

Improved assessment needed for young doctors



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Young doctors, being both employees and trainees, serve two masters, and two articles in this issue of the Journal suggest that the tools and processes we have to monitor their performance and help them develop in these roles could be better.

Bingham and Crampton present an important review of 3390 New South Wales prevocational progress assessment forms (*page 410*). These were introduced in 2009, and their elements were derived from the Australian Curriculum Framework for Junior Doctors. Many items in this Framework are aspirational, and being assessed on performance items such as “demonstrates professional responsibility” would be challenging for most. Completing these forms represents a substantial workplace activity. Bingham and Crampton’s analysis suggests it is also pointless — trainees assess themselves as performing at the expected level while supervisors assess trainees as performing at or above the expected level on all assessment items, and written comment from supervisors lacks specificity. The tool appears unable to detect underperforming doctors, and may not aid their professional development. It will now be hard to justify its use.

The perspective by Mitchell and colleagues (*page 382*) highlights aspects of the Australian Medical Association’s (AMA’s) 2010 Specialist Trainees Survey. Although there were sampling issues, those who did respond reported general satisfaction with training but were negative about college processes in relation to appeals, capacity to raise concerns without fear of reprimand, recognition of prior learning, provision of remediation, responsiveness to cases of bullying and harassment, and cost.

The dual roles of vocational trainees as employees of a health department or a private hospital and trainees of a

college may create problems. Exactly whose responsibility is management of bullying? Who is responsible for, and will fund, remediation? This is a difficult issue, because the college may require extra supervision that needs to be funded by the employer. Also, unlike in, say, law firms where junior lawyers may progress to become partners, clinical supervisors and area health services may have no long-term investment in their trainees.

United States educationalists have recently questioned the system of rapid rotation through training posts (*Med Educ 2011; 45: 69-80*). Certainly, the AMA survey found that many specialist trainees find mandatory rotations inflexible and difficult to reconcile with their personal circumstances. Given that graduates are now older, it is likely that this may be more of a problem than in the past. Regular upheaval makes it difficult for doctors to gain competence in teamwork and to develop meaningful relationships with their supervisors, who are usually present for only part of each week. This may help to explain superficial assessment and feedback, and the failure to identify and remediate serious deficiencies in trainees.

It seems that more than the poor assessment process requires attention. We need to revisit the employee/trainee issue, especially if more training is to be done in a private setting where clinical efficiencies will be particularly valued. We need to reconsider the effectiveness of rapid rotation. We need to graduate competent doctors who feel that they have been well treated by the system so that good patient care is delivered and so that we have a supply of engaged supervisors for future trainees.