How Do Clinical Competency Committees Make Decisions About Internal Medicine Residents’ Achievement of the Milestones? A pilot study using a grounded theory approach

Andem Ekpenyong*, Rush University Medical Center, Internal Medicine, Chicago, IL, USA

Background: Clinical competency committees (CCCs) are required to rate residents’ achievement of the milestones biannually. CCC faculty may not be well versed in compiling large amounts of assessment data (obtained over the course of various learning experiences and created by a variety of faculty and peer raters) in order to make determinations as to a given resident’s competence. How do these CCCs make decisions about residents’ achievement of the milestones?

Summary of Work: All 16 CCC members (except this author) were invited to participate in the study. Using Schon’s reflective practice as a conceptual framework, they completed a questionnaire about their experience providing milestones ratings during the first reporting period to the ACGME. Using constant comparative analysis, the data was coded to identify themes until thematic saturation was reached. An outside expert reviewed the coding procedure. Member checking was performed.

Summary of Results: 7 of the 16 invited CCC members chose to participate. 9 themes were identified resulting in the first draft of a conceptual framework in response to the study question. The ability to generate milestones ratings for residents involves the following factors: 1) faculty comments 2) knowledge of the milestones and assessment methods; 2) the “hidden curriculum” e.g. “hearsay” from other colleagues and 3) contextual influences e.g. ACGME expectations, workload etc.

Discussion and Conclusions: Our CCC unanimously agreed on the usefulness of comments provided by faculty on end-of-rotation assessments and the “hidden curriculum” as opposed to numerical ratings.

Take-home messages: This study underscores the importance of understanding the culture of CCC committees prior to engaging in faculty development.

Swedish internship ranking as a consistent indicator of quality

Maria Ehlin Kolk*, Swedish Junior Doctors Association, Stockholm, Sweden
Kajsa Holmberg, Swedish Junior Doctors Association, Stockholm, Sweden

Background: The Swedish junior doctors association (SYLF) performs an annual ranking of the Swedish hospitals providing internships. The ranking is widely used as an indicator of quality of internships. The ranking is based on the junior doctors own comprehensive grade of their internship. SYLF has performed an in depth analysis of the 2014 internship ranking to identify which factors effect the grade.

Summary of Work: The internship ranking is based on a web-based questionnaire sent to all un-licenced or recently licenced members of SYLF. 1717 junior doctors responded in 2014 giving a response rate of 71%. Using regression analysis the association between the comprehensive grade and other factors such as the grades of individual clinical placements was analysed.

Summary of Results: Our analysis shows that the grades of the individual clinical placements and grading of the ability to influence the work environment explain 75% of the comprehensive grade. When including introduction, education, supervision and collegial support 85% of the comprehensive grade is explained.

Discussion and Conclusions: This analysis shows that the comprehensive grade given by the junior doctors is based on factors that are relevant to the internship and can be improved by the hospital rather than factors outside of the reach of the hospital. The ability to affect the work environment is together with the quality of the individual clinical placements most important for the overall perceived quality of the internship and therefore most important to improve.

Take-home messages: Junior doctors are consistent when grading their internships and the ability to affect the work environment is crucial to the perceived quality.
Using reflective narrative as a strategy for curriculum reform and faculty development in emergency medicine training

Yu-Che Chang*, Chang Gung Memorial Hospital, Chang Gung University College of Medicine, Department of Emergency Medicine; Department of Medical Education, Taoyuan, Taiwan
Chung-Hsien Chaou, Chang Gung Memorial Hospital and Chang Gung University College of Medicine, Department of Emergency Medicine; Department of Medical Education, Taoyuan, Taiwan
Chih-Hsing Lee, Chang Gung Memorial Hospital, Chang Gung University College of Medicine, Department of Emergency Medicine, Taoyuan, Taiwan
Chien-Kuang Chen, Chang Gung Memorial Hospital and Chang Gung University College of Medicine, Department of Emergency Medicine, Taoyuan, Taiwan
Chip-Jin Ng, Chang Gung Memorial Hospital, Chang Gung University College of Medicine, Department of Emergency Medicine, Taoyuan, Taiwan
Jih-Chang Chen, Chang Gung Memorial Hospital, Chang Gung University College of Medicine, Department of Emergency Medicine, Taoyuan, Taiwan
Che Chang*, Chang Gung Memorial Hospital, Chang Gung University College of Medicine, Department of Emergency Medicine, Taoyuan, Taiwan
Chang Chen, Chang Gung Memorial Hospital, Chang Gung University College of Medicine, Department of Emergency Medicine, Taoyuan, Taiwan
Chang Kuo, Chang Gung Memorial Hospital, Chang Gung University College of Medicine, Department of Emergency Medicine, Taoyuan, Taiwan
Kuang Chen, Chang Gung Memorial Hospital and Chang Gung University College of Medicine, Department of Emergency Medicine, Taoyuan, Taiwan
Hsing Lee, Chang Gung Memorial Hospital, Chang Gung University College of Medicine, Department of Emergency Medicine, Taoyuan, Taiwan
Hsien Chaou, Chang Gung Memorial Hospital and Chang Gung University College of Medicine, Department of Emergency Medicine, Taoyuan, Taiwan

