'Ready to Reg' – a pilot trial of experiential medical registrar training

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Introduction

Pre-registrar experience of the duty medical registrar (DMR) role is limited to opportunistic encounters, often in under-resourced settings with a rota gap. A previous survey has showed that 44% of core medical trainees (CMTs) feel unprepared to take on the role as DMR.[1] The role is perceived by some early trainees to be 'impossible', requiring 'superhero' skills.[2] Medical registrars and consultants themselves acknowledge the complexity of juggling a high workload, providing leadership and dealing with acutely unwell patients.[3,4] These perceptions and lack of experiential DMR training could contribute to a decline in acute medical specialty recruitment. Further, trainees who eventually take on the role often experience a 'trial by fire', leading to undue stress and anxiety.

The UCLH 'Ready to Reg' programme aims to provide CMTs with hands-on field training as a DMR under direct guidance of another medical registrar.

Methods

This pilot will be trialled between January–March 2019 with voluntary rolling recruitment. CMTs completed online pre-session questionnaires prior to being paired with a registrar. Participation on a particular day excludes CMTs on the acute take, to preserve staffing levels. Participants are provided with pre-session guidelines on conduct as well as suggestions on maximising their experience. During the session, the CMT responds to all DMR referrals, emergency calls and organises the take team, with a registrar present for on-the-spot advice. Post-session questionnaires were completed by CMTs and SPRs to aid reflection as well as obtain feedback.

Results and discussion

Five (20 total) CMT2s have completed a session, with another four signed up to do so (until end March 2019). None of the nine participants have prior DMR experience, and seven indicate worry about taking this on. From the pre-questionnaire, their top three concerns include: urgent decision making (8/9), insufficient medical knowledge (5/9) and intensity of workload (4/9). There was a lack of confidence in their ability to provide good quality advice to referrers with only one respondent feeling moderately confident of doing so.

Full post-programme feedback is not available as the scheme is ongoing. However, preliminary responses indicate that the actual challenges faced did not mirror pre-scheme concerns, especially in terms of medical knowledge and urgent decision making. Confidence in assuming the DMR role has improved, and participants feel that this will improve their first independent DMR shift, especially with delegation. The discrepancy in pre- and post-session concerns is likely because the role of a CMT is vastly different to that of the DMR, and hands-on experience is necessary to understand its requirements. This variance could affect preparation for the role and should be used to inform future local curriculum decisions and training.

Conclusion

Experiential learning is important in training for the DMR role, especially with leadership skills such as delegation. Early supported experiential learning provides better perspective and confidence in tackling the challenges of the DMR role. This could lead to better recruitment to acute medical specialties and eventually better patient care. ■

References

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