Malatest International

Report:

Medical Council of New Zealand: Establishing a Prevocational Training Baseline

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1. Executive Summary

The Medical Council of New Zealand (MCNZ) is implementing changes to prevocational training for postgraduate year 1 (PGY1) and 2 (PGY2) doctors. These changes aim to ensure public health and safety by providing an improved quality of learning for interns and increased opportunity for interns to learn the broad based competencies needed for medical practice in New Zealand and to gain a general scope of practice.

Council has requested a robust baseline against which the effectiveness of the changes can be measured once the changes have been fully implemented. To achieve this an evaluation framework including indicators linked to the proposed changes was developed from the MCNZ's logic model, a review of relevant documents and interviews with key stakeholders. Baseline data have primarily come from three online surveys sent to the 2014 cohort of PGY1 and PGY2 interns, prevocational educational supervisors and clinical supervisors, and RMO unit managers. Survey data were collected near the end of 2014. This report provides a summary of baseline data. Analysis of the reasons underpinning responses was out of scope for this project.

Interviews were used to gather data from prevocational training key stakeholders. In interviews, key stakeholders from the different groups were asked to discuss their expectations of the changes, measures of success from their perspective, the strengths and potential risks of the changes to the programme.

The key stakeholders were interns (both PGY1 and PGY2), supervisors (prevocational educational supervisors, clinical supervisors and clinical directors of training) and managers (CMOs and RMO unit managers).

1.1 Interns

Although over half of the cohort of interns was aware of the learning objectives they were required to complete by the end of the year, over one-third of PGY1s and PGY2s were aware only to a limited extent or not aware. Most prevocational educational supervisors and clinical directors of training (educational supervisors) were clear about the learning outcomes for PGY1 but 22% considered the learning outcomes for PGY2 were not defined at all.

The majority of PGY1 interns saw their upcoming PGY2 year as mostly (57%) or completely (13%) a learning year and 70% felt that it would help them acquire the competencies they needed at this stage of their training. PGY2 was less likely than PGY1 to be considered a learning year by educational supervisors and RMO Unit managers.

By the end of PGY2, 92% of doctors intended to enter a vocational training programme and 75% thought they had the skills to do so. Fewer (67%) of educational supervisors and RMO unit managers (5 of 8) considered that interns completing PGY2 mostly or completely had the skills to enter the vocational training programme they wanted to enter.

1.2 Prevocational educational supervisors

Fifty educational supervisors from fourteen DHBs responded to the online survey. Nearly all educational supervisors thought that education was an important part of their role and enjoyed their educational role. Most (84%) were satisfied with their educational role and most (82%) had received some training for their educational role in the last three years, mostly on how to give feedback to interns. MCNZ was most often the training provider. Many (62%) would like the opportunity for further training.

Approximately three-quarters of educational supervisors mostly (58%) or completely (20%) understood the education opportunities for interns on clinical attachments available at their DHB. A similar proportion mostly (58%) or completely (16%) understood the educational experiences interns have on clinical attachments at their DHB.

Challenges in their educational role included heavy workloads, lack of support for their educational role by other staff, and DHB management.

1.3 Clinical supervisors

In the month before the survey, most clinical supervisors said they were responsible for one or two interns. Nearly all clinical supervisors thought their educational role was important (95%) and enjoyed it (86%). If given the choice, most (77%) would continue to be involved in teaching or supervising interns. A few were unsure (16%) or would prefer not to continue (7%).

Many clinical supervisors had received training about aspects of teaching and learning, most commonly from their vocational colleges. Approximately half would like further training or professional development focussed on their educational role. In the last 12 months, few had received feedback from colleagues or from their DHB managers about the effectiveness of their education role.

Many clinical supervisors spent more time on activities relating to education than contracted. Clinical supervisors often mentioned the impact of their overall workload as something that could be changed to improve prevocational training as they felt their effectiveness in their educational roles was limited by their workloads. Overall, half of clinical supervisors considered their education roles were not supported by

DHB management. One-third considered their roles were not valued by DHB management or their RMO unit and only 55% felt that other staff supported them in their education role.

1.4 RMO managers

Seven of the eight RMO Unit managers who responded to the survey felt the RMO Units were supported by DHB management and provided effective support to the interns.

Potential areas for improvement suggested by RMO Unit managers included increased numbers of clinical supervisors, improved communication with clinical supervisors and increased recognition of the RMO Unit role. Four of the eight RMO Unit managers wanted increased recognition of the seniority of their roles.

1.5 Supporting interns' development

The introduction of the e-portfolio system is one of the changes to prevocational training. The e-portfolio system aims to make it easy for the doctors to track their progress and help them to target their learning around the things they need to learn and build on.

Prior to the changes:

- Professional development goals were set at the start of their year by 39% of PGY1 interns, compared to 57% of PGY2s.
- More than two-thirds (69%) of educational supervisors reported that they met with most or all of the PGY1 interns to set professional development goals at the start of PGY1.
- Three-quarters (75%) of educational supervisors said they met with all or most of the interns at the end of clinical attachments.
- Half of PGY1 (50%) and PGY2 (55%) interns reported that they had set professional development goals for their last attachment.
- Half (50%) of clinical supervisors reported that they met with all of their interns to discuss their education objectives at the start of their attachments. A further third (34%) met with most of their interns.
- Most clinical supervisors (85%) also said they met with all or most of their PGY1 and PGY2 interns at the mid-point and end of their attachments to provide feedback on progress.
- One-third (37%) of clinical supervisors said they did not have enough information during attachments to identify interns having difficulty. More than half (55%) did not have the information they needed to manage those

having difficulty during attachments. Their suggestions for improvement focussed on better handover information between attachments.

- Over three-quarters of interns in both PGY1 and PGY2 reported that they mostly or completely understand the areas of their clinical practice that are their strengths and those where they need further training.

1.6 Interns' experiences of their last clinical attachments

Most interns in both years were positive about their last clinical attachment with the majority agreeing that their supervisor was interested in making them a better doctor, they were treated with respect and were valued as a member of the team. The aspects of an attachment that interns thought made it either better or worse than others were the work atmosphere, teaching quality, amount of teaching time, amount of clinical contact time and their level of autonomy.

Most (74%) PGY1 interns agreed that the learning outcomes for their last clinical attachment were clearly defined. PGY2 interns were less likely to agree the learning outcomes for their year were clear.

The majority (over 80%) of both PGY1 and PGY2 interns reported that the overall quality of teaching on their last attachment was either satisfactory, good or very good, with almost no interns reporting that it was very poor. Almost all PGY1 and PGY2 interns agreed that there was enough time for direct clinical contact. However, less than half of PGY1 (41%) and PGY2 (43%) interns agreed that there was adequate protected teaching time for education. While approximately half agreed there was adequate balance between service obligations and clinical education, a quarter disagreed. There were a number of comments that adjusting the balance between service obligations and clinical education would improve prevocational training.

1.7 Quality of prevocational training

Overall, 65% of PGY1 and 76% of PGY2 interns were satisfied with the quality of their prevocational training. Most interns in both PGY1 (83%) and PGY2 (76%) interns were confident that they had gained enough experience for the stage they were at in their training.

Of the NZCF topics, clinical management was the area where PGY1 were less likely to agree that they had received sufficient teaching, learning and experience. In contrast educational supervisors were least likely to agree that prevocational training is effective in developing skills in communication (although 67% considered the training on this topic effective).

The extent PGY1 and PGY2 interns agreed their training had prepared them to provide healthcare in community settings and their understanding of community

based specialties was less than their preparation and understanding of hospital based settings. Interns from both years also felt they had less understanding of the primary secondary care interface than of hospital settings and specialties.

Interns in both years had mixed views on whether the DHB demonstrated that they valued their education role. PGY2 interns were less likely to agree that the DHB had done so.

1.8 Overview

Overall, opinions of those responding to the survey were positive about many aspects of prevocational training. MCNZ's proposed changes have the potential to address some of the main concerns and suggestions for improvement that were identified in the baseline data:

- The NZCF provides greater clarity about the learning outcomes for PGY1 and PGY2 and increases the focus on PGY2 as a learning year.
- The e-portfolio provides a mechanism for recording information about an intern's professional development goals, achievements and areas for development. It has the potential to provide the information clinical supervisors need to understand the strengths and development needs of interns starting clinical attachments.
- Greater accountability of training providers and accreditation of attachments has the potential to:
    - Improve the balance between clinical obligations and education that were identified as a problem by PGY1 and PGY2 doctors and their clinical supervisors.
    - Improve the already positive learning environment by increasing the extent interns and their supervisors feel their educational role is valued by the training provider.
- Increased opportunities for interns to work in community based and outpatient settings have the potential to improve doctors' understandings of community practice and the primary secondary care interface.

Most educational supervisors and RMO managers were aware of the changes to prevocational training and the curriculum framework. However, clinical supervisors were less aware of the changes and some said they were not at all aware of them.

2. Background

Prevocational medical training spans the two years following graduation from medical school and includes both postgraduate year 1 (PGY1) and postgraduate year 2 (PGY2). The Medical Council of New Zealand (MCNZ) is implementing changes to prevocational training and education for doctors that aim to improve patient safety and the performance of doctors.

The planned changes aim to strengthen an important part of a doctor's education by providing more structure to the educational objectives and outcomes through the development of the New Zealand Curriculum Framework for Prevocational Medical Training (NZCF). The curriculum framework covers five main areas: professionalism, communication, clinical management, clinical problems and conditions, procedures and interventions. The planned changes include a new component of three months experience in a community setting.

Curriculum development was based on advice from a working group that included members with experience and expertise in medical education, intern training, medical regulation and service provision. The proposed changes have been discussed through a national roadshow and meetings with key stakeholders such as the DHBs and intern supervisors.

Implementation of the NZCF will be phased in over a 12 month period and commenced in November 2014. Full implementation will occur after clinical attachments have been accredited, scheduled for November 2015.

The outcomes Council aims to achieve are:

- Increased opportunity for interns to obtain the broad based core competencies needed for medical practice in New Zealand
- Increased opportunities for all interns to work in community based and outpatient settings
- Greater accountability of training providers
- Improved balance between service demands and training requirements
- Improved vertical integration on the continuum of learning, and transition between medical school, prevocational training and vocational training
- Improved quality of learning for interns
- Ensured public health and safety.

A robust baseline is essential to assess any impacts of changes to the doctors as well as other stakeholder groups. This report sets out the evaluation framework, data collection and baseline data for the prevocational training programme.

3. Information sources

Evaluation planning included a review of key documents to build an understanding of the current prevocational training processes and policies, as well as the existing research available on prevocational training and to identify any existing validated scales used in assessing changes to education programmes.

3.1 Key stakeholder interviews

Interviews were used to gather data from key stakeholders and were conducted with a semi-structured interview guide. The guide was developed based on the topics outlined in the project workplan and agreed with the MCNZ. Key stakeholders were asked to discuss their expectations of the changes to prevocational training, measures of success from their perspective and the strengths and potential risks of the changes. In total, 19 of interviews were completed with:

- Evaluation working group members (4)
- Representatives from the New Zealand Medical Students Association (2)
- Members of other prevocational working groups (9)
- DHB CEO (1)
- Health Workforce New Zealand (2)
- New Zealand Medical Association (1).

Exploring potential indicators with knowledgeable staff that are involved with the management, deployment and development of prevocational training ensures that the baseline report can provide the post-implementation evaluation with a foundation to track changes and answer the evaluation questions. Information from the interviews was also used as part of the baseline data collection for stakeholder groups where interviews are the most appropriate method of collecting data.

3.2 Evaluation framework

An evaluation framework was developed based on MCNZ's logic model and expected outcomes from the changes, a review of relevant documents and interviews with the key stakeholders. The evaluation framework sets out the evaluation questions and indicators of change that can be measured. The baseline information also collected information about the education and training context as this information will be useful for the subsequent evaluation in explaining the outcomes resulting from the changes to prevocational training.

3.3 Online survey questionnaire development

Three questionnaires were developed based on the indicators in the evaluation framework and pretested with advisory group members, the Medical Council team, and PGY1 and PGY2 interns (Table 3-1). Where possible indicators and the wording of questions were drawn from published studies of trainee doctors experiences.[1,2,3] Questionnaires consisted primarily of rating scales with some open-ended questions for respondents' comments. Following pre-testing, questionnaires were revised and programmed for deployment as online surveys. Links to the online survey were provided to MCNZ for final sign off.

Copies of all questionnaires, invitation emails and other communications material are provided in the Data Collection Tools document.

Table 3-1. Survey questionnaires.

Online survey	Survey sub-groups
Intern survey	• PGY1 and PGY2 interns – doctors who are under the current prevocational training programme and will not be required to meet the new requirements as of November 2014
Supervisor survey	• Prevocational educational supervisors • Clinical Supervisors • Clinical directors of training
Management survey	• CMOs • RMO Unit Managers

3.4 Survey administration

Questionnaires were distributed as online surveys. The survey form was personalised with the MCNZ logo. The survey included an introduction and concluding notes to provide participants with sufficient information on the purpose of the project and the survey, their privacy and the voluntary nature of their participation. The survey took an estimated 10 minutes to complete. On completion

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[1] Edler A, Piro N,Dohn A, Behravesh B. Using Resident Perceptions to Improve Educational Quality and Accountability, Stanford University

[2] Jalili M, Mirzazadeh A, Azarpira A. A Survey of Medical Students' Perceptions of the Quality of their Medical Education upon Graduation Ann Acad Med Singapore 2008;37:1012-8

[3] United Kingdom General Medical Council http://www.gmc-uk.org/education/surveys.asp

of the survey respondents exited to the prevocational training page on the MCNZ website.

Online survey invitations were distributed using email address lists provided by MCNZ. An invitation letter outlining the reason for the survey was signed by the MCNZ Chair.