Background: Reflection is a cognitive process to help emergency medicine (EM) trainees identify what is meaningful in their learning process. We aim to analyse the reflective narrative of postgraduate year-one (PGY1) residents and undergraduates to explore and compare their learning gap.

Summary of Work: Reflective narratives for the EM curriculum are required at the end of trainees’ EM rotation. PGY1 residents and undergraduates are required to reflect the disparity between learning outcome and expectation. They must also record what they consider to be the essential content as well as which assessment tool is helpful for their EM training.

Summary of Results: For the expectation survey, 22.7% of the undergraduates and 9.7% of PGY1 residents did not achieve their learning goal. Undergraduates complained about performing too many basic procedural skills, inadequate approaches to treating new patients and inadequate provision of teaching time. PGY1 residents suggested that the program could be enhanced by introducing a better teaching model with improved content and offering students more opportunities to develop their advanced procedural skills. Trainees in both levels considered competence of emergency care, pattern recognition and clinical reasoning to be the essential core contents. Moreover, PGY1 addressed communication skill while undergraduates emphasized procedural skill practice in managing emergency patients. PGY1 preferred Mini-CEX while undergraduates preferred the e-portfolio as an assessment tool.

Discussion and Conclusions: Analysis of the reflective narratives of junior EM trainees in rotation is helpful for understanding their learning gap and can help facilitate strategy making for curriculum reform and faculty development.

Take-home messages: Reflection analysis could be considered an effective tool in EM education.

No expertise without experience; how many acute medical cases should a year one trainee doctor clerk?

Andrew Hastings*, Worthing Hospital, Department of Medicine, Worthing, UK
Roger Duckitt, Worthing Hospital, Department of Medicine, Worthing, UK
Debbie Jones, Worthing Hospital, Department of Medicine, Worthing, UK
Gordon Caldwell, Worthing Hospital, Department of Medicine, Worthing, UK

Background: Previous work suggests that UK Foundation trainee doctors cite lack of experience in acute admissions as a key concern in the structure of their training. There exists little quantitative data regarding this key area of inpatient medical training.

Summary of Work: We present a retrospective analysis of 4 years of data comprising every medical admission by Foundation Year One Doctors (FY1s) at one District General Hospital. Data was collated using the eWhiteboard electronic admissions system.

Summary of Results: 131 FY1s admitted 8373 patients, out of a department total of 45279, (18.9%). FY1s undertook either one or two four month medical placements, admitting an annual mean of 63.9 patients. The most prolific saw 150 and the least prolific 16. Thirty six trainees (27%) admitted fewer than 40 medical patients in a year.

Discussion and Conclusions: Our data suggest that experience of medical admissions is very variable, with the least experienced trainees completing few admissions. The Foundation Programme has no mandatory minimum number of admissions in medicine or other specialties, and there is no requirement for trainees to log their experience of acute admissions. Whilst working patterns differ across the country, our analysis, in many cases, bears out concerns that FY1 training in acute admissions is limited. We hope it will inform discussion and planning of future training structures.

Take-home messages: Acute admission numbers were highly variable between different FY1s in our hospital. One quarter of trainees completed fewer than 40 acute medical admissions in their first year of postgraduate training.
Old school vs new school: do graduate medical trainees really benefit from the change?

