# Lessons learned in developing new postgraduate medical specialist training programs for Australia and New Zealand

What can be learned from the process of introducing major postgraduate medical education reform?

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Considerable changes in the processes of medical student education have been occurring for the past 20 years. Such changes began with the recognition that the curriculum was becoming increasingly full, leading to fatigue and loss of enthusiasm for the craft of medicine in medical students just as they were entering the medical workforce.[1] Changes in medical student education have included limitations on curriculum content; new ways of learning, such as inquiry-driven learning using problem-based learning principles; formative assessments; more feedback on student performance; emphases on ethics, communication and clinical reasoning; and greater integration of preclinical and clinical learning opportunities.[2-4]

Have these changes been mirrored in postgraduate medical training? In a general sense, changes in postgraduate training for graduates of these new medical courses have been limited.[5] It could be argued that, as postgraduate trainees are already "trained" and have commenced work, such reforms are not really necessary. However, the changing health care environments in which trainees work have placed the traditional apprenticeship model under severe duress. Erosion of the apprenticeship model has weakened the previously strong links between trainee and trainer, lessening the capacity to train our medical workforce at the very time that the community is demanding greater competence and accountability.

The Royal Australasian College of Physicians (RACP) trains many of the medical specialists in Australia and New Zealand, with more than 6000 trainees currently spread across 60 different training programs. Most trainees are training in internal medicine (and its many subspecialty components) or paediatrics, but training in public health, occupational and environmental medicine, rehabilitation, sexual health and addiction medicine are also covered under the RACP's programs.[6] As such, the RACP is a highly complex medical education enterprise. In 2004, the Australian Medical Council undertook its first external review of the RACP training programs. This review recommended changes to the education programs of the RACP, hastening the process of educational reform.

> "Developing a deep understanding of educational and training processes . . . takes time and persistence"

## Principles underlying the new RACP training programs

Design of a new postgraduate training framework for the RACP was predicated on ensuring, wherever possible, that processes and principles of training had resonance with medical school education reforms. A "handshaking" process, by which trainees feel familiar with postgraduate training as it resembles what they encountered in medical school, strengthens the vertical nature of medical training, even if that training is spread across different training bodies and locations.

Foundational to the changes introduced by the RACP in the new Physician Readiness for Expert Practice (PREP) program[7] has been the principle that workplace-based education is highly effective, provided there are scaffolds for both trainees and their supervisors to articulate such learning. These supporting frameworks should:

- enable trainees to know what it is they need to learn;
- enable trainees to recognise that they are learning the required material;
- provide educational evidence of attainment of the learning objectives, for the benefit of both trainees and their supervisors; and
- ensure that reflective learning (ie, trainees thinking about their learning and the impact they are having on their patients and the health care team) is developing the trainees into mature and competent professionals.

Another key consideration in the design of the PREP program has been the development of a wide range of discipline-specific curricula, together with a Professional Qualities Curriculum that runs across all the training programs.[8] The Professional Qualities Curriculum places emphasis on matters such as quality and safety, leadership, education, communication, ethics and cultural competency.

The key principles underpinning the educational developments are:

- The trainee is an active participant in the learning process, as opposed to being a passive recipient of information.
- The role of the teacher is no longer to only deliver factual information, but also to facilitate the trainee's learning.
- The trainees, by taking ownership of and responsibility for their own knowledge and skills acquisition, can direct, manage and organise their own learning needs within a supportive and clearly

defined curriculum framework that will guide them through a defined learning pathway.
- By thinking reflectively about what they need to learn and how they learn, the learning process becomes personalised and the trainees become self-motivated to achieve their own academic goals.
- The programs reflect current Australian and New Zealand workplace practices and changing regulatory requirements. They emphasise the provision of exemplary patient care within the context of an increasingly complex, multidisciplinary team-based working environment.

## Lessons learned

The introduction of major educational changes across the clinical and medical education sectors involves extensive planning and resourcing. Several key lessons have been learned throughout this reform process.

First, educational change requires a narrative — a description of why things need to change and the value of the new way of supporting and educating trainees in their learning and professional development.

Second, educational change requires time. Under the PREP program, clinicians need to have an understanding of the new educational tools and processes, and health services need to be aware of and support the reforms. Developing a deep understanding of educational and training processes, and their interface with clinical service delivery, takes time and persistence. Slow and progressive implementation of the PREP program was needed to enable trainees and supervisors to become familiar with the new requirements over time and to enable health services to adapt.

Third, educational change requires extensive investment. The RACP invested heavily in these training reforms, including establishing an Education Deanery to support the development of a completely new postgraduate training program. The RACP also provided support for hundreds of workshops around Australia and New Zealand and extensive communication processes with trainees, Fellows and health departments. Beyond these initial investments, supervisors and trainees must invest time and energy to understand and participate in the components of the new training program. The most common response from supervisors has been the request for their employers (mostly health departments) to provide the resources needed to allow them the time and capacity to fulfil the duties of supervision and documentation of their trainees' performance.

Finally, educational change requires lots of communication and clinician participation. Simply providing information on the educational changes is not sufficient — active processes are needed to engage clinicians in the reform process itself, along with the narrative of the changes, using many communication channels as frequently as possible.

## Conclusions

As these training program changes are still being progressively introduced, it is too early to conclude what their impact on training outcomes and clinical practice will be. Anecdotal reports of the individual experiences of many trainees suggest that documenting their learning, observation and systematic feedback on their educational journey is helpful. Moving to an electronic platform to document their training and the construction of learning plans by trainees have been less acceptable.

Australia and New Zealand have excellent medical training at all levels, and postgraduate vocational medical training is moving rapidly towards being structured along a continuum from medical school programs. Changes in the health services, changes in the profession of medicine and medical educational reforms are kept in balance through active reforms in postgraduate medical education processes. These postgraduate training reforms are extensive and expensive. Most of this "cost" is borne by the supervisory workforce — clinicians who are committed to ensuring not just their own practice of medicine, but also that of the future professional workforce, is of the highest order. What remains is the need for careful evaluation of the effectiveness of these educational changes and their impact on health service and individual clinical practice.

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