

Consultant supervision of trainees seeing inpatient ward referrals – a cause for concern?

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ABSTRACT

The adequate supervision of trainee doctors seeing ward referrals is critical to the quality of patient care and medical training. This survey assessed the level and nature of supervision of trainees in neurology and comparable specialities. 123 neurology specialty registrars from nine deaneries across the UK and 81 dermatology, rheumatology and infectious disease specialty registrars from the London deanery completed the survey. Only 11% of first year neurology and 21% of first year non-neurology registrars reported that the most common method of supervision when seeing ward referrals was for consultants to see ward referrals with them. The remaining first year neurology and non-neurology registrars reported being primarily supervised by discussing cases with consultant (62% and 37% respectively) or being asked to contact a consultant if help was needed (35% and 42% respectively). The lack of adequate supervision of junior trainees seeing ward referrals has significant implications for both patient safety and training.

KEYWORDS: Training, neurology, supervision, ward referrals

Introduction

The supervision of specialty registrars by consultants in the UK has become more formalised in recent years, with the introduction of annual appraisals of training and workplace-based assessments.¹ Specialities in which procedures such as surgical operations, colonoscopies and coronary angiograms form an important part of training are more straightforward than the supervision of some medical disciplines. How to optimise the supervision of ward rounds, outpatient clinics and inpatient ward referrals has received less attention.

In major medical specialties such as cardiology, chest medicine and gastroenterology, patients are usually transferred to the care of relevant specialists. However, most

patients in neurology remain under the care of non-specialist teams, with neurological input provided by a visit from a consultant or specialty registrar in the process we refer to as 'ward referrals'. Other medical specialties that operate a similar model of service include rheumatology, dermatology and infectious diseases.

The main aim of this study was to investigate the nature of consultant supervision reported by neurology specialty registrars seeing ward referrals. The second aim was to compare the supervision of neurology specialty registrars with the three comparable specialties named above.

Method

We used a short, single-sheet questionnaire (Box 1) containing 12 questions in order to ascertain the nature of supervision of trainees:

- > Questions 1–5 were demographic in nature, ascertaining the year of training and the number and location of referrals seen per week.
- > Questions 6–11 were aimed at assessing the nature of consultant supervision.
- > Question 12 invited open comments.

The questionnaire was handed out anonymously at regional training days for neurology specialty registrars in a total of seven centres throughout the UK, including Scotland and Wales. Only specialty registrars with a national training number (NTN) who saw ward referrals in 2010 and 2011 took part in this study. In the second part of the study, the same questionnaire was handed out in a similar fashion at a single regional training meeting in rheumatology, dermatology and infectious diseases in London.

Results

Table 1 contains the demographic breakdown of completed questionnaires among neurology and non-neurology specialty trainees. Table 2 summarises the results across all neurology trainees and non-neurology trainees.

Neurology trainees

A total of 123 neurology specialty registrars completed the questionnaire (about 50% of all registered neurology specialty

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Box 1. Questionnaire: how are neurology trainees supervised when doing inpatient ward referrals: a trainee audit.

We would be immensely grateful if you could take a couple of minutes to fill in this *short* and *anonymous* questionnaire, regarding your experiences and thoughts on ward referrals.

1 Are you doing ward referrals this year (2011)?

Yes No

If YES, base the remainder of your answers on your experience in 2011

2 If NO, did you do ward referrals in 2010?

Yes No

If YES, base the remainder of your answers on your experiences in 2010. If NO, stop here.

3 What training year are you?

1 2 3 4 5

4 Where are you carrying out ward referrals?

District general hospital Regional neuroscience centre Both

5 How many ward referrals do you see on average per week?

1–2 3–4 >4

6 What is the most common way in which consultants supervise ward referrals with you?

See with you Discuss but not see Ask you to contact if help needed

7 How many unsupervised referrals do you see (ie consultant does not see case)?

Many Some Few None

8 How often do consultants see each patient with you on the same day?

Always Usually Sometimes Rarely Never

9 How often do consultants write their opinion after yours?

Always Usually Sometimes Rarely Never

10 Have you ever filled in a mini-CEX after doing a ward referral?

Yes No

11 How would you ideally like consultants to supervise referrals for your stage of training?

See with you Discuss with you Be contacted if you want help

12 Please comment on your experience of ward referrals, how they are currently used and how they could best be used in training and education. Please email any additional comments to ward.referrals.audit@gmail.com

mini-CEX = mini clinical evaluation exercises.

registrars in training in the UK), with a return rate of 87% (Table 2). The response rates were skewed towards junior trainees, with 57% being in their first or second year of training and 43% in years 3, 4 or 5. Seventy-five per cent reported that they were seeing four or more ward referrals per week. Only 20% of respondents reported seeing referrals only in a district general hospital.