Raymond Fong, Changi General Hospital, Medicine, Singapore
Roy Debajyoti Malakar, Changi General Hospital, Medicine, Singapore
Teck Boon Low, Changi General Hospital, Medicine, Singapore
Vanessa Au*, Changi General Hospital, Endocrinology, Singapore
Shui Boon Soh*, Changi General Hospital, Endocrinology, Singapore
Andrew Kwek, Changi General Hospital, Gastroenterology, Singapore
Kiat Sern Goh, Changi General Hospital, Geriatric Medicine, Singapore
Siang Chew Chai, Changi General Hospital, Cardiology, Singapore

Background: A new ACGME-styled residency training system was introduced in 2011 to phase out the traditional medical specialist training modelled after the UK system to address the problems of poor training structure, insufficient trainee supervision and protected training time.

Summary of Work: A survey was conducted to compare the perception of the trainees of their respective systems in relation to their educational experience. A 6-part questionnaire (5-point Likert scale) on program experience, faculty quality, evaluation and feedback, training environment/resources, and personal well-being was sent to 20 Advanced Specialist Trainees (ASTs) under the traditional system and 20 Senior Residents (SRs) under the new system.

Summary of Results: More SRs (65% vs 44%) felt that they had a positive educational experience. The majority of SRs (90% vs 78%) also felt that that they received effective training and close supervision, in a conducive environment. Despite having more protected time, only 35% of SRs agreed that they had sufficient time for research (vs 15% ASTs). Only half of the ASTs (vs 88% SRs) were satisfied with the performance evaluation and feedback methods. Despite measures to enhance resident well-being, similar rates of burnout (50% SRs vs 55% ASTs) and poor work-life balance were reported.

Discussion and Conclusions: The general satisfaction of trainees in the new system may have risen but there remains room for improvement in areas of personal wellness and research activities.

Take-home messages: A new training system may have addressed the need for more effective training but a holistic approach will optimise the overall program experience.

#7HH05 (26868)

Implementation and results of internal educational audits of Post Graduate Medical Education (PGME)

J. Mooij*, University Medical Center Utrecht, Educational Center, Utrecht, Netherlands
E. Klarenbeek, University Medical Center Utrecht, Educational Center, Utrecht, Netherlands
J. Martens, University Medical Center Utrecht, Educational Center, Utrecht, Netherlands
A. Berns, University Medical Center Utrecht, Educational Center, Utrecht, Netherlands
S. Imhof, University Medical Center Utrecht, Department of Ophthalmology, Utrecht, Netherlands
E. ter Braak, University Medical Center Utrecht, Educational Center, Utrecht, Netherlands

Background: Complying with external regulations in the Netherlands we implemented educational audits by peers as part of a comprehensive institutional program for quality improvement (QI) and quality assurance (QA). Audits occur under the governance of the institutional Central Council for PGME.

Summary of Work: To date, 22/37 programs participated. Satisfaction with the procedure was evaluated with an electronic survey among 104 participating program directors and residents. Using a qualitative approach, 22 audit reports were analysed concerning issues quoted as calling for improvement. Data were grouped and coded into categories and subcategories based on applicable directives.

Summary of Results: Respondents (40%) rated their overall satisfaction with the procedure 8 (range: 6-9)/10 points. Responses indicate a safe atmosphere during the audit conversation, perceived as an opportunity to learn from peers.

Qualitative analysis of audit reports (n=22) revealed 12 categories with overall 41 subcategories of separate improvement issues. Most frequently named were: participation in courses covering general competencies (10/22), structuring and enhancing meaningful feedback (9/22), transfer of expertise from consultants to residents (i.e. during morning reports) (5/22), documenting and accomplishing intended improvements (8/22).

Discussion and Conclusions: Internal educational audits created a suitable setting to identify needs for improvement of individual programs. Analysis of all audit reports show common issues potentially calling for generic support on the institutional level.

Take-home messages: Internal educational audits encourage continuous evaluation and renewal of individual residency programs, simultaneously identifying issues suitable for shared approach.
Clinical Audit as an educational tool in Dental Foundation Training works best if you teach in the ‘Goldilocks Zone’ – findings from a qualitative evaluation study using focus groups

Peter Thornley*, Warwick Medical School/Health Education West Midlands, Medical Education, Coventry, UK
Alyson Quinn, Warwick Medical School, Medical Education, Coventry, UK
Karen Elley, Health Education West Midlands, Dentistry, Birmingham, UK

Background: This study reports on an evaluation of Clinical Audit pedagogy and service delivery outcomes in a Dental Foundation Training (DFT) programme. Although previous studies have evaluated the service delivery elements of audit, few have examined its use as an educational tool in Foundation Training. The aim was to evaluate the Clinical Audit module in a DFT scheme, from the perspective of Foundation Dentists (FDs), to find out what they think about Clinical Audit, how their learning affects their clinical practice, and any suggestions for improving the Clinical Audit teaching.

