Scenes from Postgraduate Life

Clinical tutor – mark II?

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Postgraduate medical education is under the microscope, with two recent critical reports highlighting the conflict between the demands of clinical work on the one hand, and the need for education and training on the other.^{1,2} This central dilemma is equally relevant to the role of clinical tutor, a post established on the recommendation of the Christ Church Conference and perceived as pivotal in the delivery of postgraduate medical education at hospital level.³ This landmark conference proposed that a consultant should be nominated in each hospital to act as clinical tutor who would assume responsibility for the teaching programme and the general care of those in training. Equally important was seen to be the promotion of an educational atmosphere in hospitals and also the concept of protected time for postgraduate education for both senior and junior medical staff. It was expected that the tutor would be based in a postgraduate centre, anticipated that the nominee would carry a reduced clinical load and administrative support would be provided.

Christ Church Model

The pattern was set for the next 30 years but even before the introduction of audit it was apparent that the aspirations of the early 1960s proved extremely difficult to achieve. The role of clinical tutor was usually assumed by a consultant with an educational interest but carrying a heavy clinical load and with time and administrative support at a premium. With no financial reward other than a niggardly honorarium there was usually little competition for the post, and it is a testimony to the dedication and hard work of clinical tutors that the system has survived so long. The introduction of the recent health reforms⁴ heralded a wind of change and it was at last recognized that the clinical tutor should be fairly rewarded. However, commensurate with the financial lollipop came significantly increased responsibilities; in addition

to identifying the education and training needs of hospital doctors and constructing an appropriate educational programme, the clinical tutor has become a budget holder, is expected to be involved in audit, and to provide pastoral care and career advice for the junior medical staff.

The expanded job description has made it even more difficult for an already hard-pressed consultant to take on the role of clinical tutor for a clinician inevitably feels that, when there are conflicting calls on his or her time, the major priority must be patient care. Equally suggestions as to how the load can be lightened such as sessional locums or job sharing are not easy to achieve in practice.

Mark II?

We report an alternative model where the concept of protected time for the co-ordination of postgraduate education is guaranteed, that is, a part-time clinical tutor without responsibility for patient care. This innovative approach was made possible by a fortuitous combination of circumstances:

1. The total failure of the previous clinical tutor to find a successor from his consultant colleagues despite intensive canvassing.
2. The local availability of an early retired general physician who was a former College Regional Adviser and who had maintained a strong educational interest.
3. The change in clinical tutor remuneration from an honorarium to a sessional basis.

Other equally important components of the plan were a unit management keen to heighten the profile of postgraduate medical education and enthusiastic support by the postgraduate dean. Being a university appointment the Department of Health restrictions on the re-employment of early retired consultants have not been contravened and the appointee acts as an independent contractor to the unit, the fees and appropriate expenses being reimbursed by the postgraduate dean. The innovation was welcomed by both the consultant medical staff and by the local medical committee and with

all the pieces of the jigsaw finally in place the proleptic appointment commenced at the beginning of February 1992, the substantive post being assumed from the beginning of August the same year. Recognizing the strong links between research, audit and education argued cogently by Black,⁵ a research facilitating role has been incorporated into the post (financed from local research trust funds) as has involvement with the structure and process of medical audit.

Advantages and potential disadvantages

The outstanding advantage of the new-style tutor has been the availability of time to devote to the expanded duties outlined in the current job description – whether educational, administrative, financial or counselling. The fact that the incumbent worked in consultant practice in a busy specialty alongside junior medical staff for over 20 years means he is able to both sympathize and empathize with the needs, pressures, anxieties and aspirations of hospital medical staff at all levels. Likewise the relative seniority of the tutor means he probably has access to a greater range of personal contacts (local, regional and national) than would a more junior appointment, and similarly aids the discussion of potentially sensitive issues with consultant colleagues. In addition the important counselling role of the clinical tutor, who is increasingly seen as intercessor and confidante for the junior medical staff, may be assisted by relieving any misgivings they may have that one of the consultant body serving this function may not be or perceived to be impartial.

Disadvantages have remained potential rather than real. In particular the credibility of a tutor without clinical responsibility has not proved a problem – hardly surprising in view of the situation of the postgraduate dean! Similarly communication with and being responsive to the medical staff

has probably been enhanced rather than hindered by the new arrangement.

Mark III?

The new clinical tutor model we outline may not be universally appropriate but the provision of time exclusively for the delivery of postgraduate medical education at hospital level represents a quantum leap and is a principle which deserves wider consideration. With the recently introduced measure of the regional retention of half of the basic salary costs of all approved NHS posts in the medical training grades, to be reimbursed to provider units and trusts by the postgraduate dean only if acceptable educational criteria are met,⁶ the responsibilities of the clinical tutor seem destined to enlarge even further. If this financial penalty is not an empty threat, the educational content of junior medical staff posts will need to be critically reviewed and an educational contract agreed allowing for personal variations in objectives and incorporating assessment to ensure they have been fulfilled. Bearing in mind the tutor's counselling role and the necessity to tackle the recognized deficiency in the teaching skills of many consultants, it will ultimately be impossible for these obligations to be met on a part-time basis. Perhaps our local innovation should be regarded as a portent for the appointment at some stage of a full-time director of education in each hospital or hospital group so that the educational requirements of junior medical staff can at long last receive the attention they deserve. A respected consultant with an educational interest and acknowledged teaching skills could move into such a role in the same way that those with managerial interests are currently encouraged to do.

The days of the cherished amateur status of clinical tutors have indeed gone⁷ – but not before time.

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