically during the term by the junior doctor and supervisor, so that areas of learning that have not been reviewed can be addressed. ◆

Although a high workload makes learning difficult, increasing numbers of junior doctors will not alleviate this problem unless adequate resources are provided for training. A survey of medical students and interns in WA showed that 80% of respondents predicted a negative effect of the increased medical student numbers on teaching, and 77% predicted a negative effect on training positions for junior doctors.[4] A very strong emphasis on training is necessary to cope with increasing numbers of medical graduates. In keeping with this, the Productivity Commission has identified the inadequacy of funding for clinical training, and a failure to consider the clinical training implications of increases in the number of undergraduate university places.[5]

The state of prevocational medical education in Australia stands in stark contrast to that in the United Kingdom, where an overhaul of training for junior doctors has recently taken place. The resulting Foundation Programme is well organised and has pledged funding of £73 million.[6,7]

The Australian Curriculum Framework for Junior Doctors

With the development of prevocational curricula overseas, there has been a move towards curriculum development in Australia. This has led to the production of a draft Australian Curriculum Framework for Junior Doctors (Box 1), based heavily on existing curricula developed by the Postgraduate Medical Education Councils of NSW, SA and WA, the Committee of Deans of Australian Medical Schools, the Australian Council for Safety and Quality in Health Care, and curricula from the UK and Canada.[7,9-14] The Framework, produced under the auspices of the Confederation of Postgraduate Medical Education Councils, will be available for viewing and feedback at http://www.cpmec.org.au/curriculum.[8] The first substantive version of the Framework was launched at the 11th National Prevocational Medical Education Forum in Adelaide on 29 October 2006.

The Framework recognises many of the training needs of prevocational doctors, and has created a unique opportunity to improve the quality of medical training in Australia. The long-term outcome depends on how conscientiously and effectively it is implemented and resourced. Some brief suggestions regarding implementation appear in the preamble of the current version of the Framework, and it is expected that implementation will vary with local practice. A steering committee will be formed to discuss implementation in more detail, but it is important that we, as junior doctors, express our views beforehand.

The Framework is designed to support the process of turning medical graduates into generalist doctors. For this objective to be met, a number of areas must be addressed (Box 2).

3 Recommendations on implementation and resource allocation for the Australian Curriculum Framework for Junior Doctors

Do	Do not
• Consult stakeholders, especially junior doctors. • Use the Framework to guide allocation of specific and adequate funding for teaching time, facilities and learning resources, including regular, protected, paid education sessions. • Use the Framework to promote teaching and learning, and ensure a high standard of clinical ability in junior doctors. • Use the Framework to assess teaching opportunities provided by hospitals as part of accreditation.	• Use the Framework as a barrier requirement to vocational training. • Use the Framework as a "log book" or check-list for junior doctors to chase. • Expect all aspects of the Framework to be learnt through clinical attachment alone. • Expect senior clinicians to have sufficient "spare time" to teach junior doctors during day-to-day work.

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The use of the Framework must not become a chore for the junior doctor to complete in his or her free time. The demands of working as a junior doctor are too great to have this additional burden. Training of junior doctors should be seen as a key result area for every Australian hospital. As such, the hospital and individual departments should take responsibility for the education and competency of junior doctors. Hospitals and governing bodies have a duty of care to the Australian populace that requires they ensure doctors are trained as well as possible. Not adequately meeting these needs has far-reaching implications for the general community for years to come.

Conclusion

Australia has the economic and intellectual resources necessary to train the best doctors in the world, and we believe that this should become a reality. The education of junior doctors as generalists before entry into vocational training is integral to the development of highly skilled medical practitioners. Ensuring that this process is as effective as possible will require debate and centralised organisation. Although ostensibly daunting, this is by no means a far-fetched task — it merely requires a modicum of funding and some creative changes to our training system and culture. The Australian Curriculum Framework for Junior Doctors has the potential to add to this process, provided it is well resourced and implemented in an effective manner with substantial input from junior doctors (Box 3). At stake is the standard of health care provided to the community. For this to be protected, an ongoing investment in prevocational medical education is required.

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Competing interests

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