Summary of Work: A qualitative research methodology was used. Digital audio recordings of semi-structured Focus Group interviews with two groups of Foundation Dentists (FDs) were triangulated by an interview with a third group of Training Programme Directors (TPDs). The interviews were transcribed and thematically analysed using a “Framework” approach within Nvivo Data Analysis Software.

Summary of Results: FDs report considerable learning and behaviour change. However, TPDs have doubts about the long term effects on service delivery. There can be substantial learning in the Clinical, Managerial, Communication and Professionalism domains and development of time management, organisational and team-working skills. Information is provided about use of resources and interaction with teachers and colleagues.

Discussion and Conclusions: Clinical Audit provides learning opportunities not produced by other educational activities which include “difficult conversations” with team-members in the context of change management and providing feedback.

Take-home messages: Suggestions for improvements to resources and teaching support include working in the “Goldilocks zone” of optimal trainer intervention, “not too hot or cold, but just right” within the learner’s zone of proximal development.

Will short break cause delay for off-duty or improve work and learning efficiencies? Four years experiences in the Southern Taiwan leading/largest medical center

Chih-Hung Chen*, Kaohsiung Chang Gung Memorial Hospital, Internal Medicine, Niao Sung Hsiang, Kaohsiung Hsien, Taiwan
Chia-Te Kung, Kaohsiung Chang Gung Memorial Hospital, Emergency Department, Niao Sung Hsiang, Kaohsiung Hsien, Taiwan
Junnyie Sheu, Kaohsiung Chang Gung Memorial Hospital, Division of Cardiovascular Surgery, Niao Sung Hsiang, Kaohsiung Hsien, Taiwan
Jung Fu Chen, Kaohsiung Chang Gung Memorial Hospital, Endocrinology and Metabolism, Niao Sung Hsiang, Kaohsiung, Taiwan
Meng-Chih Lin, Kaohsiung Chang Gung Memorial Hospital, Chest, Niao Sung Hsiang, Kaohsiung Hsien, Taiwan

Background: Fatigue is the major cause for resident doctor involving in medical lawsuits. PGY students shall have a short break after duty. However, most student worry this system might delay off-duty time, thus distorted the original good purposes.

Summary of Work: During 8/1/2013 till 7/31/2014, 159 PGY graduated who participated and enrolled this system, anonymously handout a consensus forms during the first and last weeks. Analyses and compare the discrepancies between for future improvement. Effective consensus forms were 58 which covered the previous and current forms [(reliability) Cornbach α 0.73,(validity) 0.9].

Summary of Results: 1. A short break after on-duty can significant reduce degree of fatigue (p < 0.03).
2. We strongly suggest that hospital shall apply this short break to general subjects and other major specialties (p < 0.001).
3. Our results showed that a longer delay (p: 0.105) in 2013. The possible explanation was that the medical center were under review, staffs share extra preparations loadings.

Discussion and Conclusions: 1. Student tended to finish the works sooner to avoid delay off-duty is the most important factor. (previous vs current results in participated student were 30:32, respectively).
2. The teaching activity shall arrange proper resting time, because most of the activities are conducted before noon that it might interfere with student off-duty. (previous vs current results in participated students were increased from 18 to 30).
3. To avoid the interference, we believe that the rest scheme will provide the positive learning efficiency to reach the goal of early off duty.

Take-home messages: Worry delay off-duty time is human natural. Therefore, to arrange the course properly, avoid shifting courses without earlier notices, assist student suitable learning planning schedule. Ultimately let the student find the balance between physical conditions and learning efficiency is our biggest goal.
Mazes of Clinical Supervision

Tabassum Zehra*, Aga Khan University, Departments for Educational Development and Medicine, Karachi, Pakistan
Rukhsana Zuberi, Aga Khan University, Department for Educational Development, Karachi, Pakistan

Background: Clinical supervision has vital role in residency training programmes. Clinical supervision has been least investigated in medicine. There is limited evidence on supervision practices, models based on theoretical perspective with dearth of resident’s perspectives. Few multispecialty reviews exists in literature, no study was found regarding nature and adequacy of residents’ clinical supervision. Study explored ‘what are the needs of residents’ regarding clinical supervisor’s roles at Aga Khan University (AKU), Pakistan aligned to literature’, proposing model for clinical supervision based on Bandura’s Social-Cognitive Learning Theory.

