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Making the Most of Medical Orientation – A New Approach

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Abstract Orientating new junior medical staff can be a complex and time consuming task. Traditional models have typically involved a day or longer of lectures. This involves a large number of senior staff being available on the first day of term. It also means that junior staff not present on the first day had any access to an orientation program at all. Evaluation of our program confirmed the belief that the day was dull and that there was simply too much information for new staff to absorb. As a result of this feedback we extensively updated our orientation program. Pre-reading of the junior staff manual became compulsory. We departed from the traditional lecture style program and devised a new ten- station scenario based interactive program. The stations were designed to cover aspects of the hospital's mandatory education and key educational requirements in order to function effectively on our campus. Station leaders were selected and trained in the goals of the new process. Several of our secondment sites were engaged in the development of the project topics. We hoped that our secondment sites would be relieved of some orientation responsibility if core material was delivered centrally.

The strength of the new orientation is that it is portable, reproducible and uniform. It is also available via video conferencing. A single person can educate new staff in three hours if the need arises. Most importantly all new staff will have access to the program within a week of starting a term at our hospital.

Key words: medical orientation; junior staff; interactive

Orientating new junior medical staff to a new hospital or campus can be a time consuming, repetitive and important task. Orientation is vital to reduce new doctor's anxiety and to allow them to become competent members of the health care team as quickly as posible.[1-3]

The hospital has certain mandatory obligations it needs to fulfill during the orientation process. Issues that particularly need to be covered in New South Wales, Australia, includes child protection responsibilities, certain elements of the hospital's emergency plan such as fire safety, evacuation and clinical emergencies as well as other occupational health and safety priorities including the management of needle stick injuries.

There is very little in the medical literature that describes best practice for orientating new staff. At Sydney Children's Hospital, Randwick, we employ approximately one hundred and thirty junior medical and surgical staff at the beginning of each clinical year. However many of the individuals rotate across other sites of our network and at least two hundred junior staff is based at Randwick for more than three months throughout any year. These consist of residents, registrars and fellows. All have varying degrees of postgraduate work experience. Some are experienced trainees in pediatrics while others have not worked with children and their families since medical school.

Patently there is too much information to cover in a one -day orientation program.[1,2,4] Similarly more lecture time does not translate into greater knowledge

retention. In fact, the opposite may apply.[2] Programs that consist of day long didactic lectures are not beneficial to new doctors needs.[1] In our evaluation of the Junior Medical Staff (JMS) 2002 orientation program, feedback consistently showed that the lecture style was considered dull and boring. We were criticized for attempting to squeeze too much information into too little time.

The New Program

With this feedback in mind, a small team at Sydney Children's Hospital, Randwick set about devising a completely new orientation strategy for 2003. When we reviewed the content of the orientation day we realized that it could be divided into two broad components. First, there is the key operational aspect that involves surviving at the Sydney Children's Hospital. This relates to the safe functioning of the hospital and the entire medical campus, which we share with the Prince of Wales Hospital and the Royal Hospital for Women. The second component of the orientation concerned educational aspects relating to the core clinical practice of pediatrics. (Resuscitation, fluid management, surgical emergencies).

Our first decision was to postpone the clinical components from the initial orientation. The “lecture style” talks could be covered best as part of the in house resident diploma course. It was not critical that they are covered on day one as clinical manuals and supervision of junior are well maintained. We retained all the operational aspects relating to safety for the very important first day. Without this information effective functioning as a medical officer in the Sydney Children's Hospital team would be very difficult.

A key component of the new orientation was the redevelopment of the Junior Medical Officer handbook. A new streamlined manual including changes to hospital procedures and policies was compiled and distributed to all junior medical staff, old and new, one month prior to orientation. Together with the updated manual a letter was attached which explained that it was compulsory for all junior staff to read and be familiar with the contents of the manual. The letter also mentioned that aspects of the manual would be tested at orientation. All staff had to sign an acknowledgment form stating that they had read the manual and this acknowledgment was to be returned it to the Chief Resident’s Office.

Our third decision was to depart from the traditional lecture style and aim for a more interactive scenario based orientation program. Details passed on in the traditional lecture style are poorly absorbed and poorly remembered.[1-3] consequently a ten-station, OSCE format was developed with each scenario followed by a series of questions afterwards.

The ten stations were collaborations between the organizing panel and hospital-based staff with expertise in a specific area. Included in the stations were the mandatory components of Child Protection, Occupational Health and the emergency plan.

The other seven stations consisted of infection control, mental health and ethical decision-making, aggression management, the impaired doctor, guidelines and pathways, timesheets and medication charts. Many of the tasks that the junior medical staff was required to perform were original and interactive. Examples are the timesheet and medication stations. In these stations doctors are given incorrectly completed timesheets and medications charts and the group had to discover the errors on each chart. Items that we hoped would be common to pediatric terms regardless of which network hospital pediatric training occurred influenced the choice of topics. We hoped that our secondment sites would be relieved of some of their orientation responsibility if core material was delivered centrally. Several of our secondment sites were engaged in the development of the project topics.

The duration of each station was 15 minutes. Most stations adopted a similar format. The first segment allowed the junior staff to review the set scenario and develop a response. The middle segment was dedicated to the station leader reviewing the response with the doctors and assigning a score. This immediate feedback was an important opportunity to ensure that the doctors had a thorough understanding of the topic. Finally, the open format allowed an opportunity to cover other certain key aspects relating to the station.

Each station leader was trained in the format, style and educational objectives of the program. Feedback from the station leaders was incorporated into the scenarios. The marking system to be employed was also discussed with the station leaders.

