Transition from TI to House Officer: Room to Improve.

Discussion Document

July 2017

NZRDA has become increasingly concerned at the impact transition from TI to House Officer is having on some members. At one end of the spectrum, individuals find the transition so difficult they have to be withdrawn from work for a period and reintroduced in a more supportive and planned manner. Members have also expressed concern that they "hung on in there" but that the experience was incredibly stressful and detrimental to both their own wellbeing and potentially that of their patients.

Members of NZRDA have raised the following concerns about the TI situation:

1. Preparation as a TI to become a House Officer. Where the numbers of students are high, often where 4th, 5th and 6th years are present together in the same clinical environment, access to procedural skills and the ability to increasingly take responsibility under the supervision of the house officer or registrar is very limited. This is exacerbated by the view that a 6th year "should" already have had such experiences, especially in the skills acquisition area, and so should "step back" and let 4th or 5th years have a go can result in TIs becoming deskilled, due to failure to be able to practice and repeat procedures they need to be proficient at as a house officer. The business of the RMOs and the lack of team inclusion of the TIs also appear to be a contributing factor.
2. A definitive lack of procedures being undertaken. HOs have reported graduating without performing IV line insertion or catheterisation (let alone a lumbar puncture) yet are expected to be proficient at such from day one as a house officer.
3. A lack of practical knowledge of "how to" work as a house officer. Hospital systems, prioritisation and the need to achieve throughput (and not necessarily excellence <u>all</u> the time) challenge many.
4. A number of other comments lead us to look more closely at the balance between academic demand and practical experience in the TI year. Many commented that whilst their teams were more than happy and supportive of TI participation, the quantity of academic work including assessments, assignments and presentations was prohibitive. Some also commented that 4 week attachments were too short and that academic pressure was detriment to hands on clinical experience that should be available to trainee interns. Medicine is a science and an art that must be practiced to achieve excellence. A number of house officers commented that after 5 years of academic focus, the TI year should allow a greater proportion of time to fulfil its name: specifically practical training to be an intern.

A survey of first year house officers earlier this year sought further advice on:

1. what they should have known as a TI before they started work, and
2. What as a new house officer would have been useful for them to know/have experience with?

We also asked what needs to be done to improve the transition both at a TI level and as a new first year. Key points from that survey are:

- Only 32% of the first year house officers felt well prepared in terms of **work readiness** and 18% felt they were not well prepared at all. NZRDA believes that (much) closer to 100% of TIs should be well prepared to start work as a House Officer: 32% is far too low for us to be comfortable or complacent.
- Only 29% of house officers found their **orientation** valuable; 53% partly valuable and 28% not valuable at all. Notably Counties Manukau followed by BOP DHB were two DHBs that bucked this trend and with 61% and 45% respectively of House Officers recording their orientation in these two DHBs as "Very Valuable". Southern and Whanganui DHBs brought up the bottom of the table. Clearly orientation is inconsistent across the country and most are failing to deliver what the House Officers believe is an essential component of their on-boarding. This represents both a wasted resource and a risk to the organisations, doctors and ultimately patients.
- In answer to "What could have been done whilst you were a TI to better prepare you" and "what things now as house officers you wished you had more experience of …" more **inclusion in the team** came out overwhelmingly on top. Comments included:
  - More team involvement/integration, more practical hands on experience with patients admitting and presenting, more 1:1 responsibility and decision making regarding patients, more time with the on duty HOs.
  - Managing ward calls, On Call and evenings/long day and sole decision making experience.
  - Drug doses, IV Line insertion, prescribing.
  - Time management and prioritisation/triaging of jobs, escalation (when and who to escalate to), handover and management of paperwork.
  - Logistics of administration, hospital systems and layout.
- In response to "What could have been done in the first few months as a house officer" to help the overwhelming response was "have a **buddy**" followed by deliberate reduced workload and better orientation (see above).
- "What did the House Officers find particularly helpful with the transition?" mirrored that already stated as:
  - Supportive registrar and friendly second year HOs.
  - Buddy system (especially outside ordinary hours).
  - Practice at IV lines, catheters, blood taking.
  - Experience with working within the team.
  - Targeted teaching e.g. resus and alert courses during orientation.

There are a number of areas we believe should be explored:

1. Orientation must be improved and focus on practical knowledge doctors need. NZRDA believes a core nationally consistent clinical orientation is required to cover the essentials a new doctor needs to know, (acknowledging the local information and HR requirements of orientation also).
2. The buddying system should be provided universally to all new House Officers.
3. That as part of orientation, all DHBs should include the provision of a HOTTI (House Officer Teaching Trainee Intern) peer to peer course run by house officers for all TIs. A course outline has already been developed focusing on what a new House Officer needs to know including handover, prescribing, communication, simulation (e.g. the drowsy patient, SOB, chest pain etc.) and prioritisation.
4. That the TI year be acknowledged as a "training to be an intern" year as the priority.
    a. That we work with the universities to reduce the academic component of the TI year (push back into the first 5 years) to ensure TIs are free to attend with their teams especially when on medical or surgical runs.
    b. Where 4th and 5th year students are also present on wards, the distinctly different role of the TI should be made clear and actively delivered upon. This includes alignment of TIs within the House Officer/Registrar team.
    c. That limited registration is considered to enable TIs to undertake a higher degree of (appropriate) responsibilities.
5. That house officers and registrars have available to them "teach the TI" courses. Not only would this help with TI learning but all levels of ongoing learning throughout the doctors working (and teaching) lives.
6. That specific "new doctor mentoring/supervision" be provided including psychological support during the first month as a minimum to ensure the wellbeing of our newest and therefore vulnerable colleagues.