Background: Even within the context of resident duty hour restrictions, fatigue management is a predominant discourse. In Canada, where resident duty hours are not nationally legislated, fatigue risk management strategies (FRMS) have been proposed as an alternative to reduced hours. Prior to implementing FRMS, we require a better understanding of how residents make sense of fatigue within their clinical training environment.

Summary of Work: Using constructivist grounded theory, we interviewed 21 residents from 7 surgical and non-surgical disciplines at one Canadian institution in 2014. Iterative data collection and analysis informed theoretical sampling to sufficiency.

Summary of Results: Residents described shared understandings about the nature, meaning and implications of fatigue in their clinical training environments. Five fatigue narratives were identified: fatigue is (1) inescapable and therefore acceptable; (2) surmountable when required; (3) manageable through experience; (4) a temporary training phenomenon; and (5) necessary for competence.

Discussion and Conclusions: These five narratives highlight fatigue as a socially constructed phenomenon. Residents' social constructions are in tension with existing physiological and cognitive discourses that inform fatigue management discussions. Discussions about duty hours and fatigue need to attend to its social aspects, not only to individual decision-making.

Take-home messages: Fatigue is not only a physiological and cognitive construct, but also a social construct. Attention to the social aspects of fatigue is necessary, particularly as they may be in tension with assumptions based on physiological and cognitive premises.
Feedback in Medical Education - Assessment of graduate performance

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Background: Research has been published on methods of assessment in postgraduate medical education in many disciplines. Few have however actually incorporated subjective and objective feedback of performance of graduates of various programmes in the same clinical environment.

Summary of Work: For the past 26 years, graduates of all established and new medical programmes in Australia and New Zealand were assessed in the clinical environment based on 4 major criteria - Ability, Professionalism, Reliability and Affability.

Summary of Results: A pilot study was conducted when graduates of 13 established medical schools were appointed at the same institution. Formal assessment of applied knowledge was conducted at the start of the intern year followed by feedback of performance during the year based on the 4 criteria above.

Discussion and Conclusions: There were clear differences among the graduates at the start of the year which narrowed as the year progressed. Focus groups of all the interns helped to identify themes as to why the readiness for practice were different among the graduates of different schools.

Take-home messages: Assessment of differences in graduates of medical schools could help provide useful feedback that can enhance strengths and reduce deficiencies in training programmes.

“I felt apprehensive, I felt a bit anxious”. How do junior doctors regulate their emotions?

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Background: In medical practice, unregulated emotions impact on doctor and patient well-being. The first two years of medical practice are emotionally demanding for trainees, with little known about how they manage their emotions. A recent study into UK graduates’ preparedness for practice highlighted considerable emotional talk in their narratives. We report our in-depth follow-on study with these 26 participants (now in their second year of practice) looking explicitly at the emotion regulation strategies they employ.

Summary of Work: Sixteen Year-2 trainee doctors (F2s) from the original study agreed to participate. Our qualitative study used narrative interviewing (one-to-one and groups) and a solicited longitudinal audio-diary method to explore their emotion regulation strategies over 4-months of practice. Data are being coded deductively (using Gross’ (2005) emotion regulation theory) and inductively to develop this theoretical model.

Summary of Results: Data collection is on-going. We have conducted 10 interviews and received 70 audio-diaries from 16 doctors, totalling over 8 hours of data to date. We will report emotion regulation strategies and highlight those most commonly used by the F2 doctors in our study to regulate their emotions.

Discussion and Conclusions: The emotion regulation strategies used have implications for doctors’ mental wellbeing and patient care. Implications for medical education will be discussed including the place of training in emotion regulation skills at medical school.

Take-home messages: With the significant implications of unregulated emotions on medical practice, it is important to prepare junior doctors emotionally for current and future practice.
Poor performance among trainees in a Dutch postgraduate GP training program; frequency, nature and risk factors

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Background: To explore the frequency of poor performance among Dutch postgraduate GP-trainees and to search for risk factors, as early identification could enhance remediation.