The main aim of the study was to assess how neurology consultants supervise trainees seeing ward referrals, with particular interest in the responses from the most junior – year 1 and 2 – trainees. We therefore asked four separate but related questions to ascertain the degree of supervision provided:

- 1 What is the most common way in which consultants supervise ward referrals with you?
 - > 7% responded 'see with consultant'
 - > 51% 'discuss but not see'
 - > 46% 'contact if help needed'
 - > among first-year specialty trainees, the figures were not significantly different (Fig 1).

- 2 How many unsupervised referrals do you see (consultant does not see case)?

- > 63% said 'many'
- > 30% 'some'
- > 7% 'few' or 'none'
- > results for first-year specialty trainees were similar.

- 3 How often do consultants see each patient with you on the same day?

- > 9% said 'always' or 'usually'
- > 37% 'sometimes'
- > 57% 'rarely' or 'never'
- > figures for first-year specialty registrars again were similar.

Overall, the results for questions 1–3 showed that first-year trainees were not more closely supervised than their more senior colleagues.

- 4 How often do consultants write their opinion after yours?

- > 13% replied 'always' or 'usually'
- > 26% 'sometimes'
- > 62% 'rarely' or 'never'.

Table 1. Questionnaire response and eligibility rates across deanery training days.

	No of forms		No of trainees with NTN	Forms completed by NTN holders (%)
	Distributed	Returned		
Location of neurology trainees				
Cambridge	19	10	10	53
East Midlands	13	11	10	77
London	35	31	29	83
North East England	13	11	10	77
North West England	14	13	13	93
Scotland	14	14	14	100
Severn	15	15	14	93
Wales	9	9	9	100
West Midlands	17	16	14	82
Total	149	130	123	95
Non-neurology specialties				
Dermatology	30	30	29	97
Infectious disease	55	30	28	51
Rheumatology	26	26	24	92
Total	111	86	81	94
NTN = national training number.				

NTN = national training number.

The attitude of trainees on their preferred method of supervision was also explored. They were asked: 'How would you ideally like consultants to supervise referrals for your stage of training?'

- > 33% wanted to 'see patients with consultants'
- > 54% preferred to 'discuss but not see patients with consultants'
- > 19% preferred to 'ask for help if needed'
- > among first-year specialty trainees, 57% stated their preferred supervision was for consultants to discuss but not actually see patients with them.

Work-based assessments in the form of mini clinical evaluation exercises (mini-CEX) based on ward referrals were only reported to be carried out by 54% of all trainees.

Non-neurology trainees

A total of 81 eligible non-neurology specialty registrars completed the same questionnaire, with a return rate of 77% (see Table 2). Table 2 shows the combined results from all 81 trainees (29 rheumatology, 28 infectious diseases and 24 dermatology). The results for first-year specialty trainees were the similar to the overall results shown in Table 2 (see Fig 1).

Open comments by trainees

When trainees were asked their thoughts and ideas on ward referrals, 46 responded out of a total of 204 (response rate 25%, including 21% of neurology trainees and 26% of non-neurology trainees). Only four of the 46 responders expressed satisfaction with the current level of supervision. Representative comments are given below:

- > 'Consultants should review, I feel unsupervised.'
- > 'Referrals are never consultant's priority and therefore get neglected.'

- > 'Perhaps we should have a scheduled time to see ward referrals with consultants.'
- > 'Variable, different consultants do things differently, some want to see everything, others do not want to be contacted.'
- > 'Never felt unsupported in 4 years.'

Discussion

The inescapable result from this study is that significant numbers of trainees, particularly first-year trainees regardless of specialty, report that they are regularly seeing large numbers of patients as ward referrals, who are not reviewed by the consultant in the four specialties studied. This finding raises two separate issues: the first relates to patient care and the second to training.

