A day in the life of a doctor-in-training

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Training in a variety of skills while caring for patients, without the burden of unnecessary tasks, and with meaningful feedback and supervision and time for reflection and self-care — too much to ask?

In this issue of the Journal, Westbrook and colleagues studied the work of interns, residents and registrars across four wards in a Sydney teaching hospital (*page 506*).[1] Their findings are limited by the study's small sample size, and the fact that each participant was observed, on average, for just under 8 hours, and not during evening or night shifts. Nevertheless, their key findings are pertinent to understanding a day in the life of a doctor-in-training.

As a group, interns, residents and registrars spent about a third of their time in "professional communication", including meetings, requests for consultations and planning care, about another third on direct or indirect (predominantly reviewing results and planning care) patient care, and a surprising 17% of time on "social" activities (defined as all non-work activity or communication, including meal breaks); 7% of time was viewed as being related to education, the same amount as that devoted to medication tasks, including searching for charts. Finally, about 2% of tasks related to administrative activities that were not a part of patient care, and about another 2% of tasks were carried out while not officially on duty.[1] The findings are different from those of an unpublished survey in an Auckland hospital, which found that only 15% of employed time was spent doing things for which a medical education was necessary.[2]

So what should a day in the life of a doctor-in-training look like? The ideal day should be one that consists of training in a mixture of skills while caring for patients, without the burden of unnecessary tasks,[3] and with time for reflective education and self-care. Is this ideal "warm and fuzzy" and totally impractical, or is it a realistic goal? Let's begin by doing away with the conflicting notions that one is *either* learning or is involved in direct patient care (ie, "service"). The two are not mutually exclusive, provided appropriate supervision and feedback is given by more senior doctors in the medical team; this is the key to integrating clinical service provision by interns, residents and registrars with their "on the job" training.

Does this time-honoured "apprenticeship" model still work now that the medical team encompasses as a minimum, not only doctors, but also nurses, and allied health and clerical staff? There is a push for doctors-in-training to be allocated to a ward rather than to a traditional medical team, but the risk in this is that many doctors-in-training may lose the supervision they require. On the other hand, it is clear that supervision and feedback is not always given in the present system.

The solution is simple: if consultants want the privilege of doctors-in-training on the team, then they need to support them and help structure their days towards learning. Meaningful performance agreements between consultants and their clinical or hospital managers could resolve this, but such agreements must reflect genuine support and appreciation from hospitals and universities for the consultants providing this supervision.[4,5] In this context, the Australian Curriculum Framework for Junior Doctors[6] serves as a useful document, not only to guide the learning experiences of doctors-in-training, but also to assess the ability of hospitals to provide adequate resources and support for such experiences.

What unnecessary tasks should be removed from the doctor-in-training's daily activities? Westbrook et al point out that sometimes things that seem most burdensome are those that are frustrating rather than those that take up much time.[1] For example, doctors had included writing discharge summaries among a small number of activities that consumed "all our time", but Westbrook and colleagues found that only about 5% of time was spent on this activity.[1] With appropriate feedback, writing discharge summaries can be a valuable learning experience, as doctors must be able to liaise professionally with colleagues throughout their careers. This emphasises the need for meaningful day-to-day feedback about the role and value of individual tasks.

We should also acknowledge that the in-hospital consultation process has become unwieldy; it probably occupied a large proportion of the 33% of time spent on "professional communication" reported in Westbrook and colleagues' study.[1] This could be reformed relatively easily by ensuring that all consultations were approved first by the clinician in charge, and by specialist medical teams continuing to practise general medicine for their patients, thereby reducing the number of consultations required. This would do away with reams of paperwork and duplication of tests. A further "clerical" issue that needs to be addressed is the time-honoured process of charting admissions. It is not unusual for interns and residents in emergency departments, and then emergency or specialty registrars and ward interns to write (similar) admission notes, with no added benefit to the patient or doctor.

Finally, given the stress of the job of a doctor-in-training and the high rate of psychological and psychiatric morbidity among our junior medical staff,[7] it would be a good thing if some time each day were truly spent on activities such as speaking with their own friends and family, which might allow them to debrief and reflect on the stresses that confront them.

The early training years should be an exciting time; learning is rapid, and patients actually benefit from what the doctor-in-training does. We need to promote a strong work ethic whereby our patients come first and we work in support of, and are supported by, our colleagues; this will, by necessity, mean work after-hours, but we still need to move away from the view that "the harder I work, the better a doctor I am".[8]

The New South Wales Institute of Medical Education and Training believes true progress can be made in improving the quality and value of a doctor-in-training's day through the establishment of a training and education agreement between the doctor and the hospital. This has already been introduced in some specialty training areas, but needs to be applied very quickly to the junior medical officer workforce so that doctors-in-training can know what daily education and supervision they should expect, and the hospital knows that these doctors agree to participate actively in their learning opportunities and their service provision to patients and their colleagues.

Importantly, we need to begin training in more meaningful places, such as the private sector, general practices, and other

community settings, to define appropriate educational goals (which can now be guided by the Australian Curriculum Framework for Junior Doctors)[6] and provide proper feedback, supervision and caring for our next generation of doctors. There has been progress, but we can do better.

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