Comhairle na nDochtúirí Leighis
Medical Council

“Your Training Counts”

National Trainee Experience Survey

Consultation Paper

December 2013

Comhairle na nDochtúirí Leighis
Medical Council

Foreword

Postgraduate training years are a pivotal period in the professional lives of all doctors.

For all doctors, postgraduate training consolidates the competencies developed as medical students, and provides the opportunity to develop further as active members of a team in a clinical setting under the supervision of senior doctors. This never-to-be repeated experience is crucial to the future lives of doctors. It is the time when doctors learn to integrate knowledge, skills and attitudes, and apply learning in supervised practice with feedback and support from trainers. It is the time when career intentions are confirmed. It is the time doctors become full members of the medical profession and form friendships and collegial relationships which will endure throughout their careers.

Critically, it is a time when doctors form their professional identity. It is this identity as a professional - the values and principles that are held and how these are put into action – which in my view is the difference between having clinical knowledge and skill and being a good doctor who is worthy of public trust.

In recent years, the Medical Council has overseen significant developments in medical education and training in Ireland: it has accredited graduate entry medical programmes for the first time; it has reformed the intern year; and it is continuing to review postgraduate training.

To inform, shape and drive our work in safeguarding standards and fostering further improvement in postgraduate training in Ireland, we need to understand how this is experienced by doctors in training. What better voices could we listen to so as to understand the challenges and priorities for supporting the development of good professional practice among future doctors?

"Your Training Counts" is the name of a new National Trainee Experience Survey which will be launched by the Medical Council in 2014. Each year, we will invite doctors who are registered as trainees to tell us about their experience of training in Ireland.

We have developed ideas about how this survey will operate– the kinds of issues we will ask trainees to feed back on, and how we might use this information to inform our work.

But before we finalise arrangements, we want to test these ideas with trainees, trainers, bodies involved in medical education and training, health service providers, policy makers and the public, and hear what you think about our plans.

I'd like to invite everyone to consider the proposals set out in this paper and look forward to hearing your response.

In particular, I would encourage trainees to give these proposals consideration. Your training counts. The Medical Council is committed to hearing your views so that we can lead further improvements in the standards of medical education and training in Ireland. Through supporting doctors to develop good practice, we can ensure patients benefit from safe, quality care.

Professor Freddie Wood
President
Medical Council
December 2013

Acknowledgement
This consultation paper was prepared by Mr Simon O'Hare and Mr Paul Lyons, Medical Council.

Contents

1. About the Medical Council

2. Trainee experience matters

3. Measuring experience and driving improvement

4. Conclusion

5. Consultation questions

6. References

7. Appendix: PHEEM and DRECT – Domains and items

1. About the Medical Council

1.1 The role of the Medical Council

The Medical Council sets and monitors standards that help to ensure good professional practice amongst doctors. Through ensuring that doctors effectively develop and maintain appropriate knowledge, skills and attitudes at every stage in their professional lives, the Medical Council supports doctors in good practice, helps ensure patients receive safe, high quality care, and fosters trusts between the public and the medical profession.

While the Medical Council has had a long role in medical education and training in Ireland, that role was enhanced under the Medical Practitioners Act 2007. This Act established the Medical Council as the body responsible for assuring and fostering the quality of medical education and training across the four principle stages of the professional lives of doctors - undergraduate medical education, intern training, postgraduate training and maintenance of competence. The Medical Council sets the standards for medical education and training in Ireland. It then safeguards these standards and promotes improvement through monitoring quality of programmes of medical education and training, the bodies responsible for these, and the sites where learning is situated. It recognises and fosters good practice in medical education and training; where necessary, it can take action to ensure that standards are safeguarded.

The recent publication, **Medical Education, Training and Practice in Ireland 2008-2013 – A Progress Report**, provides useful overview of the Medical Council's role in medical education and training in Ireland.

1.2 The Intern and Postgraduate Years

Once doctors complete a programme of basic medical education, they enter training in the intern year, which is delivered through Intern Training Networks associated with universities. Intern training is a crucial formative stage in the development of doctors. Interns practice for the first time as registered doctors, learning to apply competencies developed in medical school under supervision, and they are supported with formal and informal teaching, assessment and feedback.

This year is overseen by the Medical Council, which provides doctors who successfully complete intern training with a certificate of experience. Receipt of this certificate marks the completion of basic medical training. Most doctors will move to continue their postgraduate training.

Traditionally, intern training has been in medicine and surgery and situated in hospitals, but the range of clinical settings, and indeed the areas of practice for intern training, is becoming more diverse. Beginning intern training is a key transition for new doctors; while the intern year is designed to provide training and support, it is important that medical students are prepared through undergraduate medical education to be capable, comfortable and confident in the application of their competencies in practice.

Postgraduate training provides doctors with structured, specialist training to enable them to be recognised as Specialists by the Medical Council and thus entered in the Specialist Division of the Medical Council's Register of Medical Practitioners.

