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Medical students urged to "trinity"-based professional education transformation

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EDITORIAL

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The residency training system has become a basic national policy of training qualified doctors in many countries. But such a busy medical service seems to have already squeezed out much of the planned education time for the majority of trainees or rotations. The rising conflicts between them have aroused many educators' and administrators' attention and criticism, because it may push the education mission into a "flowing form" rather than raise quality of training. In the long run, it will offset its long-term goal. Therefore, many scholars were trying to strike the balance point between medical activities and education.[1,2]

In fact, the key to solving problem is how to put the limited education resources into multifarious medical activities, such as participating in surgery, executing seniors' orders, and typing daily routine electronic medical records, etc. Therefore, we put forward the notion of "education sharing" as a new approach to navigate the bottleneck of teaching activities. Firstly, any medical institution may not provide unlimited enclosed demonstrating space despite the nation-sponsored special training base being big enough. Furthermore, the mannequin-simulated training is far from enough to meet trainees' demand of first ground.[3] Clinical teaching space is indeed limited for each department. So we implement professional training through rotation of the various professional training venues in turn, by which we can greatly improve the utilization rate of teaching places. In our teaching practice, a particular way is to conduct teaching education at least 3 times per month, with total of at least 36 times a year. But each residency, according to their own needs and schedule, needs to attend at least 20 times per year. The flexible policy undoubtedly reduces their study pressure. Secondly, time sharing. A lot of teaching tasks can be melted into daily practical activities rather than be separated as a counterpart of clinical services according to previous reports.[1,2] We now assign each residency to a definitive tutor by a point-to-point way when they enter a new department. Finally, In the teaching course, we integrate trainees at different levels, including interns and rotations, etc. through teaching interactions under a single roof. Our practices have confirmed that clinical training teachers' sharing is completely feasible.

In order to achieve the value of education sharing, we should first clear our minds, the nation residency training initiative is aiming to help the new doctors startup smoothly and to learn more. Jia et al.[4] pointed out that healthcare should be more goal-driven rather than technology-driven or policy-driven alone. However, a minority of non-clinicians-origin administrators blindly emphasise the standardization of teaching mode, they simply think that using advanced teaching equipments to complete the teaching process means perfect. Really? Actually, this is a new kind of flaw with an old notion because now is the new era of big data. "Pure education" should be changed and be replaced.[1] Is there any focus on the cultivation of humanistic spirit? Learning to "plate" is very important at the beginning of trainees. More importantly, how to play during doctor-patient communication? Sometimes communication with emotional intelligence is more important than knowledge itself. Also, how to transfer the book knowledge into

practical ability? And how to use logical thinking and innovative ideas to solve the new problems emerged in clinical practice? All of these are the basic goal of residency training. So if we continue being restricted by the rules or policies of training, we may lose more. The only way is to encourage teaching innovation, including its mode and contents.

In view of these potentials for changes, the evaluation model of "three-in-one" training reform should be able to enhance the quality of residents via a weave of an administrative grid. The goal is to reduce the proportion of the exam assessment,[5] the expedition and year-end test each accounted for 20 per cent. The usual clinical practice services, labour discipline and communication ability, book reports and lectures by rotations were up to 20 per cent, 15 per cent and 10 per cent, respectively. The standardized patient test targets at logical analysis performance and rotations' flexibility capacity,[6,7] accounting for 15 per cent. In addition, inspiring innovation, including high-quality of published papers or patents or other circumstances should be given 5 points to 15 points reward The final score ranks trainees into different grades according to a certain proportion of residents. The quality grades will be rewarded with proper allocation of national funds. Those who failed to pass tests have to remain for longer training.

In any way, medical logical thinking needs a lifetime to learn, while training of residency will impact highly on promotion for their future development.

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PEER REVIEW

Peer reviewed.

CONFLICTS OF INTEREST

The authors declare that they have no competing interests.