

How trainees can make major contributions to practice

BY PAVOL SURDA

At a time when many of our trainees feel poorly supported and disheartened, the formation of a National ENT Trainee Research Network (Integrate) has been a major advance, enabling them to develop and execute research projects directly relevant to clinical practice. The Epistaxis and Quinsy audits are excellent examples of this engagement with obvious benefits for all concerned, not least the patients.

Introduction

The NHS deals with over one million patients every 36 hours and the number of annual hospital admissions has increased by 28% over the last decade [1]. These numbers clearly show a need for the NHS to be more effective and innovative in order to remain accessible. Solutions may yet be within easy grasp – if only we are able to recognise them. Every year in the UK, more than 6,000 doctors make the transition from being medical students to junior members of healthcare teams, and yet medical trainees remain an underused resource for improving the NHS. While senior doctors direct and formulate the high-level decisions around clinical diagnoses and management, junior doctors are responsible for their execution and implementation. Junior doctors are also responsible for multiple lower-level decisions, including the ordering of laboratory tests, imaging investigations and medication prescription. This presence at the frontline makes them directly exposed to any variations in work practice within and between clinical services. It also provides a unique insight into the scheduling of individual and team duties that may create barriers to timely care. Sustainable and

effective change at the frontline requires the engagement of junior doctors.

In private industry, young researchers and entrepreneurs are an essential part of progress and innovation. However, it is unrealistic for a young physician, with a constantly beeping pager and devotion to training programme, to be as change-driven when compared to a young entrepreneur of Silicon Valley. Moreover, traditional hierarchies and cultural norms within the medical profession can disempower junior doctors. Thus, the initial period after graduation may be a key time to support junior doctors in becoming role models for change, before they become fully embedded into the status quo culture.

Traditional audit; is there a need for change?

Traditional audit is considered as one of the key instruments of change and quality improvement (QI). However, a number of studies have shown that clinical audit as taught in medical curricula is an ineffective way of improving practice or changing processes. In one study only 27% of audits were considered to be complete, and only 22% were re-audited, which may lead us to conclude that only 5% of audits led to any change in the practice or process studied [2]. There might be several reasons behind the failure of clinical audit to make a change; it takes a long time to analyse data from notes and written records, junior doctors are often in a department for only a few months, especially at the foundation level which makes finalising the audit cycle difficult. Moreover, many junior doctors feel that there is not enough support from senior staff and audit departments.

New quality improvement projects on the horizon

Young doctors are often drawn to medicine

because they see it as an opportunity to make a difference, disrupt, revolutionise and make the world a better place. How then can we ensure that the QI is not just a 'box ticking' curriculum requirement but instead an activity that inspires passion and makes a meaningful contribution? A number of innovations are underway in the UK to test the value of involving junior doctors in QI. The Royal College of Physicians initiative 'Learning to Make a Difference' introduced QI projects to core medical trainees (CMT). Sixty-four trainees completed 34 projects in the first pilot year; all participants reported that running a QI project was a valuable experience and 85% thought that they had made a difference in patient care with their projects [3]. Three years later in August 2014, QI officially replaced audit in the UK's Core Medical Training (CMT) curriculum.

The leading projects in ENT are trainee-led research collaboratives which have been recently established in several surgical specialties in the UK. These collaboratives have proved effective at instigating and delivering multi-centre observational and experimental studies, the findings of which have been published in high impact factor journals. Trainees are ideally placed to lead audits of emergency management given their exposure to emergency patients, with frequent on-call commitments and rotations through multiple units. The success of such projects, and the widespread support of both junior and senior clinicians within the specialty, has led to the genesis of the National ENT Trainee Research Network (Integrate). Integrate aims to be fundamental in promoting regional collaborative research, engaging regional trainees and coordinating a centralised data collection infrastructure, with the aim of increasing participation and reducing costs.

The formation of Integrate in the UK led to the development of the trainee-inspired

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National Epistaxis Audit to address priorities identified by the British Rhinological Society (BRS), ENT trainees and patients. The aim of this audit is to improve outcomes for patients with epistaxis by standardising care and enhancing the evidence-base for managing this common condition. Prospective data collection for the first 30-day audit cycle is now complete with over 100 sites across England, Wales, Scotland and Northern Ireland submitting data on over 1000 cases to our secure online data collection system. The findings will be disseminated later this year [4]. Another important collaborative project was the Multicentre Audit of Quinsies study, which collected data from over 40 centres in the UK and has provided a unique insight into the management of peri-tonsillar abscess. One of the significant outcomes was that shorter stay is associated with a low incidence of adverse events. This supports a move towards out-patient management of peri-tonsillar abscess in the UK [5]. Both projects demonstrate that trainees working in collaboration can effectively deliver results of national significance.

Researchers in Scotland tested a 'near-peer' teaching scheme, devised and delivered by junior doctors for final year medical students. Teaching sessions focused on clinical examination and practical prescribing. A randomised trial assessed the

effect of attending a tutorial on prescribing. Participants at various teaching sessions also completed feedback forms. Students who attended a tutorial made fewer dosing errors and most trainees attending sessions found them useful. The authors concluded that 'near-peer' teaching may be a worthwhile addition to the undergraduate programme and may assist junior doctors' professional development and focus on improvement [6].

Conclusion

Juniors on the healthcare frontline are potential agents of change who can recognise the gaps in the system. Showing our support during the tricky transition from being a medical student to a junior member of the medical team might break the constraining status quo culture in the healthcare system. In national audits, junior doctors have already shown the capability to make changes and these innovative projects seem to be a step in the right direction.

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