Summary of Work: Mixed method approach (quantitative cross section survey, qualitative content analysis of focus group discussions) using sequential explanatory strategy was used allowing the results from both sets of data to be converged to draw inferences. All the residents at AKU were surveyed. Descriptive analysis of the quantitative part and thematic coding of the qualitative part was done. Exploratory factory analysis was done to identify underlying constructs

Summary of Results: Overall response rate N=329/456 (72.1%). Residents rated the roles of the clinical supervisor very highly (Mean = 4.43 - 5.85, SD = 1.21-1.86). Two component factors were yielded by exploratory factor analysis: specialist skills and role modeling skills. These findings were supported by residents in the focus group discussion.

Discussion and Conclusions: The relevance of clinical supervision to the residents’ needs and literature in defining the roles of the clinical supervisor was supported by the findings. The expected roles of a supervisor from the resident’s perspective and aligned to literature led to the development of the Socio-Cognitive and Skill Based Model of clinical supervision.

Take-home messages: The role of Clinical Supervisor is important in resident training. It’s relevance to their needs, supported by literature defines function, process and attributes of a clinical supervisor.

Junior doctors in difficulty: evaluating support services for newly-qualified doctors

Aranghan Lingham, Royal Stoke University Hospital, Pediatrics, Stoke-on-Trent, UK
Yashashwi Sinha*, Keele University Medical School, Stoke-on-Trent, UK
Anthony Choules, Royal Stoke University Hospital, Stoke-on-Trent, UK

Background: Making the transition from medical student to Foundation year one doctors (FY1) can be challenging, but there are many sources of support available. Our aim was to evaluate the need, access, and quality of support services offered to FY1s in the West Midlands.

Summary of Work: A SurveyMonkey questionnaire was emailed to the 648 FY1 doctors in the West Midlands deanery January 2015.

Summary of Results: A response rate of 16% (n=103) was achieved. 65% of FY1s reported wanting formal support at least once, with 19% having accessed foundation/trust support services (mostly clinical/educational supervisor). FY1s primarily turned to family (80%), friends before qualification (65%), and their partners (60%) for their support needs.

Of those who accessed formal support, >80% “strongly agreed/agreed” that they were satisfied with the support provided. The largest barriers to seeking support were time constraints (66%), feeling the problem was not significant enough (38%), and feeling uncomfortable asking for help (38%).

Discussion and Conclusions: Many FY1s report wanting support but not obtaining it. Barriers to support demonstrate hesitation at seeking help alongside time constraints. Furthermore FY1s primarily turned to informal sources for the majority of their support needs. When FY1s did access support they were satisfied with the service. Support services are crucial in helping FY1s through one of the most turbulent transition phases in their career. We should work to minimize barriers to make support services more accessible.

Take-home messages: We must encourage FY1s to seek support when needed and work to minimize barriers to access.
defining resident remediation: walking a fine line between informal "coaching" and a process with potentially serious consequences

Whitney McCarthy*, Baylor College of Medicine, Department of Pathology & Immunology, Houston, USA
Kate Hartman, Baylor College of Medicine, Department of Pathology & Immunology, Houston, USA

Background: Studies of trainees within various medical specialties estimate that between 6-10% will be categorized as a “problem resident,” or “resident in difficulty” at some point during their training. These terms stem from the identification of deficiencies within the realms of medical knowledge, patient care or professionalism, and are typically reported by supervising faculty and staff via evaluations and verbal complaints. An important question that arises in attempting to correct deficiencies is when informal feedback or “coaching” crosses the line into a formal process.

Summary of Work: Although numerous reviews and case reports on this topic exist, there is no standardization with regard to terminology used to describe this process, the steps taken to correct deficiencies, and the point at which the informal/formal threshold is crossed. We propose a standardized, multi-step protocol for trainee remediation.

Summary of Results: Remediation is an intermediate step between “coaching” and probation, which precedes termination.