The organizing group debated the concept of assessing individual new staff. On the one hand we were keen to assess the new process to see if the combined pre-reading and targeted educational scenarios would lead to a thorough understanding of the priority material. In contrast we were also concerned with the potential for individual assessment to be unnecessarily anxiety provoking, even threatening to

new staff that we would be trying to make feel welcome.

As a result we eventually decided that we would not examine individuals but rather the junior medical staff would be broken into mixed groups of five to seven doctors some of which had previous experience of Sydney Children's Hospital. Each group would attend all stations and be assessed as a group. Each station leader was given specific training in ensuring that all doctors were engaged in the education and assessment process. A scoring system based on model answers was developed and distributed. The team scoring the most points would be awarded a significant prize at the welcoming lunch at the conclusion of orientation. It was expected that any teams that consistently scored poorly would need to resit stations in future and demonstrate satisfactory improvement. We felt that assigning a group score would be less intimidating to new staff and also foster open, honest debate without fear of individual embarrassment. The group approach would also serve as a valuable icebreaker amongst new staff allowing them to meet and interact with other staff in a fun and only mildly competitive environment.

By introducing a scoring system the hospital management could also demonstrate its commitment to educating and assessing junior staff about operational aspects of working at Sydney Children's Hospital and the mandatory components of orientation as well. We would hopefully also gain some insight into whether any particular topic was generally not scoring well. This could help focus our education efforts in the future.

There had also been a concern at our hospital that while much effort had been placed on the orientation day there was no guarantee that all JMS could or would attend. What about staff seconded to other sites, staff that were ill or unable to be present for a variety of reasons? In the past this often meant that staff that missed orientation day had no formal instruction at all. If we were able to make this compulsory, which was our intention, how could we make it accessible even to those on secondment, slow to start the clinical year, or rostered on unfriendly shifts? Similarly could we reproduce the program on a regular basis throughout the year in an efficient manner for all new staff seconded to our hospital each term? To achieve this we introduced two new strategies: Firstly, we offered the program via videoconferencing to our seconded trainees in the first week of term. Three sites took up the offer and initial feedback using this technology was very positive. Secondly, we evaluated the program using the chief resident to cover all ten stations individually during the course of a morning. The program will now be offered to all junior medical staff at the beginning of each term rather than each clinical year.

Feedback from Junior Staff

Eighty-one junior staff attended the orientation and seventy completed an evaluation questionnaire (86%). Overall the response from junior staff was very encouraging. Ninety six percent of respondents found the day either very good or excellent. Over 90% of respondents found the length of the orientation day and the length of the stations just right. Three percent wanted more time for discussion at each station and 5% of respondents would have liked a longer orientation day. The most popular station was the aggression management station with 25% voting for this station as their favorite station. The least favorite stations were the mental health and timesheets stations with 10% of doctors voting for these stations as their least favorite station.

Evaluation of the pre-orientation manual was also positive. Eighty percent of respondents described the manual as either helpful or very helpful. Ten percent did not read it and a further 6% did not receive the manual prior to orientation. A small number of doctors read the manual and found it unhelpful. The average time spent reading the manual was three and half-hours. Of the doctors who read the manual two thirds found the length appropriate, 30% found it too long and 5% wanted more information.

Discussion

There is little doubt that a well structured resident focused orientation program is crucial. It should not be considered a one-off event crammed into the first day of a new job.[1,4,6] For many doctors orientation is a process that continues for some months in a new job. On the first day doctors require key information that will allow them to function as safe members of the team as quickly as possible.[2,7] The most appropriate length of the program is controversial. Some relate successful programs of three to five days duration.[2,3,5] In our institution orientation for new nursing staff lasts five days. However there needs to be a balance between educational needs and service requirements and we are therefore limited to a one day program for new residents.

Many doctors will feel anxious at the beginning of a new job.[3-6] A successful orientation can go a long way to reduce this anxiety and allow them to feel and be more competent quickly.[7] This translates

into safer doctors, improved patient care and an enhanced training experience for trainees.

Our orientation program also addresses the educational objectives in an adult learning environment.[4,8] The aim of the day is to allow practical and realistic discussion that is problem focused. As in other programs there is also an emphasis on leadership, communication and teamwork.[9]

Meeting senior staff and catching up with peers in a fun environment is an important part of the orientation process.[4,5] It is difficult to define the success of this informal interaction. However it does allow junior staff the first opportunity to network and identify key role players in the institution.

The evaluation of our orientation was strongly favorable. We were pleased that the majority of respondents found the orientation day, the length of stations and the content of the manual appropriate. In our next orientation we aim to perform a pre-orientation test, an immediate post test and an identical repeat test six months later to ascertain the degree of knowledge acquisition and retention. This information together with ongoing evaluation will help us plan for future programs.

Evaluation of an orientation program depends on an individual's own learning needs and stage of career development.[1,3] In one program of didactic lectures only one of 12 house officers surveyed could recall any content and three could not recall being at the orientation program itself.[7] This is further evidence of the ineffectiveness of the didactic lecture model. Other, more interactive programs, have received better evaluation[3,8] with a published program evaluation receiving favorable evaluation similar to ours.[10]

Conclusion

The strength of the new orientation package is that it is portable, reproducible and standardized. It is not reliant an assembling a large number of busy senior staff in a lecture theatre. We believe it is learner focused, practical, inter -active and addresses resident needs on the all important first day of a new term. With the large number of trainees rotating through our hospital we now also have the capacity to orientate new residents in less than three hours. In the past these residents would simply not have been orientated. Furthermore, with the use of video conferencing almost all our seconded trainees can also be orientated in the first week of term to safe clinical care.

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