ORIGINAL ARTICLE

The new consultant survey 2005

M Beckett, D Hulbert, R Brown

Emerg Med J 2006;23:461–463. doi: 10.1136/emj.2005.030726

See end of article for
authors' affiliations

Correspondence to:
M Beckett, West Middlesex
Hospital, Isleworth, TW7
6AF, UK; michael.
beckett@wmuh-tr.nthames.
nhs.uk

Accepted for publication
21 January 2006

Background: Consultants in emergency medicine have to deal with a wide range of problems, many of which they will not have encountered during their training. One way to assess the adequacy of specialist training is to ask recently appointed consultants whether or not they feel adequately prepared for their role.

Methods: A questionnaire was sent out to 60 newly appointed consultants in emergency medicine in January and February 2005 and the results analysed.

Results: Many respondents feel that there should be greater emphasis on acquiring clinical skills, partly by greater consultant supervision and partly by providing more experience of anaesthetics and intensive care. New consultants also feel inadequately prepared for their management responsibilities, and this is a source of great stress.

Conclusions: Specialist training in emergency medicine needs to pay more attention to the acquisition of clinical skills and to preparation for management responsibility.

The purpose of specialist training is to prepare for life as a consultant. Consultants in emergency medicine have to deal with a wide range of clinical, administrative, and management problems, many of which they will not have encountered during their training. Trainees are expected to acquire generic skills and competencies that can be applied to a variety of situations, especially when dealing with managerial issues. One way to assess the adequacy of specialist training, therefore, is to ask recently appointed consultants whether they feel adequately prepared for their role. If there are areas where significant numbers of new consultants feel poorly prepared, then changes should be made to the way registrars are trained. Surveys of newly appointed consultants in emergency medicine were conducted in 1997 (unpublished survey by J Marrow), 2001,¹ and 2005. We here report the results of the 2005 survey with references to the earlier surveys for comparison. In the three diets (18 months) before the latest survey was conducted, there had been changes in the Faculty of Accident and Emergency Medicine (FAEM) exit examination with greater emphasis on assessing clinical skills.

METHODS

A questionnaire was sent out to 60 newly appointed consultants in emergency medicine in January and February 2005. A consecutive series of new consultant appointments was chosen; those who had previously held consultant posts elsewhere were excluded but those who had only previously held locum posts were included. The survey was anonymous. Fifty replies were returned in response to the initial letter or a reminder (83% response rate). The 1997 survey was sent to 47 consultants (response rate 73%). The 2001 survey sent to 60 consultants obtained a 90% response. Copies of the questionnaire form are available from the authors.

RESULTS

Consultants had been in their post for between 2 months and 2 years, with an average 10.2 months. The form was designed to elicit answers in a standardised format to specific questions with space to add freehand comments if desired. The questions and answers are given below.

1. Do you feel your training adequately prepared you in these areas? (on a scale of 0 "not at all" to 10 "completely"):
 - clinically: mean 8.6
 - academically: mean 6.7
 - managerially: mean 6.0
 - generally prepared for consultant role: mean 7.6
2. Usefulness of secondments. Anaesthetics and intensive therapy unit (ITU) secondments were considered the most useful by 65%, and 16% said 6 months or more would be preferable. Secondments should have a more formal structure and aims according to 48%, while 30% thought there should be a management secondment. Surgery was thought the least useful of the secondments. Some thought a surgical secondment was of no value: "I was treated like a medical student" and "I could already spot an acute abdomen, what more do you need to know?".
3. Exposure to different departments. Registrars had worked in between two and six different departments in their rotations; most had worked in four. Regardless of the actual figure, almost all considered the number that they had worked in was "about right".
4. Suggestions for improvement of training:
 - 33% wanted more 1:1 teaching from consultants
 - 29% wanted more management experience, but two doubted whether this could properly be learned before taking on consultant responsibility
 - 16% thought the record of in-training assessment (RITA) should be more robust
5. Consultant confidence. In which area do you feel least confident? (some respondents indicated more than one area):
 - handling management issues: 63%
 - dealing with psychiatric patients: 26%
 - other clinical problems: 30%