One prize of sponsorship to the 2015 Prevocational Medical Education Forum to the value of $1,500 was offered by MCNZ to interns completing the survey by 24 November. The online surveys closed on 8 December 2014. In response to the survey:

- 189 PGY1 interns responded – 132 opted for inclusion in the prize draw and 120 (64%) provided their contact details.
- 119 PGY2 interns responded – 69 opted for inclusion in the prize draw and 62 (52%) provided their contact details.

3.5 Survey response

Online survey response numbers and rates are reported in Table 3-2 below.

Table 3-2. Survey response numbers and rates.

Group[4]	Response	Response Rate
PGY1 Interns	450 survey invitations and 189 responses	42%
PGY2 Interns	441 invitations and 119 responses	27%
Other interns	9 responses from other interns including NZREX and PGY 3-6 from names incorrectly included in the sample list.	N/A
Educational supervisors[5]	60 invitations and 50 completions including 6 clinical directors of training	83%
Clinical supervisors	627 invitations and 239 completions	38%
RMO Unit managers	18 invitations and 8 responses	44%
CMO	Invitations were distributed by a CMO and there were two responses	10%

[4] Groups were initially classified based on the lists provided by the MCNZ. However, in the surveys small numbers of respondents self-identified in different groups. Survey results are based on respondents' self-identified roles.

[5] Note: The educational supervisor category includes clinical directors of training.

Two groups of supervisors are referred to in the results:

- Clinical supervisors: 239 total including respondents who identified as clinical supervisors (92), no designated title for education role (130), other (17).
- Educational supervisors: 50 total including prevocational educational supervisors (41), clinical directors of training (5), other (4).

3.6 Profile of respondents

Table 3-3 below provides an overview of the profile of respondents to the intern survey.

Table 3-3. Profile of intern survey respondents

Description		PGY1 n = 189	PGY2 n = 119
Gender	Female	59%	61%
	Male	41%	38%
Education	Otago University graduate	47%	45%
	Auckland University graduate	41%	41%
	Completed NZREX	12%	13%
	Australian medical school graduate	1%	1%
Age	Mean	28	28
Ethnicity Note: respondents could select multiple	NZ European	51%	52%
	Māori	8%	8%
	Cook Island Māori	2%	0%
	Samoan	1%	2%
	Tongan	1%	1%
	Chinese	15%	13%
	Indian	7%	8%
	Other	28%	26%

3.7 Limitations of the methods

The response rates are comparable to similar surveys. There is no information available about how responding health professionals may differ from those who did not complete the survey.

As with many evaluations, reliance has been placed on participants' recalled opinions and reflections about prevocational training.

4. Indicators of prevocational training changes

This section summarises the baseline measures relating to the outcomes Council aims to achieve from the changes to vocational training for PGY1 and PGY2 interns. Baseline percentages are provided for each of the indicators in the evaluation framework.

Unless otherwise stated percentages represent the proportion who answered positively (for example, those who agreed or strongly agreed with each statement, or those who answered all or most).

4.1 Improved vertical integration

Improved vertical integration on the continuum of learning, and transition between medical school, prevocational training and vocational training.

Key outcomes - interns (report sections 6.1 – 6.3)	PGY1	PGY2
Understand the learning outcomes they are required to obtain	58%	55%
PGY1 agree the coming PGY2 is a learning year	70%	-
PGY1 Agree the coming PGY2 year will help obtain the competencies they need	70%	-
Are confident they have the skills to enter the vocational training programme they want to enter	39%	75%

Key outcomes – supervisors (report sections 6.1 – 6.3)	Edu. super-visors	Clinical Super-visors
The learning outcomes for PGY1 are clearly defined	76%	-
The learning outcomes for PGY2 are clearly defined	27%	-
PGY1 is a learning year	91%	-
PGY2 is a learning year	71%	-
Interns have the skills required to enter the vocational training programme they want to enter	67%	-

Key outcomes - managers (report sections 6.1 – 6.2)	Managers
The learning outcomes for PGY1 are clearly defined	6 of 8
The learning outcomes for PGY2 are clearly defined	3 of 8

Key outcomes - managers (report sections 6.1 – 6.2)	Managers
PGY1 is a learning year	8 of 8
PGY2 is a learning year	5 of 8
PGY2 interns have the skills to enter the vocational training programme they want to enter	5 of 8

4.2 Greater accountability of training providers

Training providers are more accountable for the quality of the prevocational training they provide

4.2.1. Training providers support educational roles

Key outcomes - interns (report section 12.2)	PGY1	PGY2
Agree the DHB values their education role	63%	47%
Feel their educational needs were well supported by their educational supervisor	71%	54%
Feel supported by the RMO Unit	59%	39%

Key outcomes – supervisors (report sections 7.5 for educational supervisors and 8.6 for clinical supervisors)	Edu. super-visors	Clinical super-visors
Agree their educational role is valued by the DHB	72%	33%
Feel supported in their educational role by: • DHB management • Other clinical staff • The RMO Unit	 49% 82% 68%	 19% 55% 35%

Key outcomes - managers (report sections 9.2 and 9.4)	Managers
RMO units have a role in supporting educational supervisors	8 of 8
RMO units have a role in supporting clinical supervisors	6 of 8
The RMO Unit managers are supported by the DHB	7 of 8
The RMO Unit managers consider their seniority reflects their responsibilities	4 of 8
Clinical staff at this DHB consider their education role is very important	5 of 8

4.2.2. A positive learning experience

Key outcomes - interns (report section 11.3)	PGY1	PGY2
My supervisor was interested in making me a better doctor	75%	72%
Are valued as a member of a multi-disciplinary team	88%	87%
Are treated with respect	88%	88%

Key outcomes – supervisors (report sections 7.2 for educational supervisors and 8.2 for clinical supervisors)	Edu. super-visors	Clinical super-visors
Overall satisfaction with their education role	84%	66%
Would choose to have an education role if given the choice	-	77%
Consider teaching is an important part of their role	100%	95%
Enjoy their education roles	94%	86%

Key outcomes - managers (report section 9.2 and 9.3)	Managers
Interns have the support they need	7 of 8
Occasionally have positive comments from interns	7 of 8
Occasionally have reports of concerns from interns	4 of 8

4.2.3. Improved balance between service demands and training outcomes

Key outcomes - interns (report section 11.8)	PGY1	PGY2
There is enough protected time for education	41%	43%
There is adequate time for direct clinical contact	96%	93%
There is an adequate balance between service obligations and clinical education	50%	56%
Occasionally/frequently have to cope with problems beyond competence/experience	51%	51%
Regularly have to cope with problems beyond competence/experience	7%	6%

Key outcomes – supervisors (report sections 11.8, 7.4 and 8.4)	Edu. super-visors	Clinical super-visors
Interns have an adequate balance between service obligations and clinical education	50%	37%
My workload allows adequate time for me to provide appropriate supervision/assessment/teaching for interns	54%	29%

Key outcomes - managers (report section 9.4)	Managers
Interns have an adequate balance between service obligations and clinical education	4 of 8 (1 didn't know)
Supervisors' workloads allow them adequate time for appropriate supervision/assessment/teaching	4 of 8
Occasionally receive positive comments about workload from interns	6 of 8
Occasionally receive concerns from interns about workload	7 of 8

4.2.4. Opportunities to work in community based settings

Key outcomes - interns (report section 12.4)	PGY1	PGY2
Interns with clinical attachments in community-based settings	4%	11%
Positive learning experiences in community-based clinical attachments (note: based on small numbers)	63%	85%

4.3 Improved quality of learning for interns

Key outcomes - interns (report sections 12.1 - 12.2)	PGY1	PGY2
Overall satisfaction with the quality of their prevocational training	65%	76%
Interns consider they are well supported by their educational supervisor	71%	54%
Interns rate the extent to which programmes were organised to meet their educational needs	62%	45%

4.3.1. Improved quality of teaching/learning/supervision

Key outcomes - interns (report sections 10.5, 11.4, 11.6 and 11.7)	PGY1	PGY2
Professional development goals were set with the educational supervisor at the start of PGY1	39%	57%
Interns met regularly with educational supervisors to review professional development goals: • Those who set goals at the start of the year • Those who had not set goals at the start of the year	 59% 19%	 63% 29%
Interns set professional development goals for their last attachment	50%	55%
Interns who had set professional development goals report meeting with their clinical supervisor to discuss these goals: • At the start of the attachment • In the middle of the attachment • At the end of the attachment • At another point during the attachment	 50% 48% 56% 19%	 73% 73% 83% 17%
Interns report meeting with their clinical supervisor to discuss their learning objectives: • At the start of the attachment • In the middle of the attachment • At the end of the attachment	 84% 84% 97%	 50% 50% 65%
Quality of teaching on the last attachment was good or very good	53%	55%
Provided with informal day-to-day teaching that helps them learn	52%	71%
Clinical supervisor involvement was adequate	60%	52%
Clinical supervisor on the last attachment provided feedback that helped the intern to identify their strengths and weaknesses	65%	53%
Clinical supervisor on the last attachment provided informal feedback about how the intern was doing	19%	25%

Key outcomes – supervisors (report sections 10.1 and 10.2)	Edu. super-visors	Clinical Super-visors
Professional development goals are set with all or most interns at the start of PGY1	69%	-
Professional development goals are discussed with all or most interns during their clinical attachment	-	85%
Professional development goals are discussed with all or most interns at the end of clinical attachments	75%	79%

Key outcomes - managers (report sections 10.4)	Managers
Clinical supervisors frequently meet with interns to discuss education objectives	6 of 8
Clinical supervisors frequently meet with interns to discuss professional development goals	1 of 8 (1 didn't know)

4.3.2. Feedback mechanisms are in place for those who need additional assistance

Key outcomes - interns (report sections 10.5 and 11.9)	PGY1	PGY2
Interns understand their areas of strength	78%	81%
Interns understand areas of clinical practice where they need further development	76%	81%
Interns can ask for help from the educational supervisors if needed	88%	64%
Interns can ask for help from the clinical supervisor on the last clinical attachment	83%	81%
Interns consider assessments are: • An accurate reflection of interns' skills • Worthwhile	 58% 67%	 47% 55%

Key outcomes – supervisors (report sections 10.1, 10.3 and 10.6)	Edu. super-visors	Clinical super-visors
Supervisors consider assessments are an accurate reflection of interns' skills	60%	-

Key outcomes – supervisors (report sections 10.1, 10.3 and 10.6)	Edu. super-visors	Clinical super-visors
Supervisors have sufficient information to assess interns': • Areas of strength • Areas requiring further development	 - -	 9% 10%
Supervisors have sufficient information to assist interns to set goals that focus on their learning needs	-	25%
Supervisors have sufficient information at the start of clinical attachments to: • Identify interns having difficulty • Manage interns having difficulty	 60% 53%	 63% 45%

Key outcomes - managers (report sections 10.4 and 10.6)	Managers
Clinical supervisors frequently complete reports at the end of clinical attachments	7 of 8
The current assessment process for interns identifies all or most interns having difficulty	4 of 8 (1 didn't know)
The current assessment process for interns identifies all or most interns who should not progress	3 of 8 (1 didn't know)
The current assessment process for interns provides information to help to manage all or most interns having difficulty	4 of 8 (2 didn't know)

4.4 Ensure public health and safety

Interns to obtain the broad based core competencies needed for medical practice in New Zealand and gain a general scope of practice.

Key outcomes - interns (report sections 12.3 – 12.5)	PGY1	PGY2
Interns agree they have gained enough experience for their stage of training	83%	76%

Key outcomes - interns (report sections 12.3 – 12.5)	PGY1	PGY2
Interns have developed the skills they need to practice as a doctor in:		
• Professionalism	84%	73%
• Communication	88%	72%
• Clinical management	49%	59%
• Clinical problems and conditions	84%	85%
• Procedures and interventions	81%	84%
Interns are prepared to provide healthcare to people in:		
• A hospital setting	88%	90%
• A community setting	19%	33%
Interns report they understand:		
• What hospital based specialities do	92%	94%
• What community based specialties do	20%	34%
• The interface between primary and secondary care	48%	58%

Key outcomes – supervisors (report sections 10.3 and 12.3)	Edu. super-visors	Clinical Super-visors
Interns starting a clinical attachment have the level of knowledge and skills that meets their expectations in:		
• Professionalism		91%
• Communication		92%
• Clinical management		71%
• Clinical problems and conditions		72%
• Procedures and interventions		51%
Prevocational training is effective in developing skills in:		
• Professionalism	73%	
• Communication	67%	
• Clinical management	78%	-
• Clinical problems and conditions	80%	
• Procedures and interventions	71%	

Key outcomes - managers (report section 12.3)	Managers
Prevocational training is mostly/completely effective in developing PGY1 interns' skills in:	
• Professionalism	5 of 8 (1 didn't know)
• Communication	4 of 8 (1 didn't know)
• Clinical management	5 of 8 (3 didn't know)
• Clinical problems and conditions	3 of 8 (5 didn't know)
• Procedures and interventions	3 of 8 (5 didn't know)
Prevocational training is mostly/completely effective in developing PGY2 interns' skills in:	
• Professionalism	3 of 8 (1 didn't know)
• Communication	3 of 8 (1 didn't know)
• Clinical management	4 of 8 (3 didn't know)
• Clinical problems and conditions	3 of 8 (5 didn't know)
• Procedures and interventions	3 of 8 (5 didn't know)

5. Awareness of changes

Changes to prevocational training began to be implemented with the new cohort of PGY1 interns starting at the end of 2014.

