J R Coll Physicians Edinb 2017; 47: 70–75 | doi: 10.4997/JRCPE.2017.116 **PAPER**

# Being the 'med reg': an exploration of junior doctors' perceptions of the medical registrar role

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**Abstract**

**The role of the medical registrar is challenging and acknowledged as being a disincentive to a career in medicine for some junior doctors. We set out to build a broader understanding of the role through exploration of Foundation Doctors' and Core Medical Trainees' perceptions of the role. Data, gathered from focus groups, were analysed using a framework approach. Six key themes were identified, which were grouped under the headings 'perceptions of the medical registrar role' and 'transition into the role'. Our work builds on existing literature to inform a deeper understanding of how junior doctors perceive the medical registrar role. In light of our findings we offer suggestions on possible training initiatives to tackle the issues identified. We also highlight positive perceptions of the role and emphasise the key ambassadorial role that current medical registrars have in relation to attracting tomorrow's medical registrars to the specialty.**

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## Introduction

The medical registrar is the senior training grade for future hospital consultants in medicine in the UK and is recognised as a challenging role.[1] In recent surveys of medical registrars, almost a third had considered giving up general internal medicine training during the preceding six months and over a quarter found their workload unmanageable.[2] A total of 78% of Foundation Year 2 doctors and 74.3% of Core Medical Trainees (CMTs) (more junior medical trainees) cited the role as a disincentive to a career in internal (general) medicine.[2] There is concern among CMTs that their training does not adequately prepare them for the role of medical registrar,[3] which may be contributing to falling fill rates for CMT posts (2015: 87%; 2016: 78%).[4] Initiatives coordinated by the Royal College of Physicians and the Joint Royal College of Physicians Training Board are underway to improve the CMT experience.[5,6] Recent research, drawing on focus groups of current medical registrars, has facilitated a deeper understanding of their working experience.[7] We set out to build a broader understanding by describing the workplace experiences of Foundation Year (FY) doctors and CMTs and exploring their perceptions of the medical registrar role.[8]

## Methods

### Theoretical Stance

The phenomenon of interest in this study (junior doctors' perceptions about the medical registrar) lies within the realm of subjectivity; there is no 'one ultimate truth' for all junior doctors.[9] Therefore, an interpretive phenomological approach seeking to describe, understand and interpret experiences and views of participants[10] was employed, drawing on focus groups for data collection.

### Recruitment

NHS Newcastle and North Tyneside Regional Ethics Committee was consulted and advised no formal ethical approval was required. An email invitation to participate was sent to all delegates registered to attend the 2015 Geriatrics for Juniors conference, an annual educational event for junior doctors considering a career in geriatric medicine. Recruitment was restricted to FY and CMT delegates. Delegates expressing interest were sent further details about the project and approached again during conference registration to invite them to participate in focus groups held after the conference. Focus groups were limited to a maximum of 12 participants on a first-come, first-served basis, since groups exceeding this size have a tendency to fragment.[11] The composition of the focus groups is outlined in Table 1.

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**Table 1.** Focus group participants

| Focus Groups | | | | | |
|---|---|---|---|---|---|
| **Foundation Doctors** | | | **Core Medical Trainees** | | |
| Number | Grade | Gender | Number | Grade | Gender |
| 1 | FY1 | Male | 1 | CT2 | Female |
| 2 | FY1 | Female | 2 | CT2 | Female |
| 3 | FY2 | Female | 3 | CT2 | Female |
| 4 | Post-FY2 | Female | 4 | CT1 | Male |
| 5 | FY2 | Female | 5 | CT1 | Male |
| 6 | FY1 | Female | 6 | CT2 | Female |
| 7 | FY2 | Female | 7 | TF | Female |
| 8 | FY1 | Male | 8 | BBT | Female |
| 9 | FY1 | Female | 9 | TF | Female |
| | | | 10 | CT2 | Male |
| | | | 11 | CT1 | Female |
| | | | 12 | CT2 | Male |

Post-FY2, Completed Foundation Programme and now in non-training post; BBT, Broad-based Training; TF, Teaching Fellow

### Data collection

The focus groups were guided by a semi-structured interview schedule developed from previous research undertaken about the role of the medical registrar.[2,3,12] Questions were designed to be open-ended to facilitate free discussion. Participants were divided into two focus groups based on current level of training, since perceived hierarchies within groups can inhibit free discussion.[11] Each focus group was moderated by an experienced qualitative researcher. A second researcher, positioned outside the group, acted as observer and made notes on verbal and non-verbal interactions between participants. After focus groups were complete, the moderator and observer collated notes on their observations. All participants provided informed, written consent and were aware audio recordings were being made. All were given a book token to acknowledge their contribution

### Analysis

Focus groups were recorded using digital dictation equipment with subsequent transcription. An inductive, iterative approach to analysis involved three phases. The first involved moderators and observers working in isolation to review the transcript of the focus group they had supported. Transcripts were analysed for emerging themes that articulated the concepts and meanings of the main issues. The second phase involved researchers, working in the pairs in which they had facilitated each focus group, meeting to compare their individual notes. Themes were discussed, challenged and refined. An iterative process of repeated reading and discussion of transcripts over multiple meetings was undertaken until consensus was reached. A framework approach[13] was employed by each pair to assist with interpretation. This involved organising data into a matrix, where quotes were arranged by participants (rows) and by theme (columns) to facilitate exploratory analysis. The final phase involved all four researchers meeting to compare the themes identified from the FY and CMT groups. A further process of iterative discussion, challenging and refining the thematic framework was undertaken over several meetings until consensus was reached.

