Self-perceived preparedness of the new UK palliative medicine consultants: A survey of clinical and non-clinical preparedness after higher specialty training

Title Page

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Author contributions

Dr Sarika Hanchanale- Project lead. Project idea, survey planning, wrote protocol and ethics application. Data collected and analysed. Wrote manuscript.

Dr Amara Nwosu- Contributed to designing survey questionnaire. Edited protocol and manuscript, agreed with the final draft.

Dr Jason Boland- Supported the project throughout. Helped in writing Protocol and Ethics application. Submitted Ethics application. Contributed to designing the survey questionnaire. Edited manuscript and agreed with the final draft.

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Abstract

Objectives: Higher Specialty trainees are expected to achieve clinical and non-clinical skills during training in preparation for a consultant role. However, evidence from many specialties from different countries suggests that new consultants are less prepared in non-clinical skills. The transition from trainee to a consultant phase can be challenging. The study aims to identify if new United Kingdom (UK) Palliative Medicine consultants, within five years of their appointment, feel prepared in clinical and non-clinical skills after completing specialty training and understand the support available for them.

Method: An online survey, designed using previous literature, was distributed via the Association for Palliative Medicine email and social media. Five-point Likert scales and drop-down options to record preparedness were used. Ethics approval was obtained.

Results: Forty-four participants from different UK regions completed the survey; 80% were female. The majority felt very/extremely prepared in audit (84%), clinical skills (71%), interaction with colleagues (70%). Majority moderate preparation was Human Resources (50%), organisation structure (68%) and leadership (52%). Most were not at all or slightly prepared in financial management (70%) and in complaint management (43%). The majority (75%) reported departmental colleagues gave the most support in stressful situations but almost 49% didn't have formal support.

Conclusion: New Palliative Medicine consultants require support with some non-clinical roles such as management of complaints and finances. This is consistent with findings from other specialties. New consultants would benefit from formal support. Future research could focus on how trainees could be supported to gain more experience in non-clinical domains.

Key words: consultant, trainee, postgraduate medical training, preparedness

Key statements

What is already known about the topic?

- New consultants in non-palliative medicine specialties are better prepared in clinical areas and less prepared in management areas.
- Self-perceived preparedness of new palliative medicine consultants after completing higher specialty training in the UK is not known.
- Mentorship can be helpful for the new non-palliative medicine consultants during a challenging transition phase.

What this paper adds?

- New UK palliative medicine consultants feel prepared clinically but less prepared in financial management and complaint handling.
- Most felt well prepared in audit and time-management.
- Support from departmental colleagues is very helpful; however, only few were offered formal support.

Implications for practice, theory or policy

- New palliative care consultants may require further practical experience in management and governance in the first few years of their job.
- Research to explore what formal mentor support could work for new consultants should be offered.
- Further research is needed to assess the impact of ‘Shape of Training’ on preparedness of new palliative medicine consultants (UK).

Background

Higher Specialty trainees are expected to achieve clinical and non-clinical skills during training in preparation for a consultant role. In the UK, after graduation, doctors undergo several stages of training before becoming a consultant. They complete two years of foundation training followed by core training to achieve basic skills. To achieve further skills in a particular specialty, they undergo higher specialty training in disciplines, such as Palliative Medicine (1, 2). During the higher specialty training, trainees are expected to achieve curriculum based clinical skills such as complex symptom management and non-clinical competencies, such as leadership and management skills (3). This leads to achievement of Certificate of Completion of Training (CCT) to enable them to practise as consultants (UK) (4). Significant changes have occurred in UK post-graduate training in the last twenty years, with increased incorporation of non-clinical domains in medical education and training (5-7). These new changes, recommended by Shape of Training review, have been integrated into the new specialty palliative medicine training curriculum (8).

Along with clinical responsibilities, there is a wider expectation from consultants to actively participate in managerial and educational activities such as service planning, writing business case, financial management, and staff management (9). However, lack of training or experience in management and leadership seems to be the consistent theme coming out of several studies (10-12). Similarly, a survey (10) of new oncologists, concluded that the training prepared them in clinical skills but there was no appreciable improvement in the non-clinical skills like research, leadership, and management. Westerman et al study (13) compared the preparedness of new consultants from different specialties and two different countries; Denmark and the Netherlands and found that new Dutch consultants felt less prepared than Danish consultants in management. (10, 11). However, transition from trainee to a consultant phase can be challenging and can have an impact on perceived preparedness (10, 14).

The last study on preparedness of new UK palliative medicine consultants and year 3 and 4 trainees was published in 2006 (15). Since then, there has been change in the curriculum.

Aim:

This study aimed to identify if UK palliative medicine consultants, who were within five years of completing higher specialist training, felt sufficiently prepared to manage the clinical and various non-clinical domains of their role. We also aimed to understand the support available for the new consultants in this transition period. Understanding of perceived preparedness can help educators and policy makers to develop or modify education strategies for trainees.

Method and design:

An online survey (Qualtrics) of the new UK palliative medicine consultants was conducted between 12th September- 25th October 2022.

Survey development: The literature was searched using various databases with a question 'Do the new consultants feel prepared in clinical and non-clinical domains after completing specialty training?'. The findings of the literature helped to design the survey questionnaire. Literature review was done as a part of MSc Project. The literature highlighted multiple studies in multiple specialties. No recent study in this area was identified in palliative medicine in the UK. The survey questionnaire was developed based on the previous studies and the Palliative Medicine specialty curriculum (2010) (16). We used Qualtrics to develop the electronic survey. The survey included of a five-point Likert scale, which participants used to score their perceived level of preparedness. We piloted the survey prior to its use with the authors and consultants from other specialities, with improvements made following feedback, to ensure the survey was clear and easy to use.

Participants: New Palliative Medicine consultants who have completed higher specialty training in palliative medicine in the UK, within five years, were eligible to participate. This group was selected as they could reflect on the needs of the new consultants and the experience needed during higher specialty training. We anticipated 150 consultants would have been appointed in a post in the last five years (17) . We expected around 30% response rate: 40-50 responses (18).

Distribution: The survey was distributed to palliative medicine consultants in the UK via the Association for Palliative Medicine (APM) email with weblink. A reminder

email was sent after two weeks and the survey was closed after six weeks. The survey was also distributed via APM Twitter account. Participant Information Sheet was included in the survey for more information (Appendix 1).

Survey: The survey was anonymous, voluntary and consent was required. Participants were asked to provide information about the following (Appendix 2)

- Demographic information
- New consultant post information
- Clinical and management preparedness
- Clinical governance and supervision preparedness
- Mentor/support

Data collection and analysis:

All data was entered in an excel spreadsheet for analysis. Quantitative data was in the form of Likert scale 1-5 (preparedness level 1-not at all prepared and 5-extermely prepared). Some data was collected for some questions as drop-down answers. We used frequency analysis to establish the pattern in the data. The quantitative data was analysed using excel equation functions. Cross tabulation was used to find the relationship between the variables. We compared the preparation in different management and governance areas if acted up as a consultant/locum with those not taken up those roles to see if such roles improved preparation. Excel function was used to calculate the standard deviation of different variables. T-test was used to calculate p-values; $p<0.05$ was significant.

Ethics approval of this study was obtained from Hull York Medical School (21-22 50) (Appendix 3).

Results

There were a total 93 responses; 44 respondents answered all the survey questions and that data was analysed. The remaining answered only some demographic questions, so that data was not included. Demographic data of the respondents is shown in table 1.

Table 1. Demographic data of the respondents

Characteristics with number of respondents
Age
31-35 years-13
36-40 years-27
41-45 years- 4
46-50 years- 3
Gender
Female - 34
Male-9
Prefer not to say-1
Years as a Palliative Medicine consultant
<1 year- 8
1 year - 9
2 year- 8
3 years- 11
4 years- 7
5 years- 1
Setting
Community- 6
Hospice- 6
Hospital - 8
Multiple setting-24

Work contract % of Whole Time Equivalent (WTE)

100%- 12

90% - 4

80% - 14

70% - 7

60%- 6

Other-1 (125%)

Worked as a specialty doctor/middle grade before Higher Specialty Training

Not worked as a specialty doctor-21

Worked for < 1 year- 8

Worked for one year-10

Worked for 2 years- 1

3 years- 1

Other-3

- worked as middle grade for 10 years
- GP
- Held a LAT post for 22 months and counted 18 months to training

Acting up a consultant role or locum consultant role before starting a substantive post

Did not take any role-28

Acting up consultant- 8

Locum consultant- 7

Other- 1

- Acted up then did a locum post before taking on substantive role

We received responses from various regions in the UK as shown the figure 1.

Figure 1: Responses from different regions in the UK

Local induction: 82% received local induction. of those who received an induction, 13% found it extremely useful and 30% very useful.