Discussion and Conclusions: Essential to this protocol is a clear definition of remediation; we propose that remediation be instituted when three separate informal “coaching” sessions to address a deficiency fail. Remediation is a formal, official process that is documented in the resident’s permanent file, although the trainee will not need to answer affirmatively to questions on credentialing and licensing documents regarding disciplinary action.

Take-home messages: The cornerstones of this protocol are: extensive written documentation for remediated residents, immediate feedback, trainee due process, close follow-up, and utilization of appropriate institutional resources (e.g. legal counsel, behavioral health specialists) to generate the best possible outcome for all involved parties.

Quality of Health and Stress in Mexican residents

Dulce Victoria Varela Rojas*, Hospital Universitario "José E. González" Universidad Autónoma de Nuevo León UANL, Oncología, Monterrey NL, Mexico
Salvador B. Valdivinos-Chávez, Hospital Metropolitano "Bernardo Sepúlveda" SSNL, Jefe de Educación e Investigación, Monterrey NL, Mexico
Celia Beatriz González-Alcorta, Universidad de Monterrey, Oncología, Monterrey NL, Mexico
Hermelinda Fuentes-Luis, Instituto de Salud Mental SEP NL, Educación, Monterrey NL, Mexico
Juan Francisco González-Guerrero, Hospital Universitario "José E. González" Universidad Autónoma de Nuevo León UANL, Oncología, Monterrey NL, Mexico
Adelina Alcorta-Garza, Hospital Universitario "José E. González" Universidad Autónoma de Nuevo León UANL, Oncología y Psiconcología, San Pedro Garza García, Mexico

Background: Physician stress has possible negative impact on physical and psychological health. It is a priority to identify stressful events for residents and better support their specific needs.

Summary of Work: Ethics Committee of 2 public hospitals approved this survey, 70 subjects signed informed consent and answered Vital Events & Stress Rating (RVES) that adds up all the events in the last twelve months and the General Health Questionnaire (GHQ-28) and on Exposure of violence questionnaire.

Summary of Results: 33 women and 37 men, 28 years old, answered RVES; 40 (57.1%) had minimal stress; 5 (7.1%) severe stress; mild 13 (18.6%) and moderate 12 (17.1%). Stressful vital events most frequently were: work more than 12 hours (n = 42, 60%), aspire to great personal achievement (n = 32, 46%) working rotating schedules (n = 28, 40%) and have sleep disorders (n = 32, 28%). Physician in the second grade, had had higher health problems 18.75 (SD ± 19.63) and lower residents with 9.5 (SD = 12.14) for the last academic year. The women expressed greater stressors than men and if there was a history of abuse was most affected their health.

Discussion and Conclusions: The greatest stress is presented in the second academic year. History of abuse and being female was associated with higher stress. Also, work more than twelve hours a day, aspire to great personal achievement, rotating shifts and suffer sleep disorders.

Take-home messages: Is required by academic administrators consider these results to improve the opportunity for greater quality of life of physicians, in addition to considering institutional programs with spaces for personal or group therapy during residency.
What are the current patterns and practices in educational supervision in postgraduate medical education in England?

Priyank Patel*, Barts and The London School of Medicine and Dentistry, Queen Mary University of London, Centre for Medical Education, London, UK
Clare Penlington, Barts and The London School of Medicine and Dentistry, Queen Mary University of London, Centre for Medical Education, London, UK
Jon Fuller, Barts and The London School of Medicine and Dentistry, Queen Mary University of London, Centre for Medical Education, London, UK

Background: Educational supervision plays a key role in postgraduate medical education in the UK. However, it remains an under researched aspect of clinical teaching, from the point of view of trainees and supervisors. This highlights the clear need for a detailed study of the patterns and practices in educational supervision in order to inform developments in supervisory practice.

Summary of Work: This mixed methods study aims to gain a detailed understanding into the key aspects of educational supervision. Educational supervisors and trainees, working within a large London Trust were surveyed online about their experiences of educational supervision. In addition, observations of supervision sessions with a small group of supervisor and trainee pairs followed-up by semi-structured interviews were conducted.

Summary of Results: Data revealed some clear patterns in what is working well in educational supervision, and what needs changing so that trainees can benefit more from this supervisory process.

Discussion and Conclusions: Whilst most junior doctor and supervisors value the ideal of educational supervision as a process for engaging in mentoring dialogues; it can become a tick box exercise, devaluing its usefulness and purpose.