6. Impressions of the FAEM exit examination. Sixty two per cent either said there should be a larger clinical component or approved of the recent changes to achieve this ("We must shed the office consultant image"). Although many said the clinical component should be emphasised, only two said that it should be made more difficult.
7. What do you find most stressful in your work? (on a scale of 0 "not at all" to 10 "very stressful")
 - conflict resolution (patients): mean 3.9
 - conflict resolution (colleagues): mean 6.2
 - financial management: mean 5.2
 - targets (department, trust, and DoH): mean 7.9
 - balancing life and job: mean 5.5
8. Examples of difficult experience. In response to the question "What was your most difficult experience since becoming a consultant?", only two respondents gave a clinical situation: in both cases this involved managing a patient with a severe gastro-intestinal haemorrhage, with no specialist help available. All other replies gave examples of managerial difficulties or conflicts with senior colleagues such as dealing with poorly performing junior doctors or "tolerating fellow consultants who do not share the same work ethic". There were some lengthy accounts of serious problems which had clearly been extremely stressful.
9. What has been the biggest surprise about being a consultant? Fourteen gave positive replies reflecting the greater respect, power, and influence consultants may have. Most of the other comments were negative, due to factors such as the responsibility, administrative load, stress, and difficulty in making change happen.

DISCUSSION

Other specialties have conducted surveys of new consultants' opinions concerning their training. Since 1966 psychiatrists have been asked to rate their training experiences,² and occasional surveys of paediatricians³ and geriatricians⁴ have shown perceived deficiencies in areas such as research training and organisational skills. In accident and emergency medicine, a survey in 1988 showed concern over management issues.⁵ There have of course been many changes since 1988 such as the introduction of structured training, the exit examination, and multi-consultant departments.

Training in emergency medicine is undergoing continuous change and refinement. The exit examination is designed to reflect all areas of competence, and is considered by the Faculty board to be fit for purpose. It covers clinical, academic, and managerial activities and is currently undergoing further revision. The validity of training and assessment is best demonstrated by the performance of successful and unsuccessful candidates over a period of time. However, in a specialty such as ours where work practice is constantly changing and individual performance is difficult to measure because of team working and shared responsibility, other markers need to be used to support standard assessment data. Surveying consultants' opinions and personal experience can be a useful way of assessing the effectiveness of their training. Repeating such surveys can give information reflecting a complex situation in which specialist training, the structure of the FAEM exit examination, and the nature of consultant practice are continually changing. However, there are some persistent trends in all three surveys. Many respondents feel that there should be greater emphasis on acquiring clinical skills, partly by greater consultant

supervision and partly by providing more experience of anaesthetics and intensive care. The 2001 survey found that 14% thought there should have been better consultant supervision compared to 33% in our current survey. It is interesting that many new consultants think there should be more 1:1 teaching of trainees, since this could potentially be very demanding of consultant time. In addition, there have been recent changes to the recommendations on the amount of time registrars should be under direct supervision. At present there is no agreed definition of what is meant by supervision, and in practice this can vary from the consultant standing alongside the trainee to being available but occupied elsewhere in the department. It seems that increasing the presence and immediate feedback to the trainee on clinical performance would be welcome. There is widespread support for the increased emphasis on assessing clinical skills in the exit examination. Candidates must now pass the clinical section of the examination which accounts for 50% of the total marks. Although many wish they had received better training in these skills, clinical problems are not a major cause of stress in the life of a new consultant, so this may reflect young consultants' aspirations for the specialty in the future rather than the pressures of today's practice. The desire for increased exposure to anaesthetics and ITU may be met by the proposed "run through" training where all trainees will receive a year of anaesthetics and critical care.⁶ The clinical area where most feel poorly prepared is psychiatry, which may be due to the fact that this is not an essential secondment, and few emergency medicine trainees have had significant postgraduate experience in psychiatry.

A recurring theme of these surveys, however, is that new consultants feel inadequately prepared for their management responsibilities, and this remains a source of great stress. The 2001 survey found that 47% felt inadequately prepared for their role, all citing insufficient management training as a reason; in 2005 67% felt that management was the area for which they were least prepared, so the situation may have worsened. There are a few practical suggestions as to how this can be improved: 24% suggested a formal secondment in management and 17% had taken a locum consultant post, mostly only for a few weeks, but some up to 1 year. A few found this helpful and one suggested that a two tier consultant system would be useful. An alternative to the present management viva might be the completion of a management project as an assessment method. Most candidates pass the current management viva but it seems they still feel vulnerable and this is an area which must be addressed in both training and examination. Many of the managerial problems encountered were shop floor issues such as conflict resolution with colleagues, leadership, and supervision difficulties. Even those who strongly advocate that the emergency medicine consultants' principal role should be as a front line clinical specialist, must recognise the importance of dealing with these problems effectively.