In total, there are 13 postgraduate training bodies delivering a wide range of specialist training programmes across diverse clinical sites in Ireland. Postgraduate training provides trainees with rich and deep experience in the practice of their chosen specialty. The level of responsibility held by trainees is greater than at intern training and is graduated in response to their learning needs and competency as doctors progress through training years. Postgraduate training is undertaken with supervision by a trainer and the postgraduate body delivering the training. There is assessment and feedback to trainees, whose progress is closely monitored until ultimately they are granted evidence by their training bodies as having satisfactorily completed specialist training, and therefore eligible to register and practice as specialists. Beginning specialist training is another key transition for new doctors and it is important that intern training provides a solid foundation for trainees to take greater responsibility. Exiting specialist training is also an important transition since trainees must be ready to practice independently without supervision.

1.3 Scope of the National Trainee Experience Survey

All doctors in recognised intern and post graduate training in Ireland are registered with the Medical Council in the Trainee Specialist Division. There are currently (Dec 2013) approximately 3,000 such trainee doctors and these doctors will be invited to participate in the National Trainee Experience Survey.

2. Trainee experience matters

2.1 Learning and the environment

Understanding how doctors develop is important if the quality of medical education and training is to be fostered so as to support doctors in achieving and maintaining good professional practice. There are many different perspectives on how people learn which help us understand how doctors develop (Mann 2010). Most perspectives consider the environment as the key influence on learning, but vary in emphasis on the components of environment which are important and how learning is affected.

In traditional perspectives the most important element in the environment is the teacher; transmitting knowledge to students and shaping their behaviour using positive and negative reinforcement (Watson 1924). The provision of feedback on performance, one of the most influential factors in learning, originates in behaviourism and remains a central aspect of learning in medical education (Mann 2010).

More recent perspectives on medical education take a broader view of the learning environment. For example, Genn (2001) considers important elements in the learning environment to include: "*students chatting over lunch in the Medical Club, staff greeting students out of class, … students' reactions to the death of a patient, conversations of staff … and so on and so forth, almost ad infinitum, one could say*".

These much wider perspectives on the learning environment complement more recently developed socio-cultural learning theories; those which view learning as participative social processes, embedded in context, where the environment influences learning outcomes (Sfard 1998). From these perspectives, the context where learning occurs, is paramount: the physical environment, the people in that environment, how they talk, interact and the values they share, how they relate to the learner, and how the learner relates to the environment all shape knowledge, thinking and learning.

These perspectives on learning are especially relevant to doctors' development since it is workplace-based. They also enable an understanding of how doctors in training form values, attitudes and behaviours, which make up their professional identities, through socialisation in the workplace.

An important implication of these perspectives which emphasise where learning is situated is that a concern to ensure the quality of medical education and training must include a concern for the environment where learning takes place (Durning and Artino 2011) In fact, so important is the role of the environment in medical education that The World Federation for Medical Education (WFME) singles out the 'learning environment' as one of the targets for 'the evaluation of medical education programs' (WFME 1998).

2.2 Climate matters

In medical education, the environment is considered as the expression of the curriculum (Genn 2001a).

In the past century there has been a shift in what "curriculum" means: from a term to denote the actual formal document of what students are expected to learn, to meaning all the experiences, planned and unplanned, that occur under the auspices of an educational body and programme (Pinar 1995). In more recent concepts "curriculum" is understood as having three components: the formal, the informal and the hidden.

The 'formal curriculum' is sometimes thought of as the actual course of study, the planned content, teaching, evaluation methods, syllabi, and other materials used in any educational setting (Wear and Skillicorn 2009). There is also an extremely powerful 'informal curriculum' consisting of unscripted, unplanned and highly interpersonal forms of teaching and learning that take place among and between faculty and students (Cruess 2006). The 'hidden curriculum' can be thought of as a network of unwritten social and cultural values, rules, assumptions, and expectations, that shapes behaviour so much that mastery of it is as important as mastery of the formal one (Hafferty and Franks 1994).

The curriculum, therefore, can be usefully understood to comprehend "everything that is happening" in a programme of medical education and training (Genn 2001a). The term 'climate' is used to describe students' and trainees' perceptions of the learning environment (Genn 2001b) – how they perceive different aspects of the curriculum.

How the curriculum is perceived by trainees can impact (positively and negatively) on motivation to learn, self-confidence and self-efficacy. The climate can affect trainees' achievement, satisfaction and overall success (Soemantri et al 2010). Such outcomes as these are clearly the goals of all educators, and the linkage of these goals to climate indicates the powerful nature and influence of this otherwise intangible, ethereal and insubstantial phenomenon (Genn 2001).

In planning and changing the curriculum for the development of doctors, environment must be a key concern, and this concern demands that climate is measured (Harden 1986). Measurement of climate is necessary if medical education and training is to successfully foster good professional practice among students and trainees.

2.3 Measuring climate

The Medical Council considered a variety of instruments for measurement of the postgraduate learning climate in the Trainee Experience Survey, and used a "review of reviews" approach to identify candidate instruments. The work of Soemantri et al (2010) and Schonrock-Adema et al (2012) was influential in helping refine the number of instruments that we believe are a good fit for our context.