Take-home messages: Educational supervision is intended to provide a framework for meaningful discussions about the overall educational development between junior doctors and their seniors. The number of mandatory tasks required of both the junior doctors and supervisors when meeting can detract from this educational aim.

The SPRINT programme - structured programme of induction and training for novice endoscopists

Neil Hawkes*, Cwm Taf University Health Board, Gastroenterology, Llantrisant, UK

Background: Certification in upper GI endoscopy (UGE) requires 200 completed procedures (e-portfolio plus 10 DOPS assessments) and mandatory course attendance. Trainee surveys indicate problems performing requisite case numbers, difficulty accessing courses and lack of lesion recognition training (LRT).

Summary of Work: We designed a fast-track programme for early endoscopic skills development - SPRINT programme (supported induction, simulator training, LRT, hands-on training) and report on the pilot phase evaluating feasibility and training outcomes [recorded e-portfolio data, learning diaries, semi-structured interviews, evaluation scales]. Milestones were compared with an historical control (HC) group.

Summary of Results: All medical and surgical trainees in Wales deanery requiring UGE training agreed to participate. SPRINT group achieved faster progression to 50 [mean 10 weeks (range 7-13.5) and 100 cases [mean 20 weeks (range 14.5-29.5)] compared with HC group - 50 cases: 22.5 weeks (15.3-29.3) [p=0.002 for difference, Chi-squared test], 100 cases: 45 weeks (26.5-48) [p=0.002]. Mean Likert evaluation scores (0-10) were simulation 7.8, face-to-face LR 9.4, online LR 9.2 and ENTS 8.8. Qualitative data highlighted peer support and high level of trainer feedback as important benefits and identified key stages in cognitive framework evolution.

Discussion and Conclusions: Learning curves for SPRINT trainees were shortened. Sign off at 9 months is achievable [historical cohort 14 months (10-18)]. Simulators are most valuable in early training. LRT was highly valued if linked to structured feedback. Novices valued peer support highly; learner isolation and training fragmentation were counteracted by SPRINT. Key stages in cognitive framework evolution were identified providing insights to inform further programme adaptations

Take-home messages: Programmed training for novices learning UGI endoscopy on a national basis can effectively shorten time to certification, is achievable within current faculty constraints and offers promise for increasing longer term service delivery.
Clinical Learning during Night Call versus Day Work: Perceptions of Interns

Yan Qin*, Singapore General Hospital, Internal Medicine, Singapore
Kok Seng Wong, Singapore General Hospital, Internal Medicine, Singapore
Desiree Lie, Duke-NUS Graduate Medical School, Singapore, Office of Clinical Sciences, Singapore

Background: Clinical learning during night call has been shown to be less efficient and effective than during the day among residents. Strategies are needed to address the gap between night-time and day-time learning. We conducted a survey study to examine perceptions of night compared with daytime learning among Internal Medicine interns, and asked for suggestions to address this gap.

Summary of Work: This is a cross-sectional survey study conducted on a single class of 47 interns from Singapore General Hospital in December 2013. Interns anonymously completed a modified previously published 25-item survey. Twenty-three items asked for ratings of learning during the day vs the night using a 5-point Likert scale. The remaining two open-ended questions invited respondents to suggest improvements for teaching and learning. Analysis was done by descriptive statistics for the Likert-scale items; and thematic coding by two coders for narrative responses.

Summary of Results: Response rate was 70% (33/47). Interns rated learning during the day more positively than during night call for 23 of 23 (100%) items, with 22 out of 23 items showing significant difference. Among the 33 respondents, 20 provided narrative responses. Three major themes emerged: increasing manpower, allowing patient follow-up after night call, and more time on bedside teaching in the daytime.

Discussion and Conclusions: Our study confirms that learning during night call is perceived as less effective than during the day. We further extended this finding to offer alternate strategies to enhance clinical learning among interns.

Take-home messages: Enhance clinical learning experience during night call.

Illuminating the Nightshift: Quality Management Out-of-Hours

Richard Higgins, Health Education East Midlands, Quality & Regulation, Nottingham, UK
Simon Mallinson*, Health Education East Midlands, Quality & Regulation, Nottingham, UK
Kirsty Neale, Health Education East Midlands, Quality & Regulation, Nottingham, UK
Karen Tollman, Health Education East Midlands, Quality & Regulation, Nottingham, UK
Bridget Langham, Health Education East Midlands, Foundation School, Nottingham, UK

Background: Health Education East Midlands (HEEM) has been enhancing its approach to the quality management of education and training. Its quality management visits are now multi-professional in nature, assessing the quality of postgraduate medical education provision as well as the other healthcare professional placements it funds (for example, nursing and midwifery). The visit teams now also visit clinical areas. Annual visits to local education providers (LEPs), as well as other targeted visits have traditionally taken place during weekday, daytime hours. However, the feedback obtained from these visits, as well as local and national survey data, often point to concerns relating to out-of-hours working, including the range of training opportunities, supervision and patient safety.

Summary of Work: HEEM has embarked on a series of night visits to LEPs. To date, this has involved visits to hospitals, sometimes ‘unannounced’, where the team observes the evening handover and then spends time in specific departments or with the hospital at night team. Activities include observation, speaking to doctors and other healthcare professionals and shadowing individuals.

Summary of Results: The visits have enabled the visit team to highlight specific problems and their causes and to help LEPs with detailed action planning. A number of case studies demonstrate improvements occurring as a result of the visits.

Discussion and Conclusions: The visits have helped to both confirm and, more interestingly, challenge what learners have reported during daytime visits and via surveys.

Take-home messages: Night visits allow issues related to out-of-hours working to be explored. Resulting improvements demonstrate their value. Extending visits to weekend periods is being considered.
Residents' perception of sleep and education with new standards of duty hours

Archana Roy*, Mayo Clinic Florida, Jacksonville, USA
Caroline Burton, Mayo Clinic Florida, Jacksonville, Florida, USA

Background: Background – Long hours of work and lack of sleep is common during residency. The Accreditation Council for Graduate Medical Education (ACGME) further restricted resident’s duty hours in 2011.

Summary of Work: Objective – This study evaluates residents’ perception of sleep and education with new standards of duty hours.

Material and Methods – We surveyed our residents for their sleepiness and educational experience before (2011) and after implementation of new standards in 2013. We used Epworth Sleepiness Scale (ESS) to compare residents’ sleepiness.

Summary of Results: 50/93 (54%) medical residents responded to our survey in 2013. Average Epworth sleepiness score was 10.34 in 2013 compare to 9.51 in 2011. Average ESS for PGY1 was 11.8 compare to 9.96 in 2011. Majority (84%) of residents showed satisfaction with their education. 94% residents showed readiness for next level of responsibility.

Discussion and Conclusions: Our study shows that new standards of duty hours do not improve residents’ sleepiness. New standards have no negative effect on residents’ education.

Take-home messages: shift work does not improve residents’ sleepiness.

Older doctors and progression through specialty training in the UK: a cohort analysis of General Medical Council data

Yvette Pyne*, University of Bristol, Bristol, UK
Yoav Ben-Shlomo, University of Bristol, Bristol, UK

Background: More mature medical students are entering university to become doctors and while there is some data to suggest they do better than their younger peers during study, very little is known about how they fare as junior doctors.

Summary of Work: This population study reviewed the outcomes for 38,308 doctors' annual progression assessments (ARCP/RITA) over a 3 year period from 2009 to 2012 and determines if age (and other potential confounding variables) are a factor in the likelihood of progression.

Summary of Results: Mature junior doctors (≥ 29 years at graduation) were more likely to have problems with progression on their ARCP/RITA than their younger colleagues (Odds ratio 1.34, 95% CI 1.22, 1.49, p<0.001). This association was, if anything, even stronger (Odds ratio 1.57, 95% CI 1.41, 1.74, p<0.001) after adjustment for gender, ethnicity, type of University and specialty. The same was true when only looking at the most extreme ARCP outcome (4) which is being asked to leave their specialist programme (Odds ratio 1.81, 95% CI 1.34, 2.44, p<0.001).

Discussion and Conclusions: Mature doctors are a growing part of the medical workforce and they are likely to broaden the spectrum of doctors by bringing different life experience to the profession. These results suggest that they are more likely to have problems with progressing through their specialist training programme.

Take-home messages: This important study highlights that mature junior doctors have problems with progression through their specialist training programme compared to their younger counterparts. This needs to be acknowledged by the postgraduate education and training organisations and further research is required to determine the reasons behind these associations and how mature doctors can be supported both in choosing the best training programme and in coping with the complex demands of higher training at a later stage in their lives.