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VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Supervision and clinical autonomy for junior doctors—have we gone too far?

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Doctors in training grades can gain experience ranging from independent, lightly supervised practice to a more constant, "helicopter" presence of consultants directing most decisions.[1] Is the current balance right, or has it tipped too far towards the hands-on boss?

Helping junior doctors to feel ready for more senior, unsupervised roles as they ascend the training ladder means allowing them to work more in difficult scenarios involving team leadership, autonomy, and risk acceptance.[2] If opportunities to step up are limited, the lack of opportunity becomes self reinforcing as doctors lack the confidence to take on more senior roles.

In adult internal medicine specialties, surveys have shown that doctors are very concerned about their capacity to take on medical registrar roles. This isn't just because of the punishing workload but also because they don't feel ready to take on these roles.[3 4] In structured surveys of pre-registrar training grades, junior doctors report a surfeit of supervision and a lack of autonomy as key concerns.[5 6]

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In turn, medical registrars approaching consultant status have said in surveys that they don't get enough chance to lead and make decisions, while also being so overworked that they can feel like "clerking machines" rather than team leaders.[7 8] This is partly because of a constant focus on "senior decision makers" being present seven days a week and well into the evening. At the same time, endemic rota gaps mean that doctors of all grades often have to cross cover or "act down." This deprives them of experience at the top of their current grade.

Paradoxically, we often leave very junior doctors to cover large ward bases out of hours.[9 10] We also leave doctors on the medical take, especially overnight, feeling overwhelmed by the volume of work.

There's always a balance between service provision and training. The NHS, more than many systems, relies on junior doctors for service, although knowledge gained by experience is a key component of training. Providing safe, effective health services that reassure the public and meet current system imperatives leads to a call for ever more hands-on and visible senior doctors, seven days a week, well into the evening. I can't imagine a return to the situation earlier in my career when junior trainees ran large chunks of the acute take with consultants there only for a morning post-take ward round, when consultants came around wards only twice a week, and where registrars ran whole wards or units alone during holiday periods.

We now have higher pressure on acute beds, a higher acuity and complexity of patients, and (rightly) a more focused approach to patient safety. National guidance on improving patient flow focuses heavily on senior decision makers at the hospital front door and on constantly reviewing and updating decisions for ward patients.[11] In numerous case studies such approaches have delivered benefits for patients and systems.

The Care Quality Commission looks specifically for evidence of regular consultant review. And the national push for seven day services was linked to the Academy of Medical Royal Colleges' set of standards on early and weekend consultant review,[12] with the Department of Health pushing the cause further by publishing snapshot surveys against those standards.[13]

In our current approach we're doing ostensibly the right thing by systems, patients, regulators, politicians, and professional guidelines. My question is whether this inadvertently harms confidence among future consultants and worsens current junior doctors' training and morale. If so, how can we adjust our approaches to regain some balance between these imperatives? I have no easy answers.

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