Postgraduate Medical Journal
The Journal of Continuing Medical Education

Editorial

Training of junior doctors: the responsibility of consultants and trainers

With 31 000 doctors currently in training programmes or placements and 23 000 consultants[1] it should not be considered surprising that the vast majority of consultants working in the National Health Service (NHS) are involved in training. This role has been emphasised with the incorporation of "teaching and training" as a key attribute by the General Medical Council[2] and formalised by the publication of *The Doctor as Teacher.*[3] Teaching and training has become an integral part of the role of the consultant. Is such an approach right? If it is, what exactly are the responsibilities that this places on a consultant? And how might this role develop in the foreseeable future?

In *The Doctor as Teacher* the General Medical Council states that "all doctors have a professional obligation to contribute to the education and training of others . . ..", and that "every doctor should be prepared to oversee the work of less experienced colleagues".[3] This clearly articulates obligations for the senior professional in relation to those less experienced. But this responsibility should not only be seen as an issue of professional obligation between members of the same profession. These elements are surely also crucial if patients are to receive care that is safe. We owe it to the patients of today to ensure that the care they receive is adequately supervised by an appropriately experienced clinician; we owe it to the patients of the future that those who will be consultants at that stage have learnt how to provide safe care from observation of their seniors. For these reasons any consultant who relates to doctors-in-training must be in a position to provide effective supervision of their clinical activities including the explicit modelling of good clinical care—that is, to take on the role of clinical supervisor.

As well as clinical supervision trainees will also need someone to help them understand what they have learnt from clinical experiences and integrate this with what is learnt from formal educational activities; someone to help them understand how they learn so that they can make best use of the educational opportunities available; someone to assess their progress and provide feedback; and someone to help them overcome difficulties.[4] These are the roles of the educational supervisor.

The requirements of the roles of clinical supervisor and educational supervisor are different. Both need to have good knowledge of their clinical field and be able to demonstrate sound clinical skills that the trainee can observe. To take on the educational supervisor role an individual also needs to know what the trainee is expected to learn during their time in the training placement (the curriculum), and to have the skills of effective teaching and training—in particular the skills for supporting adults to learn[5,6] (including the ability to encourage reflection as one of the most important methods[6,7]) and the skills of effective appraisal and assessment. Finally while both must be prepared to balance challenge with support, the educational supervisor has to balance the need for subjectivity (for instance when tailoring educational activities to the particular needs of the individual trainee) with that for objectivity (for instance when assessing the performance of the trainee against specified criteria).

What this means is that the two roles are different. All consultants who relate to trainees will need to possess the attributes for effective clinical supervision; consultants without these attributes will need to placed in roles where trainees do not feature. Effective educational supervision requires a further set of attributes. Not everyone is suitable for, or wishes to take on, these additional responsibilities. Nevertheless, those responsible for training (clinical tutors, programme directors, and postgraduate deans) will need to ensure that both forms of supervision are available for all trainees.

How might this change in the future? I predict a number of changes. Firstly postgraduate medical training will become educationally more sophisticated. More emphasis will be placed on translating adult learning theory[8] into practice with a shift in the educational culture from one in which the teacher teaches (the "pedagogic" approach) to one in which the teacher moves into the role of "facilitator of learning" (the "androgogic" approach).[9] As part of this education supervisors will become more effective at balancing parallel agenda—balancing what the NHS needs doctors to learn with what those individual doctors might wish to learn, and balancing the provision of a linear curriculum (typically as preparation for a professional examination) with the multitudinous educational opportunities that arise from reflection on clinical experiences.

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Secondly changes in the work patterns of doctors (in particular the widespread introduction of shift working) will result in new patterns of training. For example a significant part of the linear curriculum may be provided through distance learning undertaken at a variety of times within the working week depending on the doctor's particular working hours at that time, or through substantial modules (for example, 2–3 days) taking place on a regular basis (for example, monthly); the reflective element may be provided through protected time within ward rounds or group discussion. Thirdly, medics' learning will increasingly be supervised by individuals who are not doctors.[10] Such people might supervise the learning of trainees from a number of different professional groupings drawing on those from the same professional group as the trainee (that is, doctor-doctor, nurse-nurse) whenever a content expert is needed. Allied to this there will be a shift to multiprofessional learning wherever appropriate with teams of trainees from different professional backgrounds at similar stages in their training reflecting on shared problems together supported by a shared generic curriculum. But education will not be entirely multiprofessional—there will also be uniprofessional education linked to profession-specific linear curricula. Fourthly, there will be a much greater emphasis on trainees acquiring (and demonstrating that they have acquired) the necessary attributes for effective teaching and training. Not only will this promote a learning culture throughout a clinical team, it will also reduce the likelihood that future consultants will find themselves expected to provide effective supervision without adequate preparation. Finally while appraisal will become an accepted and integral part of the working practices of all those involved in health care, the assessment of trainees will become more rigorous with appropriate content, clear standards, and robust assessment instruments.

Translating these predictions into practice I would foresee all consultants needing to be skilled at translating clinical experiences into opportunities for trainees to learn. They would work through problems and random cases with trainees as individuals or in groups as part of the ward round that would take place within each shift. They would also be trained to undertake effective assessment of those aspects of the trainee's performance that are not amenable to observation by external assessors. Most, if not all, of these skills would have been gained during their own training. Those consultants unable or unwilling to undertake these roles would not supervise trainees.

In addition there would be a group of programme directors—specialty programme directors for specialist registrars (as exist now) supplemented by specialty senior house officer programme directors and preregistration house officer programme directors. These individuals, who would not necessarily be medics, would manage the training. They would undertake appraisal of trainees and support the drawing up and implementation of personal development plans. These would draw linear curricula alongside opportunities arising from clinical experience, taking into account also the way in which each individual learnt. They would draw on content experts from the trainee's professional background whenever appropriate. They would provide regular feedback and support with problem areas. They would organise appropriate placements. Finally they would offer a basic level of career counselling. There would also be a cohort of consultants who would develop skills in assessment who would implement an assessment strategy for each specialty at each grade.

To enable such changes to take place the postgraduate deans working as part of the workforce development confederations would implement educational contracts with trusts that enabled adequate time to be freed up from clinical activities for those involved in education, and that enabled appropriate educational activities to be developed. In addition they would ensure that appropriate training was available for all of those involved in education and would introduce assessment to ensure that those involved in training were performing effectively.

This is a big agenda. It won't be implemented overnight, and undoubtedly the final product will not look exactly like the model predicted here. But there can be no doubt that there is a huge emphasis on training of the NHS workforce at present. What we need to do now is to begin to bring about some of these changes so that trainees get effective training and consultants have the time and skills to begin to enjoy training once again.

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