The clinical tutor function was established in the mid-1960s in parallel with provision of Exchequer funding for postgraduate education. Recognition of the need for educational facilities in district general hospitals resulted in the establishment of postgraduate medical centres, with educational programs developed and supervised by the clinical tutor. Since then the role of the clinical tutor has been more clearly defined both by the National Association of Clinical Tutors (which has informally published a draft generic job description for the clinical tutor) and in the General Medical Council (GMC) documents *The New Doctor* and *The Early Years* relating to pre-registration house officer and senior house officer training respectively. These roles are summarised in table 1.

Major policy changes such as those proposed in the government white paper *A First Class Service* have emphasised the central role of “life long learning” in the clinical governance framework, to “give NHS staff the tools of knowledge to offer the most modern, effective and high quality care to patients”, and to “allow NHS staff to identify training needs across professions to aid clinical team-working”. Implicit in these proposals has been the desire to promote multidisciplinary learning opportunities, a direction exemplified by the subsuming of MADEL funding for postgraduate medical education into the budgets of the multidisciplinary workforce development confederations.

Some trusts, particularly in large cities, are amalgamating with neighbouring trusts and streamlining management. There will be pressure to look at management of delivery of education: clinical tutors may be asked to become involved in continuing education of consultant staff and might even be asked to manage education at more than one unit. Where does this leave the clinical tutor? The GMC documents make clear the lines of responsibility of the clinical tutor as the local representative of the postgraduate dean, providing a link between the university/postgraduate dean on the one hand and the NHS trust management on the other and coordinating effective delivery of the postgraduate educational contract.

The clinical tutor has traditionally been the trainee doctors’ advocate, ensuring that posts have educational value, that formal educational time is protected, and that trainees have access to careers advice. To some extent this role is being taken on by nominated educational supervisors (distinct from clinical supervisors of specific training posts). Arguably, it will be to the detriment of junior doctor training if clinical tutors can no longer fulfil the role of advocate, especially if their responsibilities are split to include consultant appraisal and education. If the clinical tutor effectively becomes an employee of a trust it will make it difficult to be impartial with regard to issues such as protected time.

It is not inconceivable that postgraduate deans (who will now have to justify their budgets with the new workforce development confederations) may allow trusts to develop their own models of how to manage delivery of the postgraduate contract—which might not necessarily include the traditional clinical tutor role. For instance, there will be a temptation to appoint a “Director of Education” (who may or may not be a doctor and who may or may not have a seat on the trust executive board) to oversee multidisciplinary education within a trust. Who will then defend medical education? Clearly while it is laudable to encourage multidisciplinary educational opportunities where possible, much medical education cannot be delivered in this format. Oversight of postgraduate centres, particularly with regard to provision of attractive postgraduate meetings may suffer if a clinical tutor is not site-based but has rather to take responsibility for more than one unit.

Finally, most clinical tutor posts (but not all) attract one or two funded sessions: if it is proposed that the clinical tutor function includes consultant continuing education and appraisal, and particularly if an incumbent is asked to oversee more than one unit it may take up three or four sessions of time (which will need to be funded). Will the most motivated or able individuals wish to give up much of their clinical sessions? If the clinical tutor becomes a consultant, then the question of whether the role is appropriately remunerated, takes on new importance. The clinical tutor remuneration will become the subject of debate: change may be to the detriment of the role of the clinical tutor. The question of whether the role of the clinical tutor is worth protecting must be questioned. The arguments are that the role of the clinical tutor was primarily the provision of academic education to junior doctors, whereas the role of the clinical tutor as consultant is more about the delivery of education to postgraduate and junior doctors. The educational / clinical tutor role has evolved from the former into the latter, and the two roles may no longer be sustainable.
A LIFE DEFINING MOMENT

Hospital experience as a patient

Being in hospital for a life threatening condition is without doubt a significant event in a person’s life. We doctors though, tend to forget that we are also vulnerable to such diseases. I was only 24 at the time, having just finished my final year elective attachment. Still recovering from a bad flu, I could hardly wait for the holidays to finish, as I had my job interviews straight after, followed by the last four months of my student life.

As soon as I went to bed a headache started building up. Within one hour I was screaming with pain, and later on I started vomiting continuously. Two days later I was in intensive care with markedly reduced conscious level, and a heart rate of 30. I had massive cerebral oedema, which kept me in hospital for 32 days! During this very traumatic ordeal I experienced the humiliation of being washed by the nursing staff, fed by relatives, experiencing dysarthria, and suffering from delirium. Every day I could see the sadness, anguish, and fear in my friends’ and relatives’ faces. Every night I would start thinking about how close to death I had been, and most importantly what would happen to my life.

This adventure showed me exactly how patients feel when they are in our hands, and I believe this made me a much better doctor. The most important lesson I learned though was to enjoy life as much as I can, as it may end suddenly, without any warning.—Marios Tryfonidis, PRHO General Medicine, Manchester Royal Infirmary, UK; martryfon1@hotmail.com
Role of the clinical tutor

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