Soemantri et al conducted a systematic literature review of learning environment measures, which identified 79 separate studies and 31 instruments. Instruments were evaluated with the aim of finding the most reliable and valid measures of climate. Soemantri concluded that of the 9 instruments available to use in postgraduate medical training, the Postgraduate Hospital Educational Environment Measure (PHEEM)[1] was likely to be the most suitable instrument for measuring climate.

A more recent review of learning environment measures by Schonrock-Adema et al included the newly created Dutch Residency Educational Climate Test (D-RECT)[2] instrument (which was not published at the time of the review by Soemanti et al). This review applied a snowballing technique to find educational environment instruments and investigated their theoretical underpinnings – resulting in a framework of what constitutes the educational environment. Nine medical educational environment instruments were mapped onto this framework to test how comprehensive they were. In concluding, the review stated that "of all the instruments included in the study, the D-RECT (Boor et al. 2011) contains most items representing sociocultural aspects. We also found that all these items could be related to our framework".

Therefore, the two instruments that the Medical Council is considering to help measure perceptions of learning environments in its Trainee Experience Survey are PHEEM and D-RECT.

These instruments are now discussed in further detail and the domains and items are presented in an appendix.

[1]Roff, S., McAleer, S., & Skinner, A. (2005). Development and validation of an instrument to measure the postgraduate clinical learning and teaching educational environment for hospital-based junior doctors in the UK. Medical Teacher, 27, 326–331.

[2] Boor, K., Van der Vleuten, C., Teunissen, P., Scherpbier, A., & Scheele, F. (2011). Development and analysis of D-RECT, an instrument measuring residents' learning climate. Medical Teacher, 33, 820–827.

About PHEEM

PHEEM was developed by researchers in Dundee and Birmingham. In the first stage of the process a group of 12 medical educationalists and other professionals, aided by a comprehensive literature review on educational environments, agreed a list of 180 items for potential inclusion in the questionnaire. After multiple revisions (including a critique by colleagues, 117 responses to a quantitative questionnaire and several focus groups) this set of items was reduced to 40.

PHEEM evaluates three aspects of the learning environment:

- perceptions of autonomy (using 14 items);
- perceptions of teaching (15 items); and,
- perceptions of social support (11 items).

When using PHEEM, respondents are asked to rate how strongly they agree with each of the 40 statements. As an example, one of the items relating to perceptions of autonomy is: “My clinical teachers promote an atmosphere of mutual respect”.

Based on those ratings each item is given a score between 0-4. All scores are added up and this gives the overall PHEEM score for the climate (i.e. respondents’ perceptions of the environment), with a score of 160 representing an “ideal” educational environment and a score of 0 representing a very poor environment.

Scores can be totalled for each sub-scale (autonomy, teaching and social support) to develop a more nuanced measure of the quality of the environment and provide for a more targeted approach to quality management.

For example, in the sub-scale ‘Perceptions of teaching’:

- 0–15 = very poor quality teaching;
- 16–30 = in need of some retraining;
- 31–45 = moving in the right direction; and,
- 46–60 = model teachers

PHEEM can also be used to pinpoint more specific strengths and weaknesses within educational climates. Individual items that have a mean score of 3.5 or over are positive points. Any item with a mean of 2 or less should be examined more closely as they indicate problem areas. Items with a mean between 2 and 3 are aspects of the climate that could be enhanced.

About D-RECT

D-RECT's development began with a qualitative study among 40 residents, at different levels of training in various specialties, to explore which events can ''make or break'' learning climates. The first version of the questionnaire, based on feedback from the qualitative study, consisted of 83 items and 21 subscales (e.g. feedback, collaboration between peers, patient handover, workload, teamwork).

These 83 items and 21 subscales were discussed by a group of 14 experts. Duplicate or unclear items were removed resulting in a 75-item preliminary D-RECT instrument, which was then submitted to a Delphi panel.

A Delphi procedure is aimed at achieving consensus among experts in a systematic manner. In multiple consultation rounds, experts indicate their (dis)agreement with statements or concepts. After the first round, the experts can change their own rating in light of the summarized (anonymous) ratings of the other panel members. In total, 40 panellists were chosen for their involvement in postgraduate specialist training and rated every item's relevance in relation to postgraduate learning environments.

At the same time a questionnaire form of D-RECT was completed by 1251 residents. The results of these questionnaires and the Delphi panel's decisions helped refine D-RECT to 50 items. A factor analysis of responses to those 50 items indicated that the instrument was a good fit for its purpose.

D-RECT measures 11 aspects of climate:

- Supervision (3 items);
- Coaching and assessment (8 items);
- Feedback (3 items);
- Team work (4 items);
- Peer collaboration (3 items);
- Professional relations between attendings[1] (3 items);
- Work is adapted to a resident's competence (4 items);
- Attendings' role (8 items);
- Formal education (4 items);
- Role of the specialty tutor (6 items); and,
- Patient sign out (4 items).

In a way similar to PHEEM, D-RECT can be used to give an overall score of the climate, scores for each of its sub-scales and a more specific look at strengths and weaknesses in educational environments can be extracted by looking at scores on individual items.