## Results

Six key themes were identified, which were grouped under the headings 'perceptions of the medical registrar role' and 'transition into the role' (Figure 1).

### Perceptions of the medical registrar role

#### 'Superhero'

The medical registrar role was considered extremely challenging, to the point of almost being impossible, and was even described as 'super-human':

*'Expected to know everything about every single patient, to be able to do everything for every single patient, and to be in ten places at once' [FY8]*

*'It was like looking up to 'Superman' because it's essentially every single thing that goes through the registrar' [CMT10]*

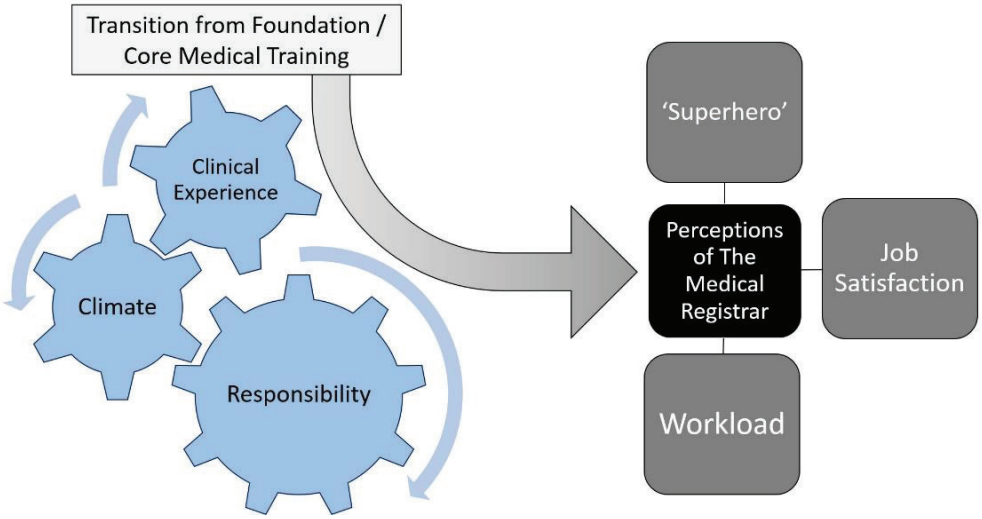
Underpinning this were beliefs about the breadth and depth of medical registrars' knowledge and that the pathway to achieving such knowledge was difficult to conceptualise:

*'It is engrained in my head – the med reg knows everything' [FY4]*

*'As an FY1 you just can't imagine ever knowing that much' [FY7]*

This perception was more prevalent in the (more junior) FY focus group, while the CMT group described a more measured understanding of the medical registrar role:

**Figure 1** Themes relating to the transition into the medical registrar role (left) and themes relating to perceptions of the medical registrar role (right)




*'I've accepted that I'm not going to know everything – there's certain things, clinical scenarios, that you'll come across and you'll deal with it' [CMT1]*

More senior participants described a support network for medical registrars including help from consultant colleagues and registrar peers. Seeing medical registrars ask for help and witnessing their fallibility appeared to be transformative:

*'Seeing them get something wrong, seeing them make their own mistakes and have to ask for help, does make you see them as human' [CMT8]*

### Workload

A strong theme that emerged was that medical registrars faced an overwhelming volume of work:

*'Constant bleeps, all of the time' [FY8]*

*'There is not enough (of them)…they have to cover the whole hospital by themselves' [FY5]*

This appeared to be a powerful deterring factor in consideration of the role as a career option:

*Moderator: 'What makes you question whether you could do the role?'*

*Participant: 'Workload. Simple as that' [FY5]*

More senior trainees were less concerned with workload; this appeared to be underpinned by development of insight into how registrars manage, primarily through effective delegation. For some though, the need to delegate and to cede a degree of control was worrying:

*'What worries me especially (is) letting go…and having to delegate, because you can't be everywhere' [CMT9]*

### Job satisfaction

Participants said that medical registrars were negative about their job, with high levels of stress, often compounded by poor work/life balance:

*'There's a lot of med regs who are quite negative about the job, because they were stressed, some were living far from their family and children. As an FY1 trying to settle into a new job and seeing that it didn't seem to be getting better, I was thinking, I couldn't be a med reg' [FY2]*

Participants described how this negativity translated into medical registrars with 'split personalities', with disparity between how they interacted with junior colleagues and with patients:

*'We have med regs come to my ward [surgery] and look disgruntled and annoyed that we've called, but when you see them reