Coda

A suitable case for treatment

In August 1982, I finished a six-month stint as a senior house officer in obstetrics, and brought my career as a hospital doctor to an end. Since then, I have worked mainly in general practice and as an educator. I have only had the typical contacts that you would expect a GP to have with the world of hospital medicine. However, a few months ago I was asked to design some training for hospital consultants in how to carry out clinical supervision effectively. Since then, I have been visiting acute hospitals for one day a week, and talking to people involved in education there. I have been trying to find out what has changed in hospital culture during the quarter of a century since I was last familiar with it. Mostly, I have been trying to distinguish how far education in hospitals has diverged from GP education in that time.

It has been a bit of a shock. Since the 1980s, GP education in Britain has been transformed beyond recognition. In order to become a GP trainer, you now have to study for at least a year, and acquire the equivalent of a postgraduate certificate in education. GP registrars are more or less supernumerary within their practices. In effect every training practice needs to be able to function without depending on its juniors, and the vast majority of GP practices do not take on registrars at all. In most circumstances, registrars are not allowed to work without continual access to their trainers for guidance and supervision. Registrars report in detail on all their difficult cases, trainers sometimes sit in on their surgeries, and both will examine video recordings of the registrar’s consultations. They hold weekly tutorials together where a great deal of time is spent in thinking about reflective practice. Much of the emphasis within GP registrar training is on the intimate connection between technical skills and communication skills. The minutiae of medical decision-making (the right advice, the right prescription, the right referral) are discussed alongside the minutiae of doctor-patient interaction (the body language, the verbal cues, the pauses, the timing and the exact wording of questions).

Virtually all of this seems to be absent from hospital training, with the obvious exception of a few specialized fields like psychiatry. I have quickly learned that becoming a trainer or supervisor still comes automatically with the job of hospital consultant. Many consultants are therefore in training roles by force of circumstance rather than through choice, aptitude, or even any specific training for the role. In some places, even staff-grade doctors seem to find themselves thrust into this position too. At the same time, I have found that much of the clinical service in hospitals still seems to be provided by juniors who are in effect unsupervised for much of the time. When supervision does take place, it appears to be snatched mainly in brief and often public moments, such as on a ward round or in a clinic. Some of the initiatives that have radicalized doctors’ working patterns in the last few years—including the European Working Time Directive and Hospital at Night—seem to have undermined the continuity of connection that consultants and juniors formerly had with each other. Currently there are added political and financial pressures that seem to be reducing even further the time and energy that consultants can give to training and supervision.

From a GP perspective, perhaps the most striking fact is that there is little or no protected time in hospitals for discussing or digesting complex cases in a reflective way on a one-to-one basis. It seems that junior doctors can still face the most harrowing emotional and technical challenges without being able to debrief privately, to help them manage and learn from these experiences. No doubt connected with this, there seems to be little or no tradition in hospitals of emphasizing communication skills as a fundamental prerequisite for good and safe clinical practice. In spite of a mass of evidence that you cannot offer good technical
care unless you have first established what the patient actually wants from you, most of the discourse that passes for supervision in hospitals still seems to address mainly the search for the ‘right’ technical answer, as if this was something that could be determined in isolation from the beliefs or values of patients and their families, or the quality of communication that led to the diagnosis in the first place.

Not everything is so grim. From the conversations I have had, and from what I have observed, I would say that some consultants remain thoroughly committed to providing good teaching and support for their juniors whenever they can. I have noticed that a sense of camaraderie and shared purpose still endures on some units, and in smaller hospital trusts. Some medical directors and chief executives do seem to understand the inseparable link between the quality of supervision and the quality of service, including job satisfaction among staff, good team-working, the reduction of serious errors and complaints, and the improvement of clinical outcome. With the changes to job structures introduced under ‘Modernizing Medical Careers’, some hospitals are genuinely beginning to treat their juniors as learners rather than workhorses, at least during their two foundation years.

However, if I am frank, I would say that the culture of training and supervision in British hospitals may still be a generation behind that of general practice. It is time to bring it up to date.

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