[1] The term 'attendings' can be mapped to mean 'consultants'

Benefits of D-RECT and PHEEM

Both PHEEM and D-RECT were developed using robust research processes and are grounded in theoretical considerations about the educational environment. Both instruments can be used to test the quality of environments in one-off and longitudinal situations. Taking a longitudinal approach with D-RECT and PHEEM can indicate if the quality of environments changes over time (potentially demonstrating if newly adopted changes to the curriculum were effective in improving climates).

Both PHEEM and D-RECT were constructed so that one can move from a general picture of climate (i.e. the total scores for each environment) to specific examples of good and poor climates (i.e. the scores for each item). This means that one can extract a nuanced idea of what needs to change in specific learning environments and how much it needs to change. For these reason, they both enable quality management.

Both instruments represent complex measures of the environment and take a rounded approach to understanding how it feels for trainees (i.e. they use 40 and 50 items to measure the concept of climate and its different components). Both instruments use language that is easy to understand.

Finally, while developed in the context of one health system, both PHEEM and D-RECT have been successfully used and evaluated across many different health systems including Brazil, the Netherlands, UK, Australia (Auret et al 2013), Japan (Shimizu et al 2013) and Singapore (Gooneratne et al 2008).

Potential limitations with D-RECT and PHEEM

An assessment of 11 different measures of climate (including D-RECT and PHEEM) by Schonrock-Adema et al (2012) concluded that D-RECT contained the most items representing sociocultural aspects of the environment. It is proposed (Boor 2011) that PHEEM's theoretical base is not as complete as that which informed the development of D-RECT.

There is some debate regarding how the sub-scales in PHEEM relate to the overall concept of climate. Psychometric testing in 2007 by Boor et al concluded that PHEEM is one-dimensional and does not measure three distinct domains of the environment. However, further testing in 2009 by Riquelme et al suggests PHEEM is multi-dimensional.

PHEEM is arguably more established as a postgraduate learning climate survey than D-RECT and there is more experience with its use in other health systems. Some of the language in D-RECT (specifically regarding roles and grades) will need to be mapped to the Irish context. It has been used in Australia (with two modifications to the language, “consultant” instead of “attending” and “educational supervisor” instead of “specialty tutor”).

Comhairle na nDochtúirí Leighis
Medical Council

2.4 Other aspects of experience

A robust, valid and reliable measurement of trainees' perceptions of the postgraduate learning climate in Ireland is a core objective of the Medical Council's National Trainee Experience Survey. However, it is also an opportunity to gather a more comprehensive and rounded view of trainees' experience of postgraduate medical training in Ireland. Conscious of the need not to overwhelm trainees with an overly extensive survey, the Medical Council is interested in also capturing trainees' views in these areas.

Transitions and preparedness

Doctors make a number of important transitions through their medical training: from medical student to intern; from intern to trainee; from trainee to specialist. The Medical Council's National Trainee Survey will be able to identify doctors at these key points of transition and ask for their feedback as to how well they felt earlier education and training had prepared them to make these important transitions. The Medical Careers Research Group at Oxford have been measuring and tracking trainee views on preparedness for a number of years (Goldacre et al 2010).

Retention and career plans

The Medical Council's Medical Workforce Intelligence Report 2013 highlighted the trainee retention challenge which faced the Irish health system. It also underscored the need to enhance health system capacity and capability for medical workforce planning. The National Trainee Experience Survey is also an opportunity to capture information from trainees about their career intentions. This is also a subject which has been tracked by the Medical Careers Research Group at Oxford (Goldacre et al 2009).

Health and wellbeing

Good health enables good practice. It is important that a doctor's participation in training is enabled through support for them to maintain good health, and to deal early and appropriately with health problems. The National Trainee Experience Survey will be able to elicit trainees views on their own health and access to support services.

Perceptions of quality of care

The GMC asks trainees for their views on the quality of care provided to patients at their training site. The 2013 State of Medical Education and Practice report[1] showed that trainees views on quality are associated with other measures of healthcare quality (GMC 2013). This is important since trainees must see safe, high quality care in action is they are to achieve good professional practice (Cooke et al 2010). The National Trainee Experience Survey could examine trainee views in this area.

[1] see http://www.gmc-uk.org/State_of_medicine_Final_web.pdf_44213427.pdf

Comhairle na nDochtúirí Leighis
Medical Council

3. Measuring experience and informing improvement

3.1 Measuring training experience

Measuring postgraduate trainee experience of climate, provides a pivot for change and improvement in the quality of the learning environment and the curriculum (Genn 2001b). Unsurprisingly, many organisations which, like the Medical Council, take a lead role in safeguarding and fostering improvements in medical educational standards use regular surveys of trainee experience to inform improvement.

The General Medical Council's National Training Survey

Since merging with the Postgraduate Medical Education and Training Board (PMETB) in April 2010, the General Medical Council (GMC) has run an annual National Training Survey (NTS)[1].