Most educational supervisors were aware of the changes to prevocational training and the curriculum framework. Clinical supervisors were less aware of the changes

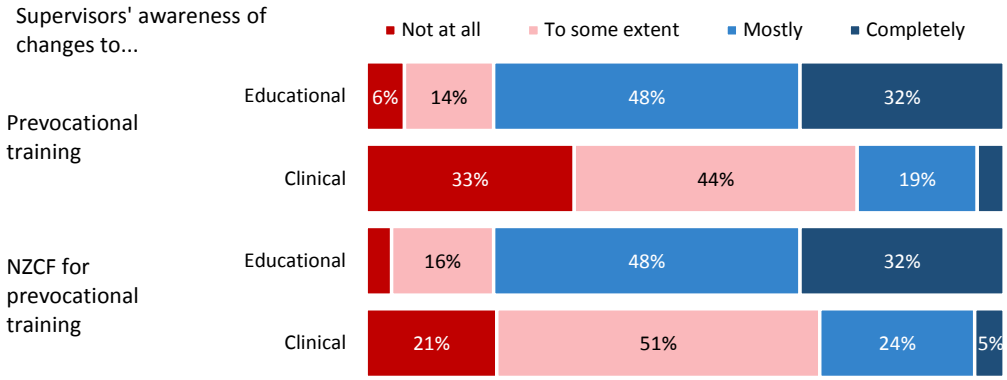

Figure 5-1. Clinical (n = 239) and educational (n = 50) supervisors' awareness of changes to prevocational training and the New Zealand Curriculum Framework for prevocational training.

Most (80%) of educational supervisors were mostly or completely aware of the changes to prevocational training and the curriculum framework. Similarly five of the eight RMO managers reported mostly or completely aware of the changes.

6. Vertical integration

6.1 Awareness of the learning outcomes for PGY1 and PGY2

More than half the interns in both PGY1 and PGY2 were mostly or completely aware of the learning outcomes they were required to obtain by the end of the year (Figure 6-1). A higher proportion of PGY2 interns than PGY1 interns were not at all aware of their required learning outcomes.

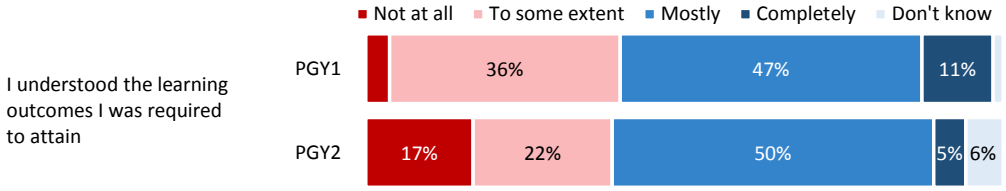

Figure 6-1. PGY1 (n = 188) and PGY2 (n = 119) interns' understanding of the learning outcomes they were required to obtain by the end of their year.

More than three-quarters of educational supervisors reported that the learning outcomes for PGY1 were well defined. Fewer felt that the PGY2 outcomes were well defined (Figure 6-2).

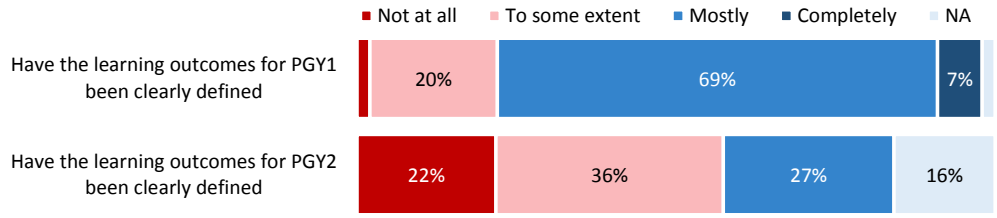

Figure 6-2. Educational supervisors' (n = 50) views on whether the learning outcomes are clearly defined for PGY1 and PGY2.

Six of the eight RMO unit managers reported that learning outcomes were mostly or completely clearly defined for PGY1, compared to three of eight for PGY2.

6.2 PGY2 as a learning year

Nearly three-quarters of PGY1 interns saw their upcoming PGY2 year as mostly or completely a learning year and felt that it would help them acquire the competencies they needed (Figure 6-3).

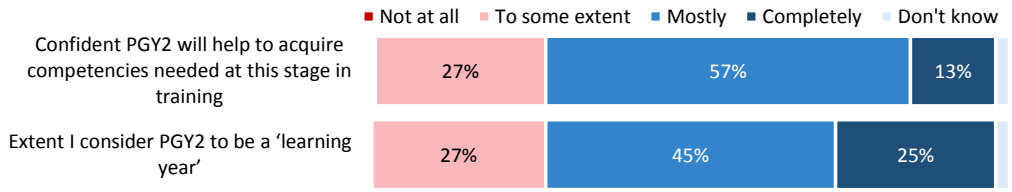

Figure 6-3. PGY1 interns' confidence that PGY2 will help them acquire the competencies they need (n = 187) and views about PGY2 as a learning year (n = 188).

Educational supervisors' views were similar to those of interns, with the majority considering that both PGY1 and PGY2 were mostly or completely learning years (Figure 6-4).

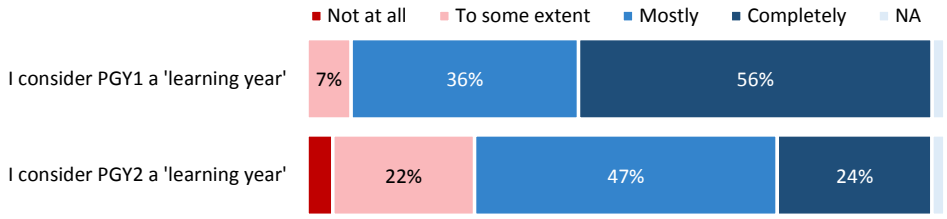

Figure 6-4. Educational supervisors' (n = 50) views on the extent to which PGY1 and PGY2 are learning years.

All of the eight responding RMO unit managers reported that they considered PGY1 to be mostly or completely a learning year while only five of the eight held that view of PGY2.

6.3 Vocational training

Almost all interns in both PGY1 and PGY2 intended to enter a vocational training programme. The proportion of those who intended to enter a vocational training programme who felt prepared to do so was higher for PGY2 than for PGY1 (Figure 6-5).

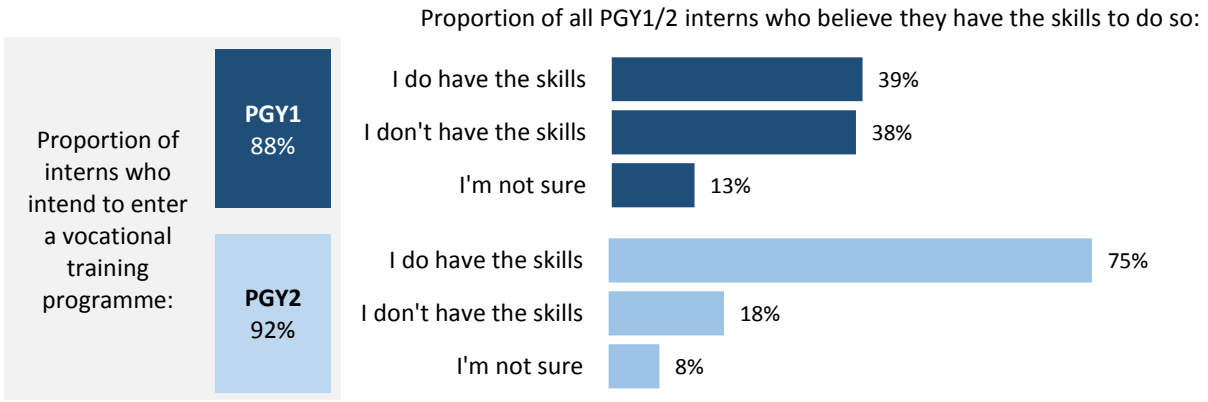

Figure 6-5. Proportions of PGY1 (n = 166) and PGY2 (n = 109) interns who intended to enter a vocational training programme and the proportion who believed they had the skills to do so.

Two-thirds of educational supervisors considered that interns had the skills to enter the vocational programmes they wanted to enter at the end of PGY2 (Figure 6-6).

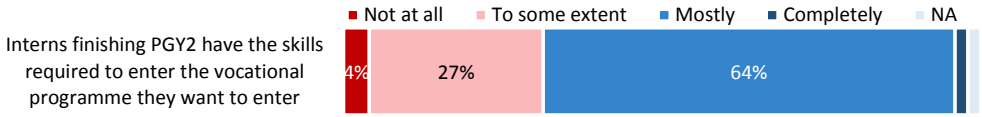

Figure 6-6. Educational supervisors' (n = 50) views on whether PGY2 interns have the skills required to enter the vocational programme they want to enter.

7. Prevocational educational supervisors and clinical directors

Prevocational educational supervisors (educational supervisors) are Council appointed vocationally registered doctors who have oversight of the overall educational experience of a group of PGY1 or PGY2 doctors.[6] Results for educational supervisors include survey responses from clinical directors of training.

7.1 Profile of educational supervisors

Fifty educational supervisors from fourteen DHBs responded to the online survey. On average, educational supervisors had been consultants for 11 years. Their areas of practice were varied and included:

- General surgery (18%)
- Specialist medicine (18%)
- General medicine (14%)
- Paediatrics (6%)
- Other areas (including cardiology, geriatric, obstetrics and gynaecology, orthopaedics, anaesthetics, nephrology, palliative care, urology and others) (44%).

7.2 Attitudes to their educational role

Educational supervisors reported that they mostly or completely understood the education experiences and opportunities available for interns at their DHBs (Figure 7-1).

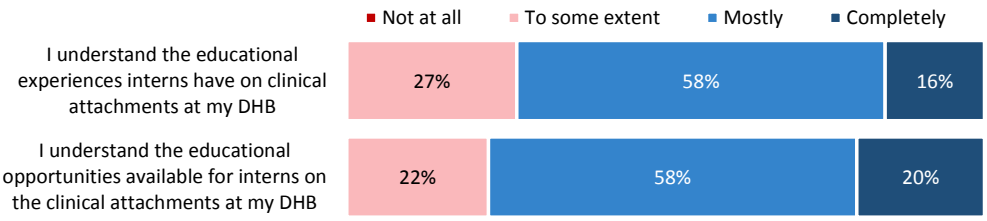

Figure 7-1. Educational supervisors' (n = 50) understanding of the educational opportunities and experiences for interns at their DHBs.

[6] https://www.mcnz.org.nz/assets/News-and-Publications/TFS-GuideforPrevocationalEducationalSupervisorsPDF.pdf

All surveyed educational supervisors strongly agreed or agreed their educational role was important and almost all enjoyed and were satisfied with their educational role (Figure 7-2).

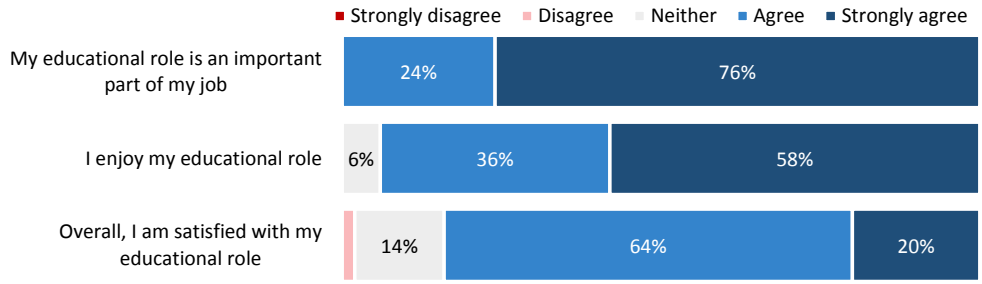

Figure 7-2. Educational supervisors attitudes to their educational role (n = 50).

7.3 Training for educational supervisors

Most educational supervisors (82%) reported receiving training in at least one aspect of their educational roles in the last three years (Figure 7-3). The topics most had received training about were how to give feedback to interns and how to support interns learning.

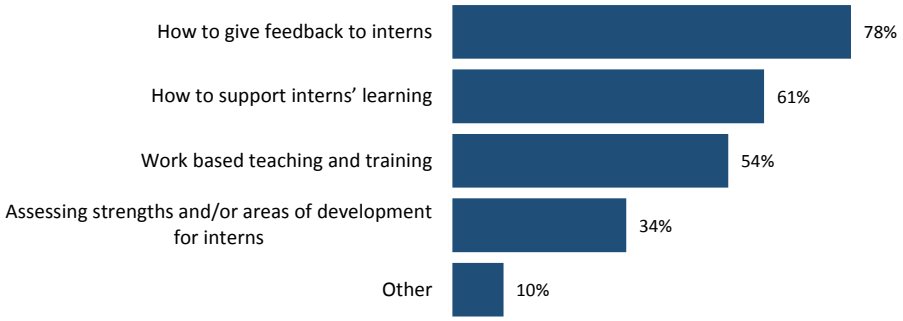

Figure 7-3. Training educational supervisors had received in the last three years (n = 50). Note: More than one option could be selected.

For the 41 educational supervisors who had received training, the Medical Council was the most frequently mentioned training provider (78%). Others had received training from their vocational college (51%) or the university medical school (24%).

Despite the high proportion who had received some training, when asked whether they wanted further training or professional development on their education roles, nearly two-thirds (62%) answered yes and one-third (30%) answered maybe. Only four (8%) said they did not want further training or professional development.

7.4 Workload

The number of interns educational supervisors had been responsible for in the last month varied, with approximately one-third responsible for 11 or more interns (Figure 7-4).

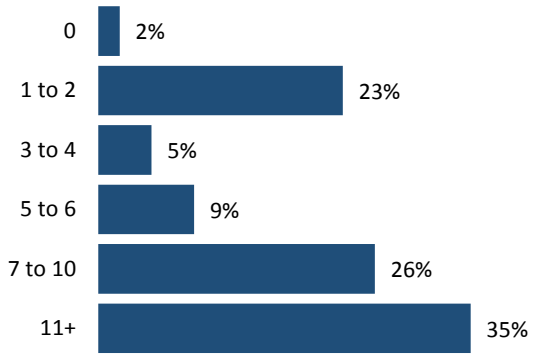

Figure 7-4. Number of interns educational supervisors were responsible for in the last month (n = 43).

The contracted educational time and the actual educational time was similar except for educational supervisors responsible for larger numbers of interns (Figure 7-5). Overall, half (52%) spent more time on the education component of their roles than they were contracted for.