Summary of Work: All trainees who started the program between 2005 and 2007 were included. Associations between individual characteristics, early assessment scores, training process characteristics and the outcome poor performance were studied using multivariate logistic regression analysis.

Summary of Results: Forty-nine (23%) of the 215 trainees exhibited poor performance mostly during one year. Main problem areas included the roles of ‘medical expert’, ‘communicator’ and ‘professional’. Trainees with sufficient assessment scores in communication and knowledge were at lower risk of poor performance; OR 0.50 (CI 0.33–0.77) and OR 0.16 (0.07–0.40). Increasing age was a risk factor for poor performance; OR 1.16 (CI 1.06–1.27). Poor performance in the previous year was a risk factor for poor performance in the 2nd and 3rd years; OR 4.20 (CI 1.31–13.47) and OR 5.40 (CI 1.58–18.47).

Discussion and Conclusions: Poor performance is prevalent, primarily occurring within a single training year. This finding suggests that trainees are capable of solving trainee problems. Increasing age, insufficient assessment scores early in the training and poor performance in a previous year constitute risk factors for poor performance.

Take-home messages: Almost one fourth of GP-trainees exhibited poor performance during a three year training program, primarily in one year. Increasing age, insufficient scores in communication and knowledge and poor performance in the previous year were risk factors. Early identification of risk factors, and remediation, is important to prevent persistent poor performance.

Using observation to understand the prescribing practice of junior doctors

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Background: Rates of prescribing error among junior doctors are high, but analysis has shown that lack of knowledge is rarely the sole cause. Interest has grown in the role that non-technical skills (NTS), ‘the cognitive, social and personal resource skills that complement technical skills, and contribute to safe and efficient task performance’, may play in junior doctors’ prescribing. NTS include cognitive skills such as situational awareness and decision making, and social skills such as team working and leadership. The skill set required for a specific task needs to be described in detail before NTS can be taught. Direct observation will be used to overcome the challenge that many errors are unremarkable when they occur, for example writing on the wrong patient’s chart, making recollection difficult, particularly for junior doctors who write many prescriptions each day.

Summary of Work: Observation of FY1 doctors prescribing in a clinical setting will be undertaken to identify NTS used when prescribing safely. Observations will be clarified and contextualised with semi-structured interviews with the FY1 doctors. Interview transcripts, field notes and notes of informal discussions with FY1 doctors will be analysed by framework analysis. A reflexive log will be maintained.

Summary of Results: Early results from observation and interviews alongside the reflexive log will be discussed, with a particular focus on the challenges and advantages of the methodological approach.

Discussion and Conclusions: Observations and semi-structured interviews are powerful tools to obtain a rich understanding of the participants’ experience of prescribing for hospital inpatients.

Take-home messages: An understanding of the relevance of NTS to prescribing practice will be obtained.
Progressing into Practice: A study of Foundation Year 1 doctor narratives about their early experiences

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Background: Little is known about the experiences of medical graduates as they enter the workplace. This study aimed to gain an understanding of the individual, situated experiences of Foundation Year 1 (F1) doctors in their first placement.

Summary of Work: A random sample of 10 F1s who had completed an earlier questionnaire was invited to take part in the study. An initial narrative interview asked them to describe their first day and early placement experiences, while serial narratives (verbal or written) (n=28) were gathered throughout the first placement.

Summary of Results: Thematic analysis is ongoing. However, preliminary findings suggest some common experiences. Common challenges include pressure of workload, relationships with other professions, and physical stressors such as long hours and lack of sleep. Other significant events were those involving responsibility for decision making and patient care, which are integral to the role of a qualified doctor. There is variability in the affective consequences of early experiences. Some identify learning opportunities in these experiences, some feel ‘useless and incompetent’, and others identify a ‘battle’ or ‘rite of passage’. While shadowing was valuable in preparing F1s for the transition, interestingly, some participants did not ‘feel like a doctor’ until some time into their first job.

Discussion and Conclusions: Although the stressful experiences associated with becoming a doctor are shared, individuals vary in their emotional response to these events.

Take-home messages: Interventions to moderate the expectations of graduating doctors and actively incorporate use of coping strategies may ease their progression into practice.