It is no longer acceptable to send a new surgical trainee to start an operation and ask them to ring if there is a problem. Surely it is similarly unacceptable in this medical context? A number of studies in the subspecialties surveyed here have shown that consultant oversight of patients improves diagnostic accuracy and the efficient use of finite and appropriate investigations and treatments.²⁻⁴ Other studies have demonstrated that poorly supervised trainees are likely to order unnecessary investigations and recommend inadequate management plans compared to more senior colleagues.⁵

How are trainees to learn if they mostly practice unsupervised? They are at risk of repeating and taking poor or inadequate practices into later years of training. Kilminster *et al* showed that direct supervision of trainees helps them gain clinical skills faster, changes their behaviour more quickly and is associated with improved patient safety and quality of care.⁶ The problem is, in part, summed up by Donald Rumsfeld's famous quote about 'unknown unknowns'. How can trainees ask about and discuss aspects of problems that their level of experience has not allowed

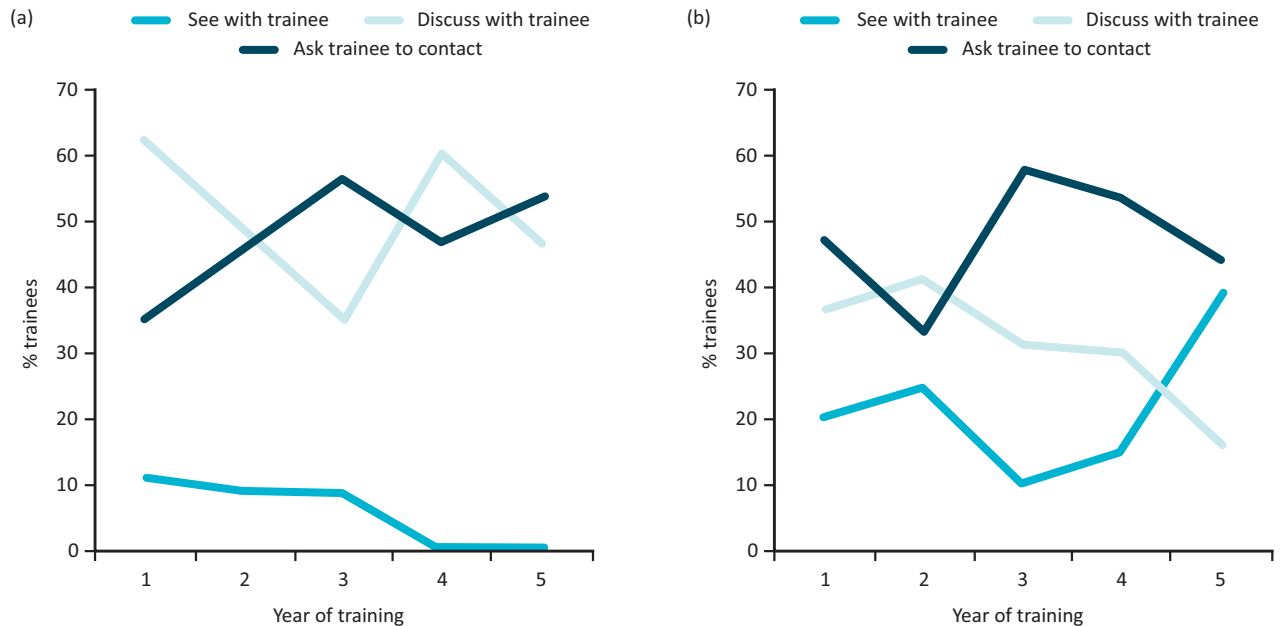


Fig 1. Method of supervision of (a) neurology and (b) non-neurology trainees seeing ward referrals, stratified by year of training.

them to perceive? They can never phone and report what they have not picked up. Studies have shown that diagnostic errors in junior trainees are not directly related to reasoning skills, which tend not to vary with experience.⁷ Rather, inexperienced trainees tend to conduct an incomplete history and examination due to inadequate knowledge of common and uncommon clinical syndromes, particularly atypical presentations of common diseases.⁸ These shortcomings in training are particularly relevant in the current, shortened and fragmented training system. The Temple report (2010) emphasised the need for all potential training opportunities to be exploited.⁹ Clearly, ward referrals represent a missed training opportunity.