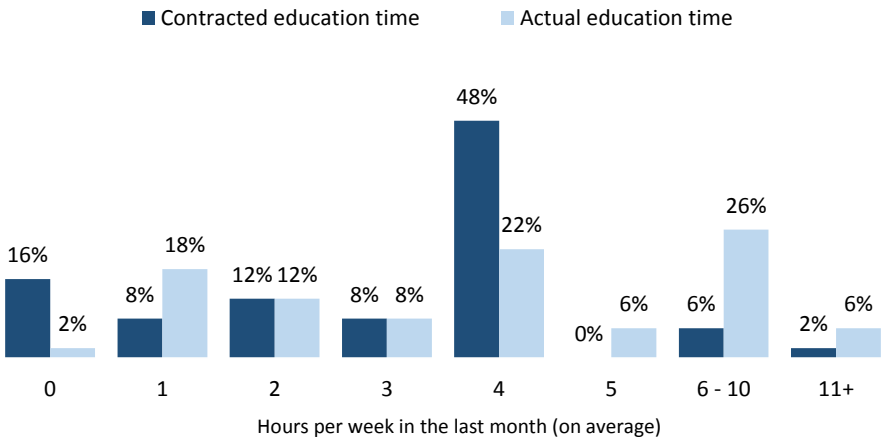

Figure 7-5 Contracted and actual hours per week spent on educational activities with interns for educational supervisors (n = 50).

Half of educational supervisors agreed or strongly agreed that their workloads allowed them adequate time for their education roles (Figure 7-6).

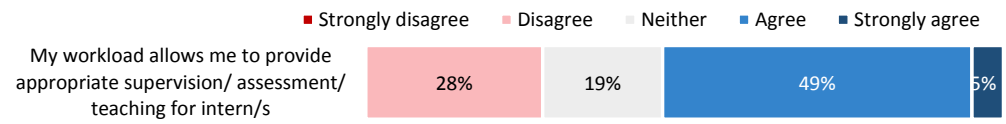

Figure 7-6. Educational supervisors' (n = 47) views on whether their workload allows them appropriate time for their education roles.

7.5 Support for supervision roles

Most educational supervisors agreed their educational role was supported by other clinical staff. Fewer, although over two-thirds (68%) agreed they were supported by the RMO unit. While 72% agreed their DHB valued their educational role fewer (49%) agreed that DHB management supported them in their educational role (Figure 7-7).

[What is working well is] Good relationships between RMO unit and Prevocational educational supervisors. (Educational supervisor)

Experienced/capable RMO Staffing unit with very effective working relationships with the Intern supervisors, very supportive Medical director/ CMA. (Educational supervisor)

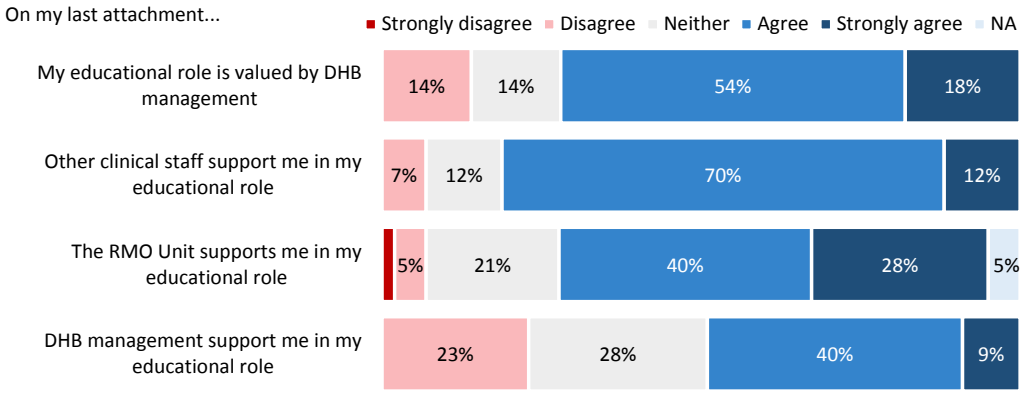

Figure 7-7. Views of educational supervisors on the support they receive in their roles (n = 50).

Almost all (83%) educational supervisors had their educational roles included in their DHB job descriptions. Two-thirds (62%) had not received any feedback from colleagues or DHB managers in the last 12 months on the effectiveness of their education roles.

8. Clinical supervisor role

A clinical supervisor is a vocationally registered senior medical officer supervising an intern on a clinical attachment (a MCNZ accredited thirteen-week rotation worked by an intern).[7]

8.1 Profile of clinical supervisors

239 clinical supervisors from eighteen DHBs responded to the online survey. On average they had been consultants for 13 years. Their areas of practice included:

- General surgery (24%)
- Specialist medicine (20%)
- General medicine (18%)
- Geriatric medicine (7%)
- Psychiatry (4%)
- Other areas (including plastics, cardiology, urology, nephrology, paediatrics, specialist surgery and others) (27%).

8.2 Attitudes to their educational role

Almost all (97%) of the clinical supervisors who answered the survey provided supervision, assessment, and/or teaching (described by the term 'educational role') during a clinical attachment.

Clinical supervisors were positive about their educational roles. Almost all supervisors saw their educational role as an important part of their jobs that they enjoyed but fewer were satisfied with it overall. (Figure 8-1).

> *It can be very rewarding to supervise the junior doctors. I get a lot of good feedback and it adds to the enjoyment in my job. I hope that it also contributes to well-rounded patient management that enhances our community. (Clinical supervisor)*

[7] https://www.mcnz.org.nz/assets/News-and-Publications/TFS-GuideforPrevocationalEducationalSupervisorsPDF.pdf

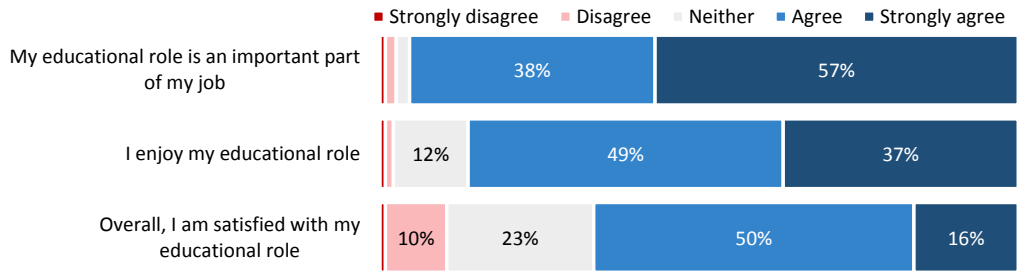

Figure 8-1. Views of supervisors with a role in clinical attachments on the supervision/assessment/teaching component of their roles (n = 239).

Most clinical supervisors (77%) reported that, given the choice, they would continue to have an educational role with PGY1/PGY2 interns. A smaller proportion (16%) were unsure and just 7% said they would prefer not to have such a role.

8.3 Training for clinical supervisors

Nearly two-thirds of the clinical supervisors had received formal training about how to give feedback to interns and half about work based teaching and training (Figure 8-2). They received their training from their vocational colleges (80%), the Medical Council of New Zealand (26%) or a university medical school (18%).

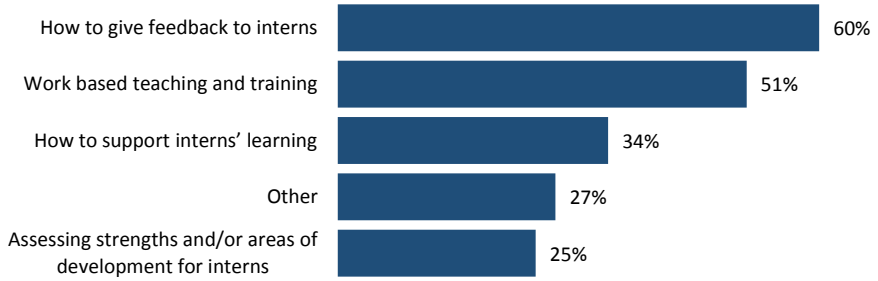

Figure 8-2. Areas that supervisors' had received formal training in the last three years (n = 121).

Few (13%) of the clinical supervisors had received feedback in the last 12 months from colleagues or from their DHB managers about the effectiveness of their education role.

When asked whether they wanted further training or professional development focused on their education role, half of the clinical supervisors (51%) said yes and more than one-third (39%) said maybe. A smaller proportion (11%) did not want further training or professional development.

8.4 Balancing education roles with other work

In the month before the survey, most clinical supervisors said they were responsible for one or two interns. (Figure 8-3). Few clinical supervisors had been responsible for five or more interns in the last month.

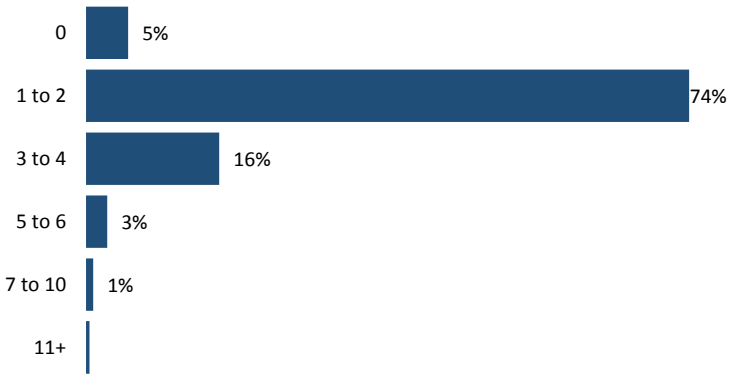

Figure 8-3. Number of interns each clinical supervisor was responsible for in the last month (n = 239).

Apart from the clinical supervisors who had not been responsible for an intern in the last month, there was tendency for supervisors to spend more time on their educational role than contracted. (Figure 8-4). Overall, 76% of supervisors spent more time on education with interns than they were contracted for.

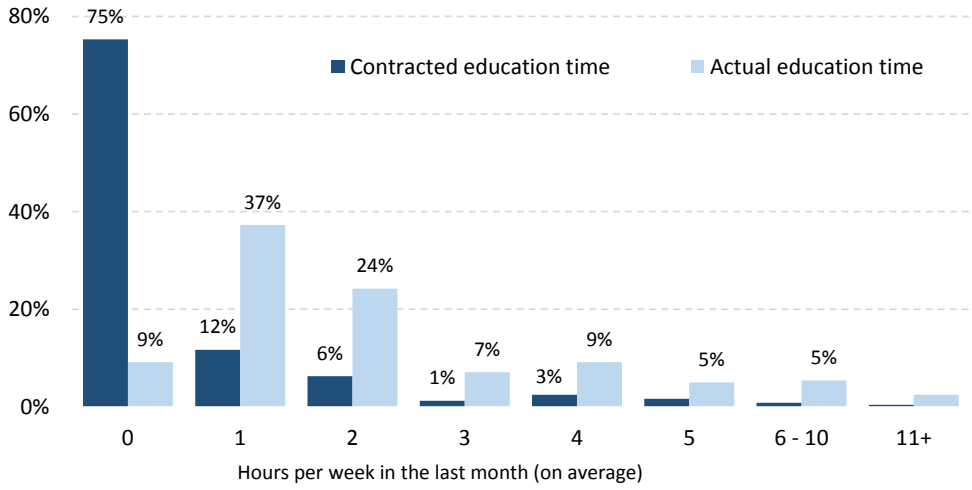

Figure 8-4. Contracted and actual time spent on education activities for supervisors per week in the last month on average (n = 239).

Clinical supervisors reported that there needed to be a better balance between teaching time and service demands for their roles and this seemed to underpin the dissatisfaction some expressed with their educational roles.

[There should be] Appropriate time for intern supervisors to adequately address supervision requirements and appropriate administrative support. (Clinical supervisor)

Clinical supervisors often mentioned the impact of their workload as something that could be changed to improve prevocational training as they felt their effectiveness in their educational roles was limited by their workloads.

I would like to have more devoted time [to train the interns] to do it properly. Currently that is not possible. Probably better if someone with more time did it properly. (Clinical supervisor)

Half disagreed that their workloads allowed them appropriate time to supervise, assess and teach interns (Figure 8-5).

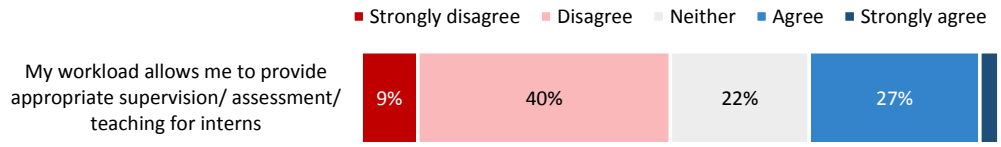

Figure 8-5. Clinical supervisors' (n = 236) views on whether their workloads allow them enough time for their education roles.

Not having enough time to provide adequate supervision was the main reason given by the few supervisors who were considering withdrawing from their role in educating PGY1 and PGY2 interns.

Limited time to supervise well, already overcommitted. (Clinical supervisor)

Having DHB management recognise the time and effort it takes to teach was the most common theme in supervisors' comments. Suggestions included increasing the time available for teaching, reducing service provision responsibilities, involving more staff and providing more funding.

[Prevocational training could be improved by] recognition of the resource needed to train and supervise (this is usually the time requirements to do so). (Clinical supervisor)

8.5 Support for clinical supervision roles

Clinical supervisors had mixed views on the support of DHB management and their RMO unit in their role (Figure 8-6). Higher proportions reported that they were supported by other clinical staff.