Acting up consultant or locum consultant: 36% took a role of acting up consultant or locum consultant and majority found it extremely (63%) or very (6%) useful in preparing them for a consultant role.

Clinical preparedness: Almost 70% respondents felt clinically very or extremely prepared (mean 3.81/5).

Management experience (Figure 2)

Figure 2: Level of perceived preparedness of new consultants in various management areas

Majority show moderate preparation in Human Resources (HR), Information management, resource management, leadership and organisation structure as in Figure 2. Self and time management are very/extremely prepared domains (64%). In contrast, most (70%) are slightly/not at all prepared in financial management.

Most found combination of learning events most useful to gain management experience; management and leadership course and attendance at management meetings were found most useful to gain management experience. Table 2 shows mean of Likert scale score of perceived management preparation for different domains.

Table 2- Level of perceived management preparation of new consultants (mean of Likert score 1-5)

Management domains	**Mean (**Likert scale 1-5)
Human Resources	2.59
Time management	3.59
Information management	3.23
Resource management	2.75
Financial management	2.19
Leadership	3.37
Organisation structure	2.93
Self-management	3.61

Clinical Governance (Figure 3)

Only 7% respondents felt very/extremely prepared for complaint management but 84% were very/extremely prepared for audit as explained in figure 3. 34% respondents felt very/extremely prepared in Quality and safety and 31% in research. Table 3 shows mean of Likert scale score of perceived governance preparation for different domains.

Figure 3: Level of perceived preparedness of new consultants in various governance areas

Table 3- Level of perceived governance preparation of new consultants (mean of Likert score)

Governance domains	**Mean (Likert scale 1-5)**
Complaint management	2.55
Audit	4.07
Quality and Safety	3.35
Research	3.09

Educational supervision: 43% had the responsibility of being an educational supervisor; 70% of them felt moderately and extremely prepared for the role.

Formal support: Formal support was not provided to 48.83% respondents. Those who were provided formal support, 72% found it either extremely or very helpful and found most support in stressful situation from departmental colleagues. Almost 89% had a senior consultant colleague when appointed as a consultant and 85% of them found them very/extremely helpful in new role.

Formal course attendance: To improve skills as a new consultant, nearly 48% respondents attended a formal course, out of which 57% attended Royal College of Physicians courses e.g. RCP New Consultants Course

Skills to interact with other colleagues: 70% felt very/extremely prepared in skill to interact with other colleagues.

Discussion:

To our knowledge, this is the first survey in the last 15 years to specifically assess the perceived preparedness of new palliative medicine consultants in the UK. This is extremely important as new consultants' preparedness can have an impact on the workforce and delivery of healthcare. This study found that the majority of new palliative medicine consultants felt clinically well prepared. The other areas of very well perceived preparations are audit, time & self-management and interaction with colleagues. The majority of new palliative medicine consultants felt less prepared in some areas of management (financial management) and governance (complaint management). Though some respondents found experience as an acting up consultant or locum consultant quite helpful, there was no statistically significant difference in perceived preparedness in clinical and non-clinical domains. The other important finding of this study is that the majority of new consultants found support from the departmental colleagues very helpful.

The previous study (15) surveyed Palliative Medicine consultants within five years of appointment and 3rd and 4th Year Specialist Registrars to identify training needs. (15) Since then, there has been change in palliative medicine curriculum. Our study found that the majority of new palliative medicine consultants felt clinically well prepared and this is consistent with studies from different specialties (11, 12, 19, 20). Along with clinical duties, consultants are expected to be involved in the financial aspect of the service to provide cost-effective and high-quality service (9). Some of the Palliative Medicine consultants start working in an independent organisation (hospice) and it's very important for them to have a knowledge and experience of management. However, most new consultants feel unprepared in financial management like other specialties (10-12, 19-22). During specialty training, experience in financial management can vary from one organisation to another (13). Many recommendations have been made by various studies on how non-clinical skills can be achieved during specialty training (11, 19-22). Though attendance at formal management and leadership courses was found helpful by most respondents, practical experience is also essential to get hands on management experience as more experience makes them more prepared (11).

Some UK studies (11, 19, 20) show that most new consultants felt prepared for a leadership role. (10). Similarly, our study shows that majority felt moderately/extremely/very prepared for leadership. This could be the result of recent attention on ‘doctors being leaders’ in healthcare (5, 23, 24).