The NTS is comprised of a set of core questions which measure trainees' perceptions of training quality with reference to GMC's standards, as well as specialty specific questions set by Royal Colleges and Faculties which examine trainee perceptions of the quality of delivery of the curricula. In the 2012 NTS trainees answered a maximum of 59 generic questions and a maximum of 17 demographic questions. Questions could not be skipped (apart from the open comments section).

The domains covered by the GMC's NTS in 2013 included: satisfaction with training; educational supervision; clinical supervision; feedback to trainees on their performance; adequate experience; handover; induction; quality of local teaching; and, workload.

Instead of relying on a set of statements, requiring trainees to rate their agreement in a consistent format, the NTS includes different types of measures to evaluate trainees' experiences – as below.

A sample of questions from the GMC's NTS for 2013

Question	Response options
Did someone explain your role and responsibilities in your unit or department at the start of this post?	Yes | No | Not sure | Not Applicable
Did you have a designated educational supervisor (the person responsible for your appraisal) in this post?	Yes | No | Not sure
In this post did you use a learning portfolio?	Yes | No | Not sure | Not Applicable
In this post did you have a training/learning agreement with your educational supervisor, setting out your respective responsibilities?	Yes | No | Not sure | Not Applicable
In this post were you told who to talk to in confidence if you had concerns, personal or educational?	Yes | No | Not sure | Not Applicable
How would you rate the quality of induction in this post?	Excellent | Good | Fair | Poor | Very poor Induction

[1] Visit http://www.gmc-uk.org/education/surveys.asp for more details

This approach blends questions about perception (subjective, qualitative, information) with categorical ones about the trainees' experiences (i.e. Yes/No type answers).

Over 50,000 trainees take part in the GMC's NTS each year. Survey results are given for specialty categories, with each given an average satisfaction score (which is tracked over years). A publicly accessible web-based database shows and compares results for each deanery. The GMC, in its Quality Improvement Framework[1], references over 9 different sources of information (including NTS results) which it uses to help gauge the quality of medical education and training.

The Accreditation Council for Graduate Medical Education's Resident Survey

The Accreditation Council for Graduate Medical Education[2] (ACGME) is a private professional organisation responsible for the accreditation of around 9,200 residency education programs in the USA.

To gain and maintain accreditation, residency education programs are expected to comply with Accreditation Standards and with Institutional Requirements. Compliance with standards is measured through periodic reviews of all programs (which includes lengthy interviews with the program directors, faculty and residents, a faculty-wide survey, as well as a review of supporting documents). The ACGME's Resident Survey is one method that can provide an early warning of potential non-compliance with ACGME accreditation standards. All specialty and subspecialty programs (regardless of size) are surveyed every year between January and June. Each specialty has a tailored questionnaire, but all include items on: cover duty hours, feedback and evaluation, education content, resources, patient safety, and teamwork. The following samples the 2013 questionnaire for Paediatrics.

The questionnaire has 35 speciality specific items seeking residents' perceptions on: how prepared they feel to conduct different procedures (without supervision), how well they feel they can carry out different patient care activities; the quality of their educational experiences; and, how prepared they feel to competently practice general paediatrics. Each item is rated on a 5 point scale. The ACGME do not contact residents and fellows directly. It is the program's responsibility to ensure their residents/fellows complete the survey. All questions have to be completed or else the response is not counted. A response rate lower than 70% triggers an automatic site visit by ACGME.

Aggregate, program-level results from the survey are provided to the program directors. Data from the survey is intended as a diagnostic tool to focus the ACGME's field staff's questions during periodic on-site visits. If interviews with residents suggest that past problem areas identified in the survey data have been corrected, the field staff member will document this in his/her report.

[1] http://www.gmc-uk.org/Quality_Improvement_Framework.pdf_39623044.pdf

[2] For more information on the ACGME visit http://www.acgme.org/acgmeweb/

Comhairle na nDochtúirí Leighis
Medical Council

The Postgraduate Medical Council of Victoria PHEEM Program

The Postgraduate Medical Council of Victoria[1] (PMCV) aims to support the education, training, welfare and career development of doctors who have recently graduated or commenced work in Victoria (Australia). The PMCV actively seeks ways to improve the educational and training opportunities available to support the welfare and career development of doctors who have recently graduated or commenced work in the Victorian health system.

To help meet this objective the PMCV has a PHEEM Program; an ongoing initiative facilitated by the PMCV and jointly conducted by Medical Education Officers (MEOs) at participating hospitals. Results from the PHEEM program are not a part of the formal evaluation processes for gauging whether sites have achieved accreditation standards.

The PHEEM instrument used in Victoria is identical to the original UK version except for minor amendments to language, which make it congruent with Australian terminology; for example, the item 'I am bleeped inappropriately' has been changed to 'I am paged inappropriately'. MEOs at participating hospitals administer the PHEEM at the end of each term rotation to junior doctors in their first, second and third postgraduate years. Completed questionnaires are collected and PMCV coordinates the processing and statistical analysis of the information, which is then reported back to participating hospitals. Each hospital is responsible for disseminating their data as necessary to address their needs.