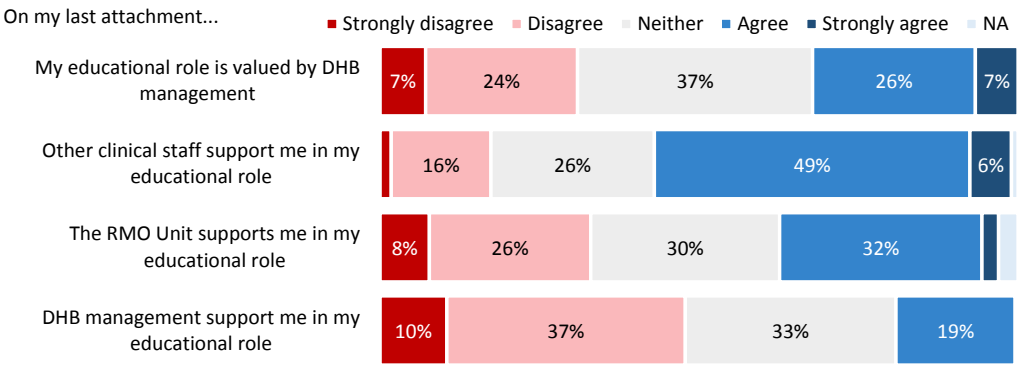

Figure 8-6. Clinical supervisors' views on the support available to them in their role (n = 232 – 239).

Two-thirds of clinical supervisors' (66%) job descriptions included their educational roles.

9. RMO Unit managers

The RMO Units are responsible for the recruitment, retention and support of PGY1 and PGY2 doctors.

9.1 Profile of RMO Unit manager

Eight RMO Unit managers responded to the survey from eight DHBs (BOP, Capital and Coast, Hawkes Bay, Midcentral, Northland, Waikato, Whanganui, Southern).

9.2 Role of the RMO Unit

Seven of the eight RMO unit managers agreed or strongly agreed that interns have the support they need from the RMO units. All RMO unit managers agreed or strongly agreed that their RMO units have a role in supporting prevocational educational supervisors and six of the eight felt that their RMO units had a role in supporting clinical supervisors.

> *As a "one stop shop" I believe our unit is well balanced and offers good support to RMOs in administrative and pastoral management with clear and consistent communications. Relationships with supervisors and pre-vocational supervisors is easy with ready access and open dialogue. Without question, [educational and clinical] supervisors are responsive if any issues are highlighted. Perfect world really! (RMO unit manager)*

Seven of the eight RMO unit managers agreed or strongly agreed that they had the support they required from DHB management and four reported that their level of seniority within their DHBs mostly or completely reflected their responsibilities.

> *The RMO Unit is currently very low on the 'pecking order'. Anything that we try to move up the chain or to the services is stymied and frustrated. While some services are receptive and supportive, most of them have a detached even adversary relationship with the RMO Unit. … This is extremely counter-productive and unhelpful. (RMO unit manager)*

Some suggested that there should be greater recognition of the role the RMO units have in supporting interns, intern supervisors and clinical supervisors.

> *Council should better recognise the role that RMO Units have in supporting interns, intern supervisors and clinical supervisors. Interns should have greater accountability when it comes to completing the requirements of their first year and not rely on the RMO Unit to manage everything for them. (RMO unit manager)*

9.3 Views on the quality of prevocational training

RMO managers were asked to comment about aspects of the quality of prevocational training, about what was working well and what they felt could be improved.

- Supervisors were frequently mentioned. Having good experienced supervisors and a dedicated prevocational educational supervisor was seen as important. Most (seven of eight) RMO unit managers said they occasionally had positive comments from interns about the quality of their supervision. Conversely, half (four) said they occasionally received concerns from interns about their clinical supervision.
- Approaches to teaching that were considered effective included tutorials, ward teaching, regular teaching sessions and the apprenticeship model - a hierarchical teaching structure where interns teach students, PGY2s teach first years, and registrars teach house officers. Some mentioned the advantages of having a separate programme for PGY1s and PGY2s, and of GP attachments.

For the past two years we have separated the PGY1 and 2s' education sessions. This has allowed a programme to be developed to "stretch" the PGY2s, and also allows for PGY1 programme better suited to their level of experience. Works well. (RMO unit manager)

Tutorial sessions work well and are well attended. Apprenticeship model in ward training works well. Access to training courses is good and is provided. Time is provided for training. Ability to work alongside SMOs from PGY1. Relationships with Consultants are great. Access to theatre, shadowing, access to the library and ICT. (RMO unit manager)

9.4 Suggestions for changes

RMO managers made some suggestions for potential ways to improve the quality of prevocational training including:

- Increasing commitment of clinical supervisors to their educational role - Five of the eight managers agreed or strongly agreed that clinical staff at their DHB considered their education roles important, one disagreed and two took neither view.
- Improving balance between service obligations and education - Four agreed that there was an adequate balance between service obligations and education in clinical attachments for interns. Two disagreed, one took neither view and one said they did not know. While most RMOs reported that they occasionally (six of eight) received positive comments about workloads and responsibilities from interns, most (seven of eight) reported

that they occasionally received concerns from their interns about their workloads and responsibilities.

The teaching programme for PGY1 works very well and is mostly well attended. There are some services who continue not to recognise the importance of the teaching session to the interns. I think on the most part the PGY2s get good support, and they are able to attend the PGY1 programme. (RMO unit manager)

- Increasing the number of clinical supervisors or reducing workloads - Four of eight agreed that clinical supervisors' workloads allowed them to provide appropriate supervision/assessment/teaching for their interns, two disagreed and two took neither view.

Another FTE to provide support for the prevocational educational supervisors. (RMO unit manager)

- Improving support for clinical supervisors - Five of the eight agreed or strongly agreed that clinical supervisors have the support they need from DHB management for their education roles.
- Improving professional development for clinical supervisors such as performance reviews and ways to share best practice
- Improving communication with supervisors

More regular / frequent communications with the clinical supervisors would be advantageous. More supervisors would also be good. A better system of capturing training e.g. ACLS, NLS etc. (RMO unit manager)

- Adopting approaches to teaching such as a structured PGY2 timetable

I think that having a structured timetable for PGY2 teaching would be fantastic. The challenge will be getting the services to recognise the requirement for these learning opportunities must sometimes come above service provision. This is a constant tension. (RMO unit manager)

- Addressing practical issues such as shortages of teaching space, difficulty in obtaining places for community attachments.

Better access to clinical lecture theatres for teaching. Greater involvement by attachment supervisors and registrars. Guaranteed positions in GP for GP community placements (our HOs get pushed out by GPEP trainees). (RMO unit manager)

All eight RMO unit managers were mostly or completely aware of the Medical Council's changes to prevocational training and the New Zealand Curriculum Framework for prevocational training. The changes to prevocational training were seen by some as an effective tool to ensure the hospitals make a greater effort to provide an effective training programme.

10. Supporting interns' development

10.1 Prevocational educational supervisors

Following the changes to prevocational training, the role of educational supervisors includes meeting with interns:

- At the beginning of PGY1 the educational supervisors should meet with interns to discuss the intern's e-portfolio, the intern's upcoming clinical attachments, the learning outcomes through the NZCF and to set goals in the professional development plan
- After each attachment to discuss the intern's performance, review and update the PDP and develop a plan to manage any performance issues
- Towards the end of PGY1to provide feedback, discuss outstanding learning outcomes and assist the intern in developing a PDP for PGY2.

10.1.1. Setting professional development goals

More than two-thirds (69%) of educational supervisors reported that they met with most or all of the PGY1 interns to set professional development goals at the start of PGY1. A higher proportion (75%) met with all or most of the interns at the end of clinical attachments. Some educational supervisors commented that career planning for interns could improve the quality of prevocational training.

> *More specific career planning sessions with PGY supervisors and the RMO unit about run allocations specific to career pathways. (Educational supervisor)*

10.1.2. Managing interns having difficulty

Educational supervisors had similar views on their ability to identify and manage interns having difficulty with slightly under half considering they did not have sufficient information (Figure 10-1).

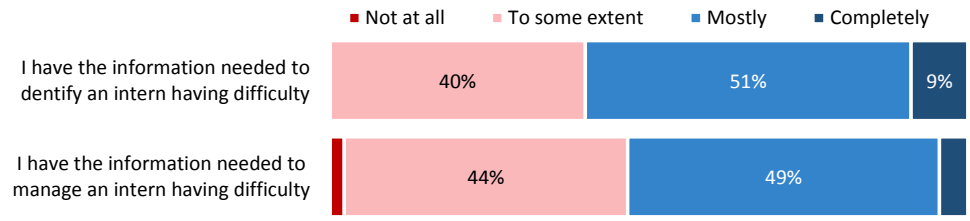

Figure 10-1. Educational supervisors' (n = 45) views on whether they have the information needed to identify and manage interns having difficulty.

Few of the educational supervisors reported that they mostly or completely had the information they needed to assess and assist interns' development at the start of the clinical attachments (Figure 10-2).

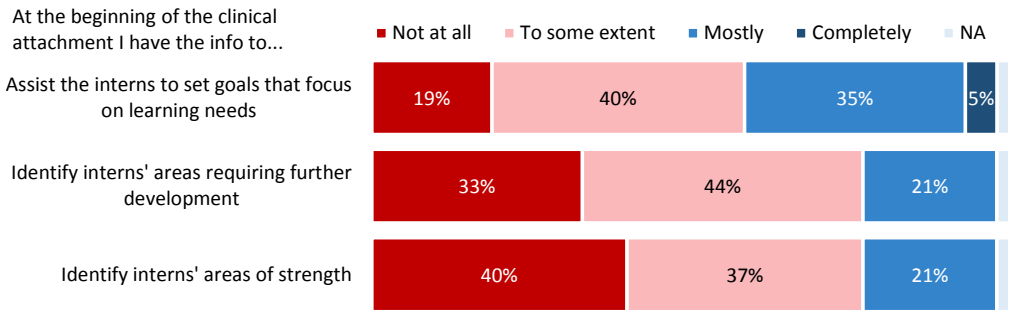

Figure 10-2. Educational supervisors' views on whether they have the information to assist interns' development (n = 239).

Some clinical supervisors suggested identifying and supporting interns who were having difficulty could be done both through raising the awareness of the requirements and reducing supervisors' workloads.

A better understanding of the PGY1 and 2 requirements would be appreciated, along with how to identify and manage those in trouble. The difficulty is that we are all so busy in our Department the juniors are often overlooked. (Clinical supervisor)

10.2 Clinical supervisors

Following the changes to prevocational training, the role of the clinical supervisor includes meeting with interns:

- At the beginning of each attachment to review the e-portfolio including the PDP and to discuss the learning opportunities available on the clinical attachment
- Midway through the attachment to provide formal feedback on their progress and performance, and to review and update the PDP
- At the end of the clinical attachment to discuss the intern's overall performance on the attachment and review and update the PDP.

10.2.1. Setting objectives for clinical attachments

Almost all clinical supervisors reported that they met with all (50%) or most (34%) of their interns to discuss their education objectives at the start of their attachments.

Three-quarters of clinical supervisors reported that they either met with all (33%) or most (42%) of their interns to discuss their professional development goals during clinical attachments. When commenting on opportunities to improve prevocational training, a small number of supervisors suggested that there should be more help for interns to plan their career.

I think most DHBs need to help prevocational house officers focus on a career pathway. (Clinical supervisor)

Career selection could do with some focus. (Clinical supervisor)

Most clinical supervisors said they also met with all or most of their PGY1 and PGY2 interns at the mid-point and end of their attachments to provide feedback on their progress (Figure 10-3).

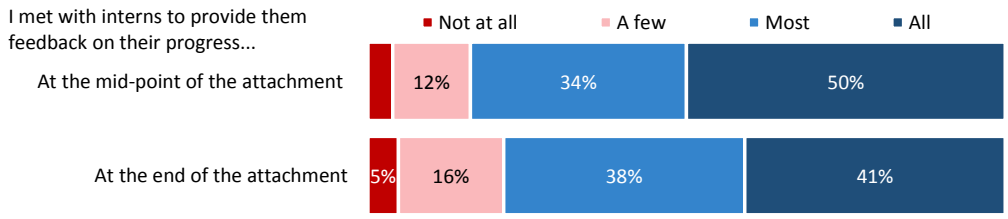

Figure 10-3. Clinical supervisors' reports on how many of their interns they met with at the mid- and end-points of their attachments to discuss their progress (n = 222).

10.3 Providing feedback

Clinical supervisors were positive about most aspects of interns' practice at the start of their attachments. They were least positive about interns' skills in procedures and interventions, with half of the supervisors reporting that a few or none of the interns had the level of knowledge and skill they expected (Figure 10-4).

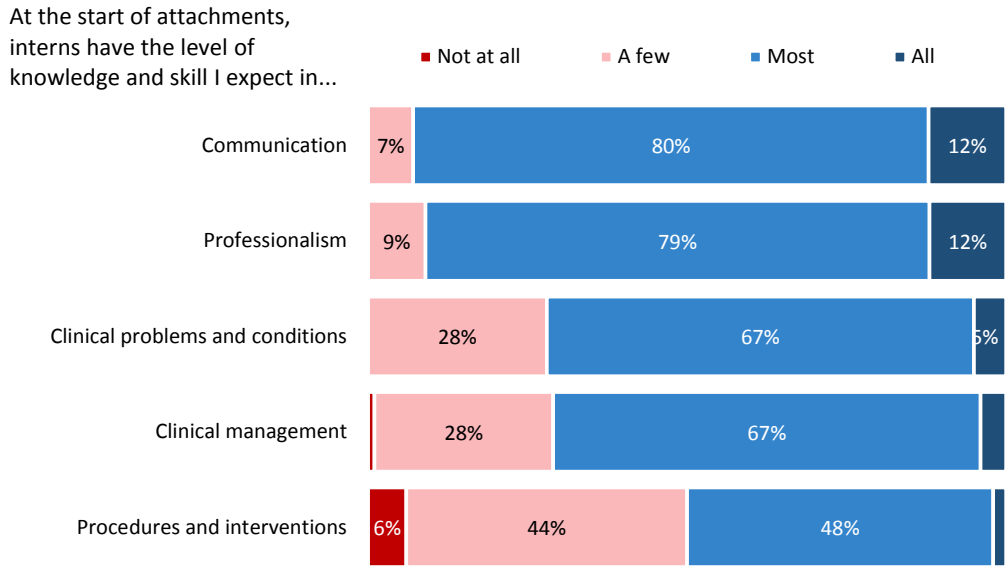

Figure 10-4. Clinical supervisors' views on whether interns have the level of knowledge and skill they should have at the start of their clinical attachments (n = 222 – 233).