Similar to multispecialty study (UK) of the new consultants (12), majority Palliative Medicine consultants felt well prepared for ‘audit’ suggests that trainees receive a good experience in audit or quality improvement project during their specialty training to fulfil the curriculum objectives. In contrast, complaint handling was one of the least prepared areas in our survey. Some studies which assessed preparedness for complaint handling showed around 50% felt unprepared for managing complaints (11, 25). The interview of new geriatricians reported complaint handling as a stressful task (22). Some practical training is required in this area during training. In contrast to Kite et al (15), in our survey, majority were very/extremely felt prepared in their skill to interact with other colleagues showing improvement in this area of training.

The transition phase can be quite challenging and having a mentor or a consultant colleagues can be very helpful for the new consultants to develop those skills. Though most find the support from departmental colleagues very helpful, some might require formal support as evidence suggests that one-third of palliative medicine consultants could be at risk of burnout (26). The mixed-method and interview studies concluded that new consultants find informal support mechanisms very helpful during the transition (11, 19, 20, 22). Flavell et al (11) mentioned that support and opportunity from senior members of the team can be positively associated with the perceived feeling of readiness in non-clinical areas (10, 20), Kite et al had (15) suggested ongoing support for new consultants from employer to thrive and avoid burnout and the respondents of our survey felt the departmental colleagues supportive during challenging situations. However, almost 49% respondents did not have any formal support when started in a consultant post. Establishing an organisational culture of mentorship can help support new palliative medicine consultants to go through a challenging transition phase. (27). This in turn lead to improved job satisfaction, less burn-out and improved quality of care (28).

Postgraduate medical education is multi-faceted and trainees are required to achieve competencies not just in clinical setting but in different dynamic settings which can impact their learning (29). Trainees learn with experience but at the same time they need guidance on how objectives can be achieved; support from educators and policy makers is required for this. Though trainees achieve their curriculum objectives before becoming a consultant, they still feel unprepared in certain non-clinical skills. Perhaps, it is likely their learning journey continues even after completing training and as per Kolb's cycle of experiential learning (30), doctors keep learning throughout their career, changing their experience into abstract conceptualisation.

Strengths and limitations of this study:

This is the first study conducted in the last 15 years to identify the preparedness of new Palliative Medicine consultants in the UK. It is estimated that approximately 150 palliative medicine consultants have been appointed in the last five years (17). It might not have been possible to reach all the new consultants as not all of them are APM members. We tried to mitigate these factors by posting the survey via APM Twitter. The low response rate could affect the transferability of findings but importantly we had representation from almost all UK regions.

There might be regional difference in preparedness which we did not investigate due to small sample size. We do not know how much experience someone had in a different speciality/professional role which could also have an impact on preparedness. As some consultants were more experienced and due to recall bias, there might be an impact on their response to perceived preparedness. Also, self-perceived preparedness is subjective and could be different from actual preparedness but it can still help in forming personal development plan.

Future research: Future research should identify how trainees could be supported in gaining more experience in non-clinical domains of training, especially with changes to speciality training; 'Shape of training' (31). Future research could also look at the difference or relationship between perceived preparedness and actual

performance. A qualitative study will help to identify how new consultants develop their skills and be best supported with this. Once we have more information on the reasons behind unpreparedness of new consultants in non-clinical skills, a change model theory (32), could be used for mapping education interventions around non-clinical domains.

Conclusion

New Palliative Medicine consultants feel better prepared clinically, in audit, time and self- management but they are likely to require support with some non-clinical aspects of their role, such as management of complaints and finances. Though most find the support from departmental colleagues very helpful, formal support could be beneficial. Future research should identify how trainees should be supported in these areas, especially with changes to speciality training; ‘Shape of training’.

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Figure legends

Figure 1: Responses from different regions in the UK

This graph shows the number of survey responses from different regions in the UK. The regions were identified as training regions in the UK. It shows representation from various deaneries.

Figure 2: Level of preparedness of new consultants in various management areas

This graph is based on the Likert scores (1 not at all-5 extremely) of preparedness. It explains the percentage of respondents' preparedness in various management areas ranging from not all prepared to extremely prepared.

*mx-management

*HR-Human Resources

Figure 3: Level of preparedness of new consultants in various governance areas

This graph is based on the Likert scores (1 not at all-5 extremely) of preparedness. It explains the percentage of respondents' preparedness in various clinical governance areas ranging from not all prepared to extremely prepared.

*mx-management