The PHEEM project was used to benchmark and to find out what hospitals individually and collectively do well and where improvement is needed. 429 PHEEM questionnaires were completed in 9 participating hospitals. The total PHEEM score for all hospitals, collectively, was 110/160 – reflecting that on average all 9 hospitals involved had a climate that was 'more positive than negative but with room for improvement'. No hospital was in the lowest two categories ('Very poor' or 'plenty of problems') and one was 'Excellent' scoring 121/160.

The most highly rate items were clinical teaching, personal security and working together. The lowest scoring items included information and support; organisational infrastructure; and interruptions. The analysis of results by postgraduate year showed that Year 2 doctors seemed more content in their environments than Year 1 doctors (especially in regards to working conditions and relationship with teachers) – demonstrating how a nuanced interpretation of results can identify specific themes for development.

[1] for more information on PMCV visit: http://www.pmcv.com.au/

3.2 Informing change and improvement

Measuring trainee experience in Ireland must have a purpose. The information gathered by the Medical Council must become a resource which informs its work, enriches its collaboration with stakeholders, and supports everyone involved in medical education and training to make changes which continually improve quality. In healthcare, measuring and publishing information about quality fosters quality improvement (Chassin et al 2010). Systematically measuring and reporting on trainee experience will also have capacity to inform improvement (Genn 2001b).

One part of the quality assessment picture

The Medical Council already has established programmes to inspect and assess quality of undergraduate, intern and postgraduate training. Through its inspection visits, the Medical Council already listens carefully to the voice of trainees to inform its assessment of training quality. The National Trainee Experience Survey will complement rather than displace this activity and will be one part of the overall quality assessment picture.

Addressing national themes

The National Trainee Experience Survey will identify cross cutting issues which will need to be taken forward nationally. The Medical Council will review its existing standards and where necessary support these with thematic guidance and other work to enhance the quality of postgraduate training nationally.

Sharing good practice and focusing on local improvement

The National Trainee Experience Survey may identify variations in experience. Where good experience is identified, the Medical Council will try to better understand and share good local practice in medical education and training. Where opportunities to improve experience are identified, the Medical Council will prioritise and target its quality assessment function to bring focus for local improvement when this is required. In this way, it will seek to ensure there is effective governance for high quality training at a local site. This function will support and complement, not displace, the role which Postgraduate Training Bodies play in safeguarding training quality at local sites.

A tool for dialogue about quality management

The Medical Council will share detailed information from the National Trainee Experience Survey with Universities, Intern Training Networks and Postgraduate Training Bodies to further enrich discussion about quality management in medical education and training.

Comhairle na nDochtúirí Leighis
Medical Council

4. Conclusion

4.1 So what next?

Your training counts

"Your Training Counts" is the name which the Medical Council is giving to its National Trainee Experience Survey. Postgraduate training is a pivotal period in the professional lives of all doctors. We are committed to ensuring that trainees' experience is aligned with our expectations around what it means to be a good doctor and thereby effectively fosters good professional practice among future doctors.

Aim and objectives

The overall aim of the National Trainee Experience Survey is to support continuous improvement of medical education and training in Ireland to underpin good professional practice among future doctors.

Specifically, the National Trainee Experience Survey will:

- Measure and report on trainee experience of the postgraduate learning environment in Ireland;
- Measure and report on other aspects of trainee experience which provide a better understanding of postgraduate training in Ireland including preparedness for transitions, retention and career plans, health and wellbeing, and trainee perceptions of quality of care;
- Inform the role of the Medical Council in fostering the quality of medical education and training through identifying opportunities for strengthening standards and guidance and through enabling prioritisation of its quality assessment role; and,
- Inform dialogue and collaboration between all individuals and bodies involved in medical education and training in Ireland so as to further enhance the experience and outcomes of trainees in Ireland.

When and how?

The survey will launch in the second quarter of 2014 as the usual postgraduate training years (which runs July-June) draws to a close. It will be administered electronically to all doctors registered in the Trainee Specialist Division with the Medical Council. It is crucial that trainees keep and maintain up to date information with the Medical Council, especially emails, so that they can be contacted about the survey. The Medical Council will be establishing a programme of communication and engagement to promote awareness of the survey from early 2014. It is critical that all trainees take the opportunity to respond to the survey.

Testing our ideas and hearing your views

This paper has set out our current thinking and plans about the National Trainee Experience Survey. We want to hear your views and you are invited to give your feedback on some consultation questions in the next section.

Conclusion

Postgraduate training counts. Through the National Trainee Experience Survey, the Medical Council wants to build on current good practice by informing change and continuing improvement. To achieve this we need engagement from trainees and we encourage all doctors in postgraduate training to get involved in this important initiative.

We also need continuing collaboration with all the individuals and organisations involved in shaping postgraduate training in Ireland and we look forward to working with everyone to apply feedback from trainees to see how we can strengthen postgraduate training and better foster the development of good professional practice.

5. Consultation questions

5.1 Consultation questions

You can respond to the following questions by completing the accompanying word document and emailing it to yourtrainingcounts@mcirl.ie or by completing an online version here: https://www.surveymonkey.com/s/yourtrainingcounts

We would appreciate your response by Monday 13th January 2014

Question 1

What aspects of training experience do you think that trainees should be invited to feedback on so that their training can be enhanced?