Some educational supervisors suggested that the feedback from clinical supervisors to interns needs to be improved.

[There should be] improved feedback from the less engaged SMOs who clinically supervise. (Educational supervisor)

Some clinical supervisors also suggested that there were opportunities to improve the feedback given to interns.

> *[There should be] formal workshops about assessment and feedback. This could be based on the RACP model, of which I am much more knowledgeable. (Clinical supervisor)*

To be effective in supporting interns, clinical supervisors need to identify interns' areas of strength and areas requiring further development to set appropriate goals.

> *[There should be] multisource feedback to identify problems much earlier (among many other benefits). (Educational supervisor)*

However, few clinical supervisors felt that they mostly or completely had the information they needed at the start of clinical attachments (Figure 10-5).

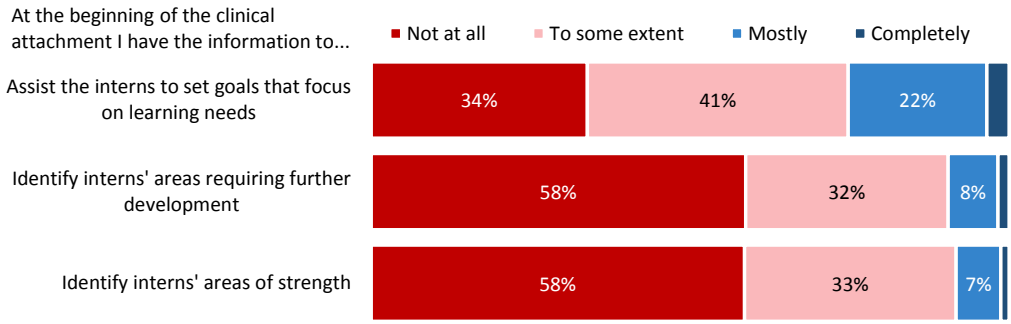

Figure 10-5. Clinical supervisors' views on whether they had enough information to identify interns' areas of strength and weakness at the start of the clinical attachment (n = 232).

10.3.1. Managing interns having difficulty

Clinical supervisors play an important role in identifying and managing interns who are having difficulty. More (two-thirds) clinical supervisors were confident that they had the information they needed to identify interns having difficulty than were confident they had the information to manage them (Figure 10-6).

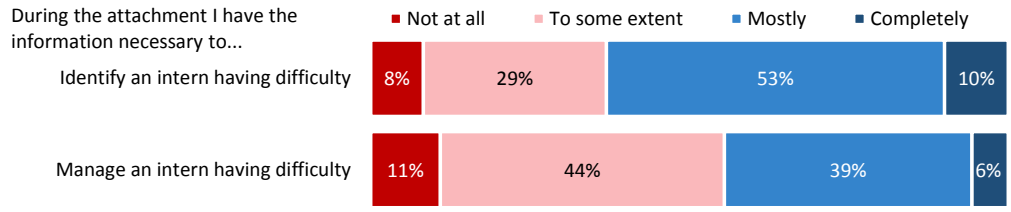

Figure 10-6. Clinical supervisors' views on whether they had enough information to identify and manage interns having difficulty during attachments (n = 232).

Some clinical supervisors suggested that prevocational training could be improved by having more thorough handovers between attachment supervisors, so they were not starting from scratch each time. The new e-portfolio aims to provide this information at handover.

Transfer of information re the performance of a PGY1 or PGY2 from one department to the next they work in would be helpful, especially in identifying deficiencies or focusing learning. (Clinical supervisor)

10.4 RMO Unit managers' perspectives

RMO unit managers reported that clinical supervisors met with their interns to discuss their education objectives occasionally (two respondents) or frequently (six respondents). Seven reported that meetings frequently occurred at the endpoint of the attachment and two said they frequently occurred in the middle of attachments.

RMO Unit managers reported that meetings to discuss professional development goals occurred less often. Only one RMO unit said clinical supervisors met with interns to discuss their professional development goals frequently. Four said the meetings happened occasionally and two that they happened rarely, while one said they did not know.

Half (four) reported that current feedback processes provided most or all of the information needed to help manage interns having difficulty. Two said current processes provided the information to help manage a few of those having difficulty and two said they did not know.

10.5 Interns

10.5.1. Setting professional development goals

More PGY2 interns reported that they had set professional development goals than PGY1 interns (57% compared to 39%) (Figure 10-7).

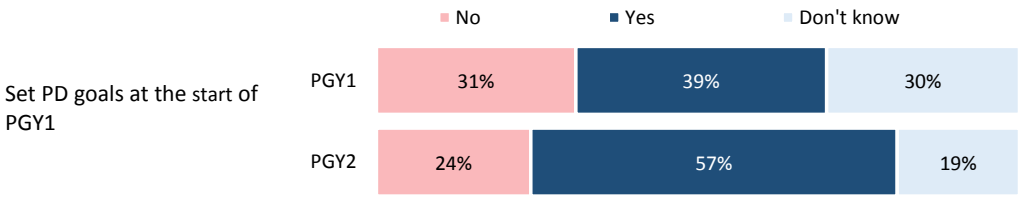

Figure 10-7. Proportion of PGY1 (n = 188) and PGY2 (n = 119) interns who set professional development goals with the educational supervisors at the start of PGY1.

Interns who set their professional development goals at the start of the year were more likely to review them regularly. Nearly two-thirds of PGY1 (59%) and PGY2 (63%) interns who set their goals at the start of the year met with the educational supervisor to review them regularly, compared to 19% of PGY1 and 29% PGY2 interns who had not set goals at the start of the year.

10.5.2. Feedback and development

Most interns in both PGY1 and PGY2 reported they mostly or completely understand the areas of their clinical practice that are their strengths and those where they need further training (Figure 10-8). PGY2 interns were slightly more confident in understanding their strengths and development needs than PGY1 interns.

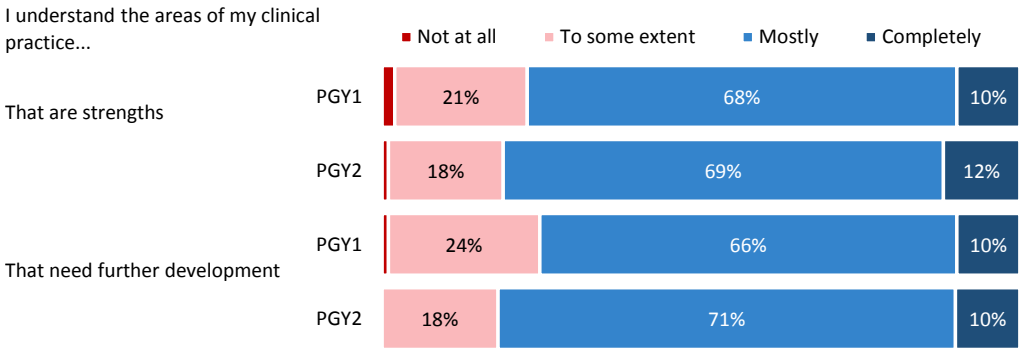

Figure 10-8. PGY1 (n = 188) and PGY2 (n = 119) interns' understanding of the areas of their clinical practice that were strengths and that needed further development.

Almost all PGY1 (88%) interns agreed or strongly agreed that they were able to ask for help from their educational supervisor if they needed to. The proportion was lower for PGY2 (64%). Almost all interns in both years reported they could ask their clinical supervisors for help if they needed to (83% for PGY1 and 81% for PGY2).

> *[The best aspect of the training was] Being given responsibility to make clinical decisions but having the reassurance that I could ask for help if needed. (PGY1)*

10.6 Assessment

Almost all educational supervisors felt that assessment of interns mostly (60%) or to some extent (36%) accurately reflected their practice. None felt that assessment completely accurately reflected interns' skills.

RMO unit managers had mixed views on the current assessment process. Most (seven of eight) RMO unit managers reported that their supervisors frequently completed assessments and reports at the end of clinical attachments, while one said they were only done occasionally. Half of the RMO unit managers were confident that the current assessment process identifies all or most of the interns having difficulty, but three reported that it only identifies a few and one did not know. Fewer (three) considered that the current assessment process identified all or most of the interns who should not progress, while one said it did not identify any and three said it only identified a few.

11. Interns' experiences of their last clinical attachment

A clinical attachment is a MCNZ accredited 13 week rotation worked by an intern. The baseline survey explored interns' experiences on their last clinical attachment.

11.1 Type of attachment

PGY1 interns' last attachments were most commonly on general medicine (34%), surgery (28%), orthopaedics (13%), psychiatry (9%) or geriatrics (5%) attachments. PGY2 interns last attachments were also commonly on general medicine (19%) and surgery attachments (9%), but were also on obstetrics and gynaecology (14%), emergency (14%), paediatrics (11%), psychiatry (4%) and specialist medicine (4%) attachments.

11.2 Variation between attachments

For nearly half of the PGY1 and PGY2 interns, the learning experience of their most recent attachment was about the same as that of their previous attachment. Interns in both years were more likely to report that their most recent attachment was better than to think it was worse (Figure 11-1).

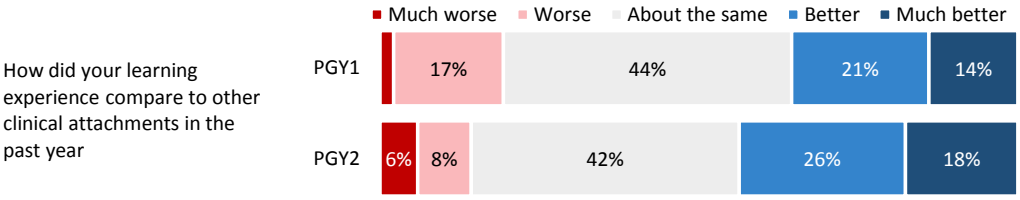

Figure 11-1. PGY1 (n = 186) and PGY2 (n = 119) interns' views on how the learning experience on their last attachment compared to that of other attachments in the last year.

11.3 Learning environment

Most interns were positive about the hospital environment in their last attachment and reported that their supervisors were interested in making them better doctors, that they were treated with respect and that they were valued as members of a multi-disciplinary team (Figure 11-2).

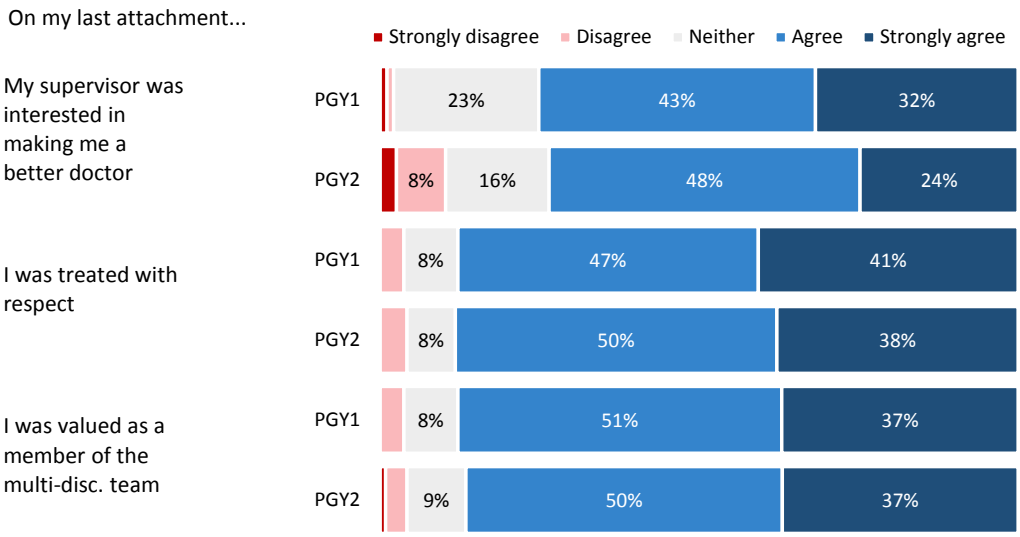

Figure 11-2. PGY1 (n = 188) and PGY2 (n = 117) interns' views on the hospital environment on their last attachment.

Work atmosphere and a supportive learning environment were two of the most common reasons interns found their last attachment better or worse. Other reasons varied slightly between PGY1 and PGY2.

Table 11-1. Themes in intern comments on factors that made clinical attachments better.

PGY1	How often:	PGY2
Work atmosphere: *[Better because] There was a close knit team, very approachable. There was slower ward rounds and a holistic approach.*	**Most**	**Amount of teaching time:** *[Better because] More time allocated to teaching. Teaching prioritised.*
Teaching quality: *[Better because] Supervisor that was more willing to teach and was very good at teaching, friendly registrar that was able to provide guidance.*		**Work atmosphere:** *[Better because] Very busy run but extremely well supported by the other Medical Registrars and Consultants - always someone to ask questions and improve your knowledge and skills.*
Amount of teaching time: *[Better because] Regular 1:1 teaching with the Consultant.*		**Clinical contact time:** *[Better because] Lots of direct patient contact, lots of experience dealing with undifferentiated patient. Each patient seen was an opportunity for teaching from consultant.*
Workload: *[Better because] A busy attachment which made leaving for formal teaching sessions difficult.*		**Interest in medical area:** *[Better because] I am going into a career in O&G so I was able to "step up" and take on more responsibility and therefore, learn faster.*
Autonomy: *[Better because] Forced to make more clinical decisions by yourself and do the acute management before calling consultants for advice or support.*		**Autonomy:** *[Better because] Seeing undifferentiated patients. More autonomy with diagnosis and management plans. Excellent nursing staff. Able to perform procedures e.g., cardioversions, chest drains, lumbar punctures.*
Confidence: *[Better because] I was more relaxed and confident in fourth quarter.*	**Least**	

Interns reported that a supportive learning environment improved the effectiveness of their training and helped them develop.

