The minimum knowledge, skills and attitudes required of trainees undertaking on-call work without direct, on-site supervision

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Background:

- Ophthalmology ≠ mandatory @ medical school
- Steep learning curve for new trainees
- Used to competency-based curriculae
- Unconscious incompetence
  - 'Don't know what they don't know'
- Lack of standards

Methods:

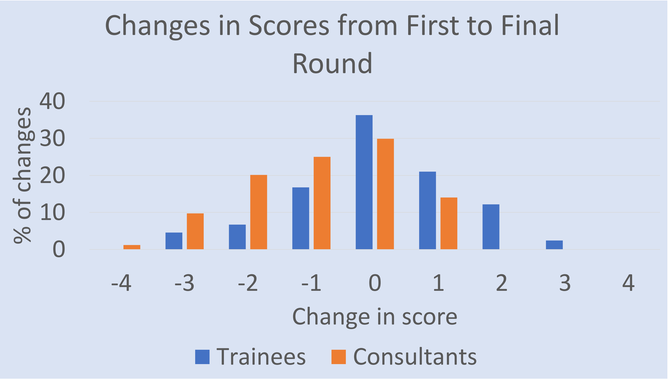
- Snowball recruitment
- E-Delphi study: 3 rounds
- Literature review to generate items for review
- Likert-scale ratings
  - Not at all important – not very important – neither important nor unimportant – important – very important
  - 1-5

Results:

- 12 participants – 8 trainees, 4 consultants
- After round 3
  - 134/175 (**76.6%)** consensus
  - 120 (68.6%) accepted
  - 14 (8%) rejected
  - 3 additional items accepted via non-consensus

Consultants vs Trainees

- Initial round:
  - Consultants would have *accepted* 16 more statements
  - Trainees would have *rejected* 4 more statements
- 2 swings to rejection by 3rd round (consultants)
- Mean change in score
  - 0.09 trainees
  - -0.85 consultants



Knowledge:

e.g. Know how to interpret ocular surface pH levels

35 accepted

Skills:

e.g. Accurately assess visual acuity at the bedside

52 accepted

Attitudes:

e.g. Works within the limits of their clinical competence

21 accepted

Educational Initiatives – Top 5

1. Formal induction to ophthalmology – clinical work
2. Formal induction to ophthalmology department
3. Simulation – skills
4. Problem-based learning: example cases, frequently encountered/highest risk
5. Provision of local handbook outlining patient flow options/telephone numbers etc

Conclusions:

- Minimum standards protect patient safety
- High level of consensus obtained
- Consultants expected more initially
- Can be used as a guide to tailor educational initiatives
- May reduce trainee anxiety
  - Move to 'know what they don't know'