Question 2

What, in your view, is the single most important aspect of training experience which should be measured so as to enhance the quality of trainee experience?

Question 3

The Medical Council is examining DRECT and PHEEM as potential ways to gather trainee views on training. Having considered the description of these two approaches, which do you think has more merit for use in Ireland? Why?

Question 4

What approaches can the Medical Council and other stakeholders take so as to maximise trainee participation in the survey?

Question 5

How do you think the results of the Trainee Experience Survey should be used to improve medical education and training in Ireland?

Question 6

What, if any, other comments would you like to make about the outlined approach for the Trainee Experience Survey?

6. References

Auret, K.A., Skinner, L., Sinclair, C., Evans, S.F. (2013). Formal assessment of the educational environment experienced by interns placed in rural hospitals in Western Australia. Rural and Remote Health 13: 2549.2013.

Boor, K., Scheele, F., van der Vleuten, C.P.M. , Teunissen, P.W., Sijtsma, K.(2007). Psychometric properties of an instrument to measure the clinical learning environment. Medical Education, Vol. 41: 92–99

Boor, K., van der Vleuten, C., Teunissen, P., Scherpbier, A., Scheele, F. (2011). Development and analysis of D-RECT, an instrument measuring residents' learning climate. Medical Teacher, Vol 33: 820–827

Chassin, M.R., Loeb, J.M., Schmaltz, S.P., and Wachter, R.M. (2010). Accountability measures – using measurement to promote quality improvement. New England Journal of Medicine. 2010. Vol 363: 683-688.

Cooke M., Irby D.M., and O'Brien B.C. Educating Physicians: A Call for Reform of Medical School and Residency. Carnegie Foundation for the Advancement of Teaching. San Francisco: Jolley Bass, 2010.

Cruess, R.L. & Cruess, S.R. (2006). Teaching professionalism: general principles. Medical Teacher, Vol. 28(3) pp. 205–208

Durning, S.J. & Artino, A.R. (2011). AMEE Guide no. 52: Situativity theory: A perspective on how participants and the environment can interact. Medical Teacher, 33: 188–199

Genn, J.M. (2001a). AMEE Medical Education Guide No. 23 (Part 1): Curriculum, environment, climate, quality and change in medical education- a unifying perspective. Medical Teacher, 23(4): 337-344.

Genn, J.M. (2001b). AMEE Medical Education Guide no.23 (part 2): Curriculum, environment, climate, quality and change in medical education – a unifying perspective. Medical Teacher 23(5):445 - 454.

Goldacre et al. (2010). Views of junior doctors about whether their medical school prepared them well for work: questionnaire surveys. BMC Medical Education 2010 10:78.

Goldacre, M.J., Davidson, J.M., Lambert, T.W. (2009). Retention in the British National Health Service of medical graduates trained in Britain: cohort studies. BMJ 2009;338:b1977

Gooneratne et al: (2008). Assessment of psychometric properties of a modified PHEEM questionnaire. Annals of the Academy of Medicine, Singapore 37(12):993-7.

Hafferty, F.W. & Franks, R. (1994). The Hidden Curriculum, Ethics Teaching and the Structure of Medical Education. Academic Medicine 69, pp 861-871

Harden, R.M. (1986). Ten questions to ask when planning a course or curriculum. Medical Education 20: 356-365.

Mann, K.V. (2011). Theoretical perspectives in medical education: past experience and future possibilities. Medical Education, 2011: 45: 60–68

Pinar WF. Understanding Curriculum. New York, NY: Peter Lang; 1995.

Riquelme, Arnoldo, Herrera, Cristian, Aranis, Carolina, Oporto, Jorge, Padilla, Oslando (2009). Psychometric analyses and internal consistency of the PHEEM questionnaire to measure the clinical learning environment in the clerkship of a Medical School in Chile. Medical Teacher,31(6): e221 — e225

Schonrock-Adema, J., Bouwkamp-Timmer, T., van Hell, E.A., Cohen-Schotanus, J. (2012). Key elements in assessing the educational environment: where is the theory? Advances in Health Sciences Education 17:727–742

Sfard, A. (1998). On Two Metaphors for Learning and the Dangers of Choosing Just One. Educational Researcher, 27(2):pp. 4-13.

Shimizu et al :(2013). The hospital educational environment and performance of residents in the General Medicine In-Training Examination: a multicenter study in Japan. International Journal of General Medicine 2013:6 637–64

Soemantri, D., Herrarra, C., Riquelme, A. (2010). Measuring the educational environment in health professions studies: A systematic review. Medical Teacher, Vol 32: 947–952

Watson, J. B. (1924) Behaviorism. New York: People's Institute Publishing Company.