Surprisingly, only 55% of the first-year trainees questioned wanted to see referrals with consultants. Considerable evidence suggests that trainee doctors have a tendency to be overconfident and have limited ability to self-assess their competence accurately.¹⁰ An alternative explanation might be that trainee responses reflect a perceived reluctance on the part of the consultants to come when needed.

Our study also shows that consultants very rarely write in the patient notes. This denies trainees the opportunity to learn how to write a succinct summary of their diagnosis and management advice to the referring team. One possible way of improving communication with the patient, the GP and the team looking after the patient is for the consultant to dictate a letter after each ward referral is seen.¹¹

The obstacles to adequate clinical supervision are many, but there seems to be a critical difference between district general hospitals, where neurology consultants see all ward referrals, and teaching hospitals, where they do not. One major problem has been the push to reduce outpatient waiting times with national targets. In many ways, this has been detrimental to providing adequate inpatient services. The solution is probably for teaching hospitals to have a designated consultant responsible for seeing

ward referrals each day. This change would clearly need to be reflected in job plans but would help meet targets for reducing the length of stay and readmission rates.

Ultimately, the potential for serious risk to patients being seen by unsupervised first-year trainees must be addressed nationally by those responsible for patient care and training. This study may help focus attention on this issue, which needs to be discussed by specialty societies and relevant training committees. We believe that junior trainees (foundation years 1 and 2) should generally see all ward referrals before the consultant and then join the consultant to assess the patient together, while more senior trainees should practise with greater independence. Ward referrals might need to become part of the annual review of clinical progress for trainees in order to ensure this actually occurs. In the short term, educational supervisors need to encourage their junior trainees to ask for help more forcefully and as often as they feel they need it, to encourage consultants to write their opinion in the notes, and not to be embarrassed to admit uncertainty.

Strengths and limitations

This study has a number of limitations. The reduced distribution of the questionnaire to non-neurology trainees compared to neurology trainees in one deanery might bias the sample. However, our analysis of the neurology data from the nine deaneries suggests there is very little interdeanery variability with regard to results. Secondly, the completion rates among the neurology and non-neurology trainees who received the form was high, which suggests minimal self-selection bias. We have combined the results from all three non-neurological specialties in order to increase the power of the study, but a greater number of centres would ideally have been used for each of the three non-neurological specialties. It could be that

Table 2. Overall results of questionnaire.

Question	Total trainees (%)	
	Neurology	Non-neurology
Most common method of supervision		
See with trainee	7	22
Discuss but not see	51	31
Ask trainee to contact if help needed	46	48
Number of unsupervised referrals seen (ie, consultant does not see referral)		
Many	63	40
Some	30	25
Few	7	35
None	0	1
How often does consultant review the patient the same day?		
Always	2	2
Usually	7	11
Sometimes	37	48
Rarely	46	37
Never	11	2
How often do consultants write their opinion after the trainee?		
Always	4	3
Usually	9	4
Sometimes	26	27
Rarely	40	57
Never	22	12
How would trainees like consultants to supervise ward referrals?		
See with trainee	33	35
Discuss but not see	54	42
Ask trainee to contact if help needed	19	27
Have trainees ever filled in a mini-CEX after seeing a ward referral?		
Yes	54	31
No	46	69

mini-CEX = mini clinical evaluation exercise.

what trainees report does not reflect what is actually occurring in these hospitals. However, a prospective audit that assessed consultant supervision in one major regional neurological centre from August 2011 to February 2012 reported that only 21% of 183 consultations were seen by a neurology consultant as well as a trainee (unpublished data). For this reason, it is likely that the information reported by trainees in this study is indeed a true reflection of the nature of supervision of ward referrals.

Conclusion

The main result in this study is that most patients seen by first- and second-year trainees in neurology, dermatology, rheumatology and infectious diseases are reportedly not seen by a consultant. This raises potentially serious issues about both

the quality of patient care and the lack of supervision of training of specialty registrars. We hope this study will encourage debate and improve the supervision of trainees seeing referrals. ■

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