> *[My last attachment was better because the] team support especially from registrars is very important as they are closer to my level of training hence can understand my knowledge gaps better, and can often teach with more detail. (PGY2)*

> *[My last attachment was worse because there was] little team support with medical issues, team bullying and bullying from nursing staff. (PGY1)*

11.4 Professional development goals for clinical attachments

Half of PGY1 (50%) and PGY2 (55%) interns reported that they had set professional development goals for their last attachment. Most interns who had set professional development goals had met with their supervisors to discuss their goals at some point in the attachment (Figure 11-3).

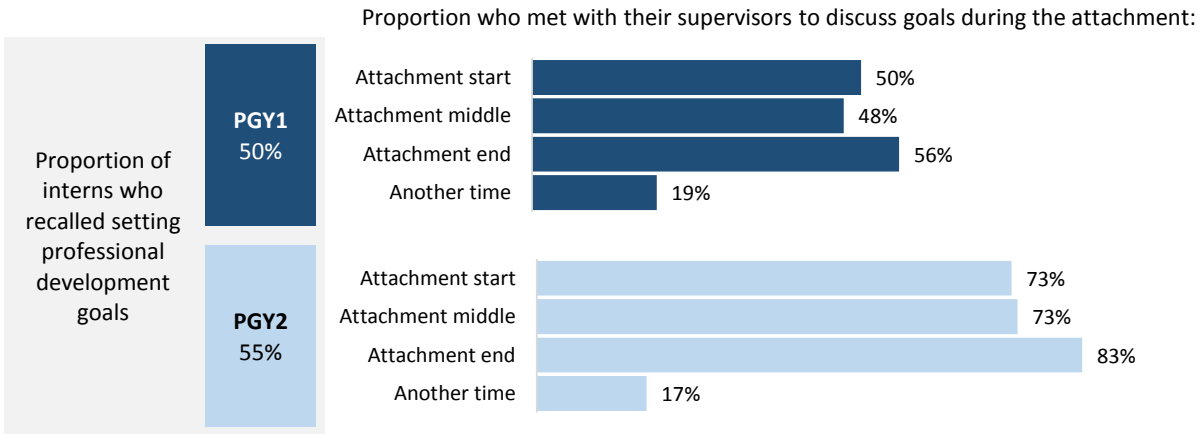

Figure 11-3. Proportion of PGY1 (n = 189) and PGY2 (n = 119) interns who set professional development goals at the start of their attachment and proportion who met a supervisor to discuss their goals at different points during the attachment. Note: Interns could select more than one point in time.

11.5 Learning objectives and outcomes

Most (74%) PGY1 interns agreed that the learning outcomes for their last clinical attachment were clearly defined (Figure 11-4). PGY2 interns were less likely to agree the learning outcomes were clear. Less than half (46%) agreed, while 36% disagreed that they were clear were clear.

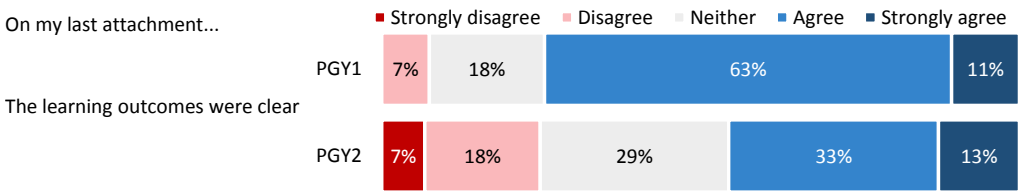

Figure 11-4. PGY1 (n = 188) and PGY2 (n = 119) interns' agreement that the learning outcomes for their most recent attachments were clear.

11.6 Meetings with clinical supervisors

Most PGY1 interns said they had met with their clinical supervisors on their last attachment to discuss their learning objectives, fewer PGY2 interns said they had had meetings (Figure 11-5). Meetings at the end of the attachment were more common than at other times.

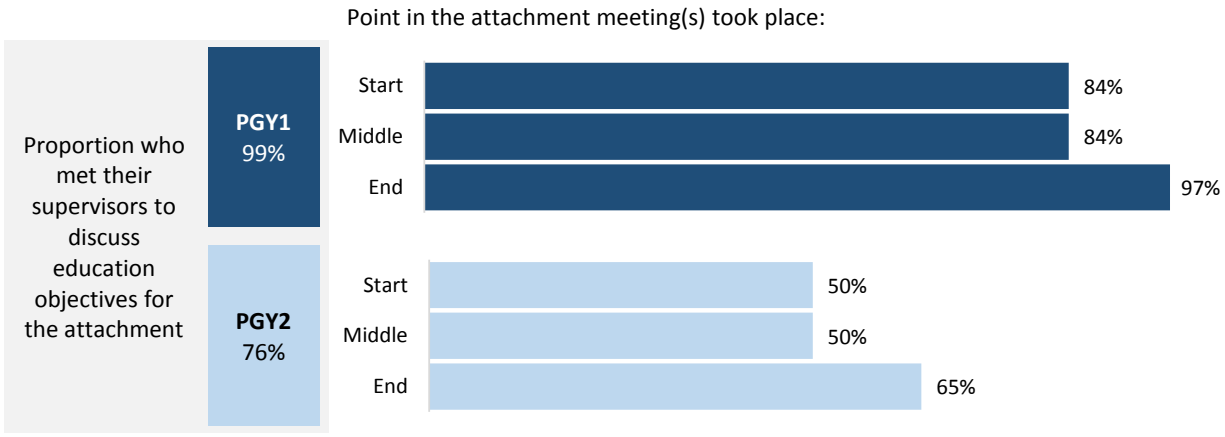

Figure 11-5. PGY1 and PGY2 interns who met with their supervisors at some point in their attachments to discuss their learning objectives.

11.7 Quality of teaching

Interns were generally positive about the quality of teaching on their last attachment. More than half of the interns from both PGY1 and PGY2 felt it was good or very good (Figure 11-6).

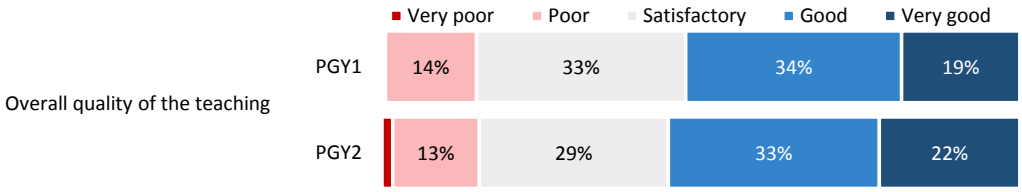

Figure 11-6. PGY1 (n = 188) and PGY2 (n = 117) interns' views on the overall quality of the teaching on their last attachment.

PGY1 interns often identified teaching quality as a factor determining the overall quality of the attachment. Interns often identified the contribution of their supervisors or individual doctors.

> *Supervisor that was more willing to teach and was very good at teaching, friendly registrar that was able to provide guidance. (PGY1)*
>
> *Dr's [X] and [Y] were exceptionally good. Great teaching, encouragement and supervision. They were contactable and approachable. (PGY1)*

While more than half of both the PGY1 and PGY2 interns agreed that there was regular, informal day to day teaching and that their supervisors were adequately involved, a substantial proportion disagreed (Figure 11-7). For example, one intern commented that their supervisor had not made himself available.

> *My supervisor was consistently late for the ward rounds and subsequently often in a hurry to go to theatre. We had minimal amount of time to discuss patients. (PGY1)*

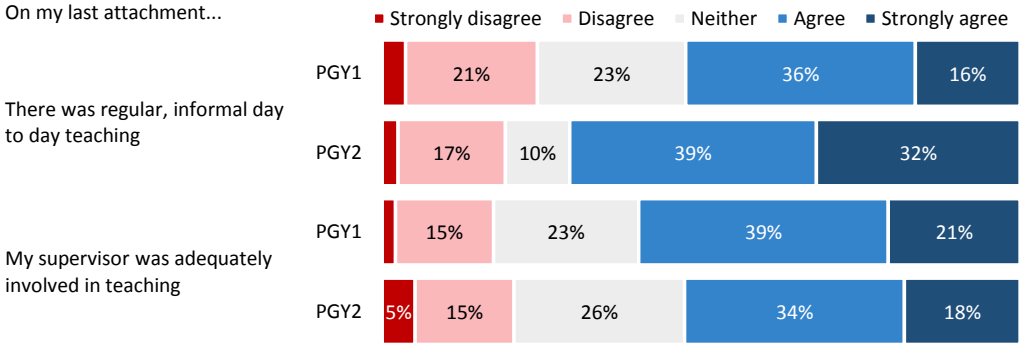

Figure 11-7. PGY1 (n = 188) and PGY2 (n = 119) interns' views on the amount of informal day to day teaching and their supervisors' involvement.

PGY1 and PGY2 interns reported that consultants and registrars were the professional group that had made the most effective contributions to them achieving their learning objectives in their last attachment (Table 11-2). Interns' peers were less effective in PGY2 than they were in PGY1. Of note is the contribution that nursing staff make to interns achieving their learning objectives. A small number of interns also reported that allied health professionals (social workers, pharmacists and optometrists) had made effective contributions in helping the interns achieve their learning outcomes.

Table 11-2. Proportion of PGY1 (n = 188) and PGY2 (n = 119) interns who reported that each professional group was effective or very effective in their contribution to the interns achieving their learning objectives in their last attachment.

	PGY1	PGY2
Consultants	71%	73%
Registrars	70%	71%
PGY1/PGY2 peers	70%	55%
Nursing teams	46%	49%

While the majority of interns agreed or strongly agreed that they were given regular, informal day to day teaching (Figure 11-8), just one-fifth (19%) of PGY1 interns and one-quarter (25%) of PGY2 interns reported that they had regular informal feedback.

Most often they had informal feedback occasionally, though some said they never had informal feedback.

More than half of the PGY1 and PGY2 interns reported that their supervisors provided feedback that helped identify their strengths and weaknesses (Figure 11-8).

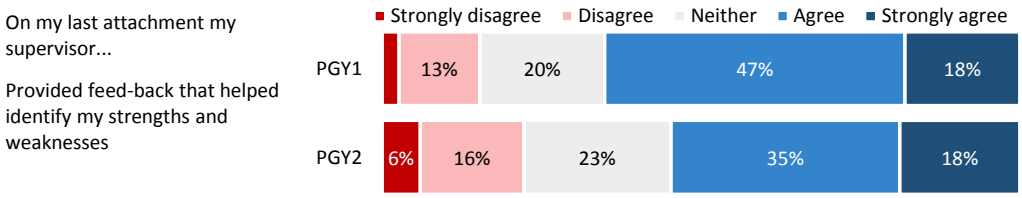

Figure 11-8. PGY1 (n = 188) and PGY2 (n = 117) interns' views on feedback from their supervisors.

11.8 Balancing demands on clinical attachments

Almost all PGY1 and PGY2 interns agreed that there was enough time for direct clinical contact (Figure 11-9). However, substantial proportions of the interns from both PGY1 and PGY2 years were concerned that there was not an adequate balance between service obligations and education, and that there was not adequate protected time for education.

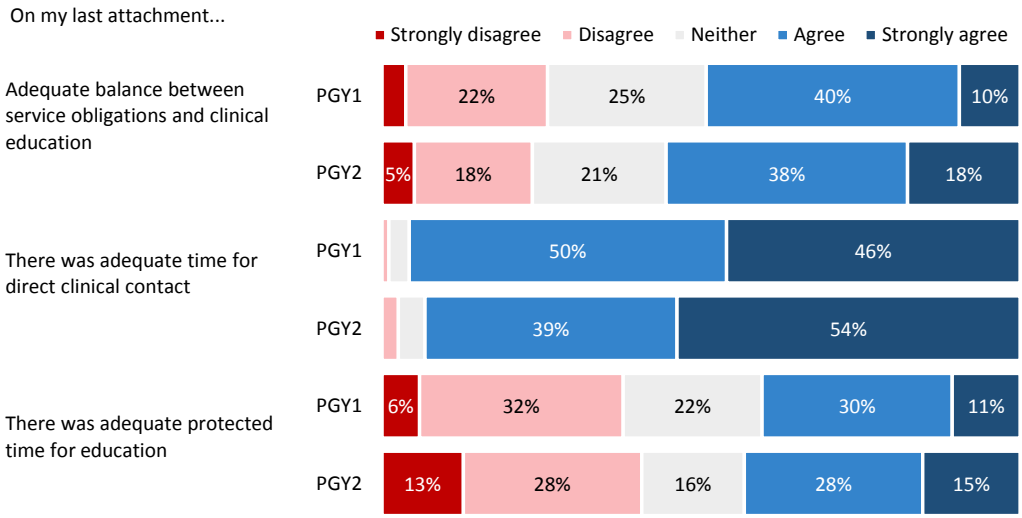

Figure 11-9. PGY1 (n = 188) and PGY2 (n = 119) interns' views on the balance of time use in their last attachment.

Some interns commented on the lack of teaching time.

> *There was a complete lack of any structured, formal teaching sessions. Teaching was in a form of sporadic and short-lasting conversations during the morning ward round. (PGY1)*

Nearly half of PGY1 and PGY2 interns reported that they had to occasionally cope with problems beyond their competence and experience (44% and 45% respectively). Only small proportions of PGY1 and PGY2 interns reported that they had to do so regularly (7% and 6% respectively). One suggested:

> *1. Ensure there is adequate cover for on-call shifts, especially night shifts. These are the times I felt least supported and most unsafe. 2. Split runs of night shifts so we don't do seven nights in a row. I feel this is unsafe for patients. (PGY2)*

> *No one even showed us how to use a slit lamp and yet expected us to run the acute clinics unsupervised from week 1. Could not be more unsafe, more stressful. (PGY2)*

Supervisors too recognised the difficulty balancing service obligations and clinical education for interns (Figure 11-10).