Our new consultants feel inadequately trained in dealing with the managerial issues generated by today's emergency departments. If specialist training in emergency medicine is to be considered "fit for purpose" it needs to address this issue.

Authors' affiliations

M Beckett, West Middlesex Hospital, Isleworth, TW7 6AF, UK

D Hulbert, Southampton General Hospital, Southampton, SO16 6YD, UK

R M Brown, St Mary's Hospital, London, W2 1NY, UK

Competing interests: none declared

Ruth Brown is Registrar of the College of Emergency Medicine

REFERENCES

- 1 **Beckett M**, Hulbert D. The new consultant survey. Poster at FAEM Scientific Meeting, Plymouth, UK, 2001.
- 2 **Brook CP**. Postgraduate psychiatric training. *Med Educ* 1981;**15**(5):335-9.
- 3 **Lenton SW**, Dison PJ, Haines LC. A BPA survey of newly appointed consultants. *Arch Dis Child* 1994;**71**(4):381-5.
- 4 **Sandler M**. Training experience and views of newly appointed consultants in geriatric medicine. *J R Coll Physicians Lond* 1992;**26**(1):44-6.
- 5 **Driscoll P**, Cope A, Miles SA. Adequacy of senior registrar training in accident and emergency medicine over the last 5 years. *Arch Emerg Med* 1988;**5**(3):162-8.
- 6 **McGowan A**. Modernising medical careers. *Emerg Med J* 2005;**22**(suppl):7-8.

Clinical Evidence—Call for contributors

Clinical Evidence is a regularly updated evidence-based journal available worldwide both as a paper version and on the internet. *Clinical Evidence* needs to recruit a number of new contributors. Contributors are healthcare professionals or epidemiologists with experience in evidence-based medicine and the ability to write in a concise and structured way.

Areas for which we are currently seeking contributors:

- Pregnancy and childbirth
- Endocrine disorders
- Palliative care
- Tropical diseases

We are also looking for contributors for existing topics. For full details on what these topics are please visit www.clinicalevidence.com/cweb/contribute/index.jsp

However, we are always looking for others, so do not let this list discourage you.

Being a contributor involves:

- Selecting from a validated, screened search (performed by in-house Information Specialists) epidemiologically sound studies for inclusion.
 - Documenting your decisions about which studies to include on an inclusion and exclusion form, which we keep on file.
 - Writing the text to a highly structured template (about 1500-3000 words), using evidence from the final studies chosen, within 8-10 weeks of receiving the literature search.
 - Working with *Clinical Evidence* editors to ensure that the final text meets epidemiological and style standards.
 - Updating the text every 12 months using any new, sound evidence that becomes available.
- The *Clinical Evidence* in-house team will conduct the searches for contributors; your task is simply to filter out high quality studies and incorporate them in the existing text.

If you would like to become a contributor for *Clinical Evidence* or require more information about what this involves please send your contact details and a copy of your CV, clearly stating the clinical area you are interested in, to CECommissioning@bmjgroup.com.

Call for peer reviewers

Clinical Evidence also needs to recruit a number of new peer reviewers specifically with an interest in the clinical areas stated above, and also others related to general practice. Peer reviewers are healthcare professionals or epidemiologists with experience in evidence-based medicine. As a peer reviewer you would be asked for your views on the clinical relevance, validity, and accessibility of specific topics within the journal, and their usefulness to the intended audience (international generalists and healthcare professionals, possibly with limited statistical knowledge). Topics are usually 1500-3000 words in length and we would ask you to review between 2-5 topics per year. The peer review process takes place throughout the year, and out turnaround time for each review is ideally 10-14 days.

If you are interested in becoming a peer reviewer for *Clinical Evidence*, please complete the peer review questionnaire at www.clinicalevidence.com/cweb/contribute/peerreviewer.jsp