Wear, D. & Skillicorn, J. (2009). Hidden in Plain Sight: The Formal, Informal, and Hidden Curricula of a Psychiatry Clerkship. Academic Medicine, Vol. 84 (4)

World Federation For Medical Education (1998). International standards in medical education: assessment and accreditation of medical schools' educational programmes: A WFME position paper, Medical Education, 32(5), pp. 549–558

7. Appendix: PHEEM and DRECT Questions

PHEEM – Domains measured and items used	
Domains measured	Items
Perceptions of role autonomy (14 items)	• My clinical teachers promote an atmosphere of mutual respect • The training in this rotation makes me feel ready for the next step. • My workload in this job is fine. • I feel part of a team working here. • I have opportunities to acquire appropriate skills in practical procedures • My hours conform to the AMA HMO Certified Agreement. • I have the opportunity to provide continuity of care. • There are clear clinical protocols in this rotation. • I am paged inappropriately. • I have to perform inappropriate tasks. • There is accurate, unit specific written information available. • I had an informative orientation programme. • I have the appropriate level of responsibility in this rotation. • I have a contract of employment that provides information about hours of work.
Perceptions of teaching (15)	• The clinical teachers provide me with good feedback on my strengths and weaknesses. • My clinical teachers encourage me to be an independent learner. • I have enough clinical learning opportunities for my needs. • My clinical teachers have good teaching skills. • My clinical teachers are accessible. • Senior staff utilise learning opportunities effectively. • There is access to an educational programme relevant to my needs. • I get regular feedback from seniors. • My clinical teachers are well organised. • My clinical teachers are enthusiastic. • My clinical teachers have good communication skills. • I am able to participate actively in educational events. • My clinical supervisor set clear expectations. • I have protected educational time in this rotation. • I have good clinical supervision at all times.
Perceptions of social support (11)	• There is racism in this rotation. • There is sex discrimination in this rotation. • I have good collaboration with other junior doctors. • I have suitable access to careers advice. • This hospital has good quality accommodation for junior doctors, especially when on call • I feel physically safe within the hospital environment. • There is a no-blame culture in this rotation. • There are adequate catering facilities when I am on call • My clinical teachers have good mentoring skills. • I get a lot of enjoyment out of my present job. • There are good counselling opportunities for junior doctors who experience difficulty regarding their training in this rotation.

Comhairle na nDochtúirí Leighis
Medical Council

D-RECT: Domains measured and items used	
Supervision (3 Items)	• The guidelines clearly outline when to request input from a supervisor • The amount of supervision I receive is appropriate for my level of experience • It is clear which attending supervises me
Coaching and assessment (8)	• I am asked on a regular basis to provide a rationale for my management decisions and actions • My attendings coach me on how to communicate with difficult patients • My attendings take the initiative to explain their actions • My attendings take the initiative to evaluate my performance • My attendings take the initiative to evaluate difficult situations I have been involved in • My attendings evaluate whether my performance in patient care is commensurate with my level of training • My attendings occasionally observe me taking a history • My attendings assesses not only my medical expertise but also other skills such as teamwork, organisation or professional behaviour
Feedback (3)	• My attendings give regular feedback on my strengths and weaknesses • Observation forms are used to structure feedback • Observation forms are used periodically to monitor my progress
Teamwork (4)	• Attendings, nursing staff, other allied health professionals and residents work together as a team • Nursing staff and other allied health professionals make a positive contribution to my training • Nursing staff and other allied health professionals are willing to reflect with me on the delivery of patient care • Teamwork is an integral part of my training
Peer collaboration (3)	• Residents work well together • Residents, as a group, make sure the day's work gets done • Within our group of residents it is easy to find someone to cover or exchange a call
Professional relations between attendings (3)	• Continuity of care is not affected by differences of opinion between attendings • Differences of opinion between attendings about patient management are discussed in such a manner that is instructive to others present • Differences of opinion are not such that they have a negative impact on the work climate
Work is adapted to residents' competence (4)	• The work I am doing is commensurate with my level of experience • The work I am doing suits my learning objectives at this stage of my training • It is possible to do follow up with patients • There is enough time in the schedule for me to learn new skills

Comhairle na nDochtúirí Leighis
Medical Council

D-RECT: Domains measured and items used - cont'd	
Attendings' role (8)	• My attendings take time to explain things when asked for advice • My attendings are happy to discuss patient care • There is/are NO attending physician(s) who have a negative impact on the climate • My attendings treat me as an individual • My attendings treat me with respect • My attendings are all in their own way positive role models • When I need an attending I can always contact one • When I need to consult an attending, I can always contact one • When I need to consult an attending they are readily available
Formal education (4)	• Residents are generally able to attend scheduled educational activities • Educational activities take place as scheduled • Attendings contribute actively to the delivery of high-quality formal education • Formal education and training activities are appropriate to my needs
Role of the specialty tutor (6)	• The speciality tutor monitors the progress of my training • The speciality tutor provides guidance to other attending's when needed • The speciality tutor is actively involved in improving the quality of education and training • In this rotation evaluations are useful discussions about my performance • My plans for the future are part of the discussion • During evaluations, input from several attendings is considered
Patient sign out (4)	• When there is criticism of a management plan I have developed in consultation with my attending physician, I know the attending physician will back me up • Sign out takes place in a safe climate • Sign out is used as a teaching opportunity • Attendings encourage residents to join in the discussion during sign out