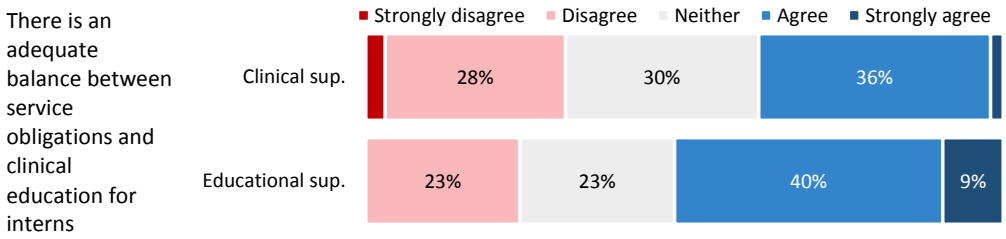

Figure 11-10. Clinical (n = 237) and educational (n = 40) supervisors' views on whether there is an adequate balance between service obligations and clinical education for interns.

Some clinical supervisors commented that interns need more time away from service provision or to have fewer patients to allow for more time to spend on education. One suggestion to help this was the addition of nurse practitioners.

> *Introduce more CTC (clinical team coordinator) who are like advanced nurse practitioners and only offer out of hours help with practical things like phlebotomy and catheterisation services etc. And have them function during the day to reduce some of the work load for PGY1&2 in surgery. All PGY1&2 consistently find the surgical run exceptionally busy - this is not conducive to learning. (Clinical supervisor)*

> *Decrease service commitments for both of us to allow more educational interaction. (Clinical supervisor)*

Educational supervisors held similar views with half (50%) agreeing there was balance and one-quarter (23%) disagreeing.

> *Ameliorate excessive working load at night and in surgical services. (Educational supervisor)*

11.9 Assessment

Many of the interns in both PGY1 and PGY2 felt that the way they were assessed on their last clinical attachment was an accurate reflection of their skills and that the assessment process was worthwhile (Figure 11-11).

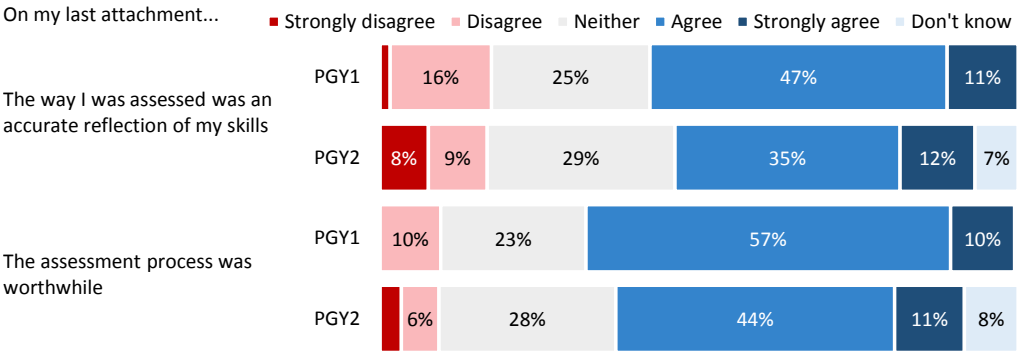

Figure 11-11. PGY1 (n = 188) and PGY2 (n = 118) interns' agreement with statements about their assessment on their last attachment.

12. Quality of prevocational training

12.1 Quality of training in PGY1 and PGY2

Overall, the majority of PGY1 and PGY2 interns were satisfied with the quality of their prevocational training (Figure 12-1).

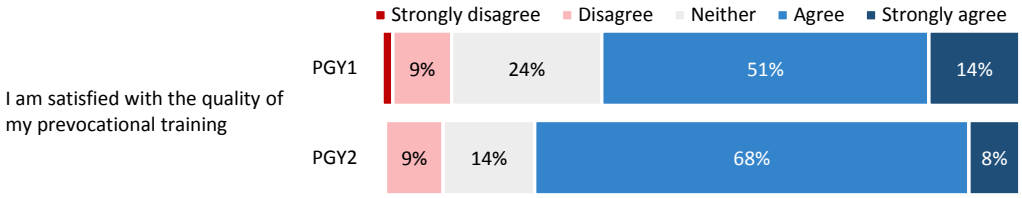

Figure 12-1. PGY1 (n = 188) and PGY2 (n = 119) interns' agreement that overall they were satisfied with their prevocational training.

12.2 Support through PGY1 and PGY2

Interns in both years had mixed views on whether the DHB demonstrated that they valued their education role. PGY2 interns were less likely to agree that the DHB had done so (Figure 12-2).

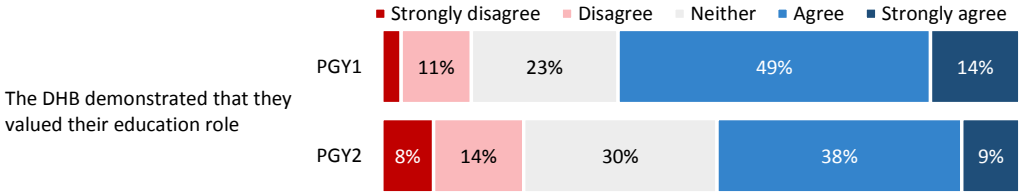

Figure 12-2. PGY1 (n = 188) and PGY2 (n = 119) interns' agreement that the DHB had demonstrated that it valued its education role.

PGY1 interns were more likely than PGY2 interns to agree that their educational needs were supported by the RMO unit and their educational supervisors (Figure 12-3).

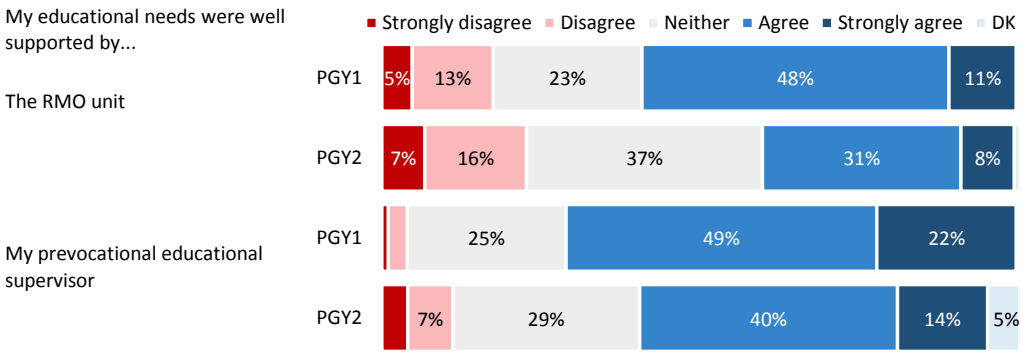

Figure 12-3. PGY1 (n = 189) and PGY2 (n = 119) interns' agreement that the RMO unit and the educational supervisors supported their educational needs.

12.3 Obtaining broad-based competencies

Most interns in both PGY1 and PGY2 were confident that they had gained enough experience for the stage they were at in their training, through the proportion decreased for PGY2 (Figure 12-4).

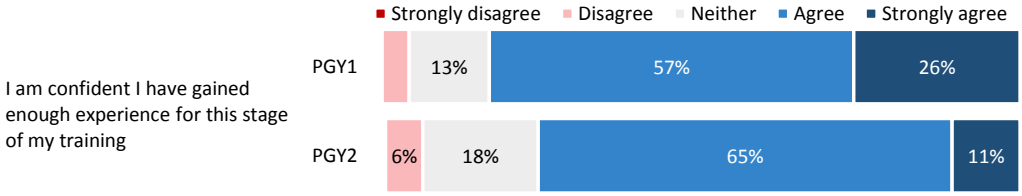

Figure 12-4. PGY1 (n = 119) and PGY2 (n = 188) interns' agreement that they are confident they have gained enough experience for this stage in their training.

Interns were confident that they had sufficient teaching, learning and experience in communication and professionalism, though PGY1 interns agreed more strongly than those in than PGY2. Most interns in both years also agreed that they had sufficient teaching, learning and experience in clinical problems and conditions and procedures and interventions. They were less likely to agree that they had received sufficient teaching, learning and experience in clinical management (Table 12-1).

Both educational supervisors and RMO unit managers were less confident that prevocational training would mostly or completely develop interns' skills in those practice areas.

Table 12-1. PGY1 (n = 188) and PGY2 (n = 119) views of the respondent groups about the amount and effectiveness of teaching, learning and experience in different aspects of their practice (DK is don't know).

	Interns' who agree they have sufficient learning and experience in…		Stakeholder views that prevocational training is mostly/completely effective in developing skills in each area:		
Learning area	PGY1 interns n = 189	PGY2 interns n = 119	Educational supervisors n = 50	RMO managers about PGY1 n = 8	RMO managers about PGY2 n = 8
Professionalism	84%	73%	73%	5 of 8 (1 DK)	3 of 8 (1 DK)
Communication	88%	72%	67%	4 of 8 (1 DK)	3 of 8 (1 DK)
Clinical management	49%	59%	78%	5 of 8 (3 DK)	4 of 8 (3 DK)
Clinical problems and conditions	84%	85%	80%	3 of 8 (5 DK)	3 of 8 (5 DK)
Procedures and interventions	81%	84%	71%	3 of 8 (5 DK)	3 of 8 (5 DK)

12.4 Preparation to work in a community setting

As expected only a small proportion of interns reported that they had had the opportunity in the past year to work in clinical attachments in community based settings: 4% of those in PGY1 and 11% of those in PGY2. An increased focus on community placements is one of the planned changes to prevocational training.

Most PGY1 interns who had the opportunity to learn in a community setting thought their experiences had been good or very good. The proportion was lower for PGY2 interns (Figure 12-5). It should be noted that these figures are based on small numbers and so should be interpreted with caution.

Offer plenty of ED and GP rotations to encourage generalist and community based practice. (PGY2)

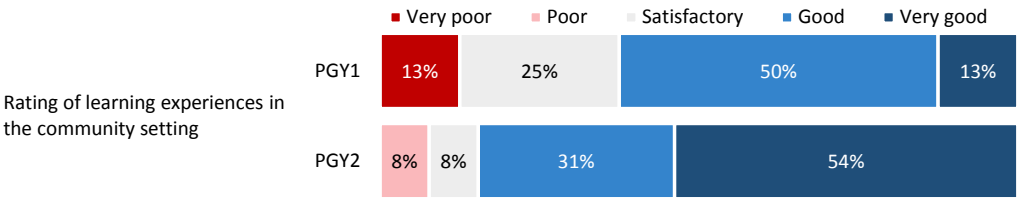

Figure 12-5. PGY1 (n = 8) and PGY2 (n = 12) interns' ratings of learning experiences in a community setting in the last year.

Small proportions felt that their clinical training had mostly or completely prepared them to provide healthcare in a community setting and that they had an understanding of community based specialties (Figure 12-6).

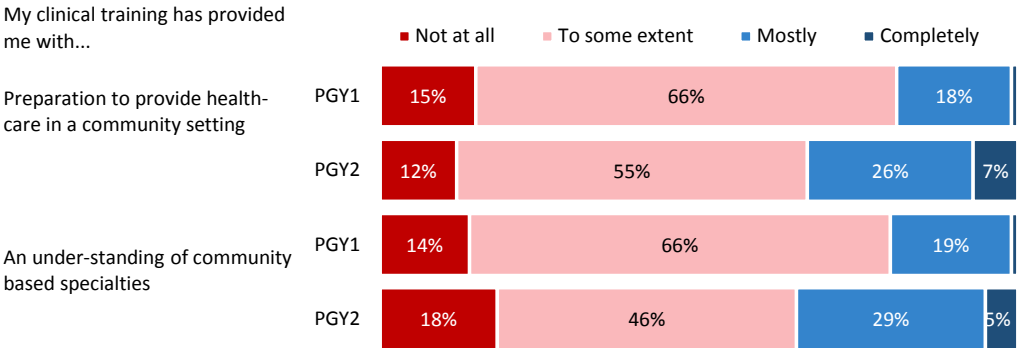

Figure 12-6. PGY1 (n = 188) and PGY2 (n = 119) interns' ratings of their preparation to work in the community setting.

12.5 Preparation to work in a clinical setting

Interns felt more prepared to work in hospital based clinical settings. Almost all felt that their training had prepared them to work in a hospital setting and provided them with an understanding of hospital specialties (Figure 12-7). However, understanding of the primary/secondary care interface was lower.

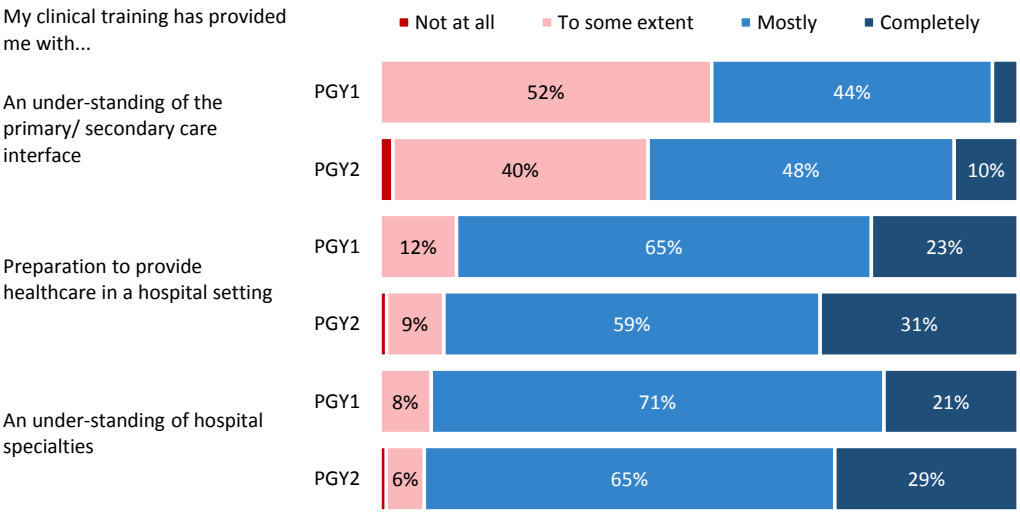

Figure 12-7. PGY1 (n = 188) and PGY2 (n = 119) interns' ratings of their preparation to work in the hospital setting and their understanding of the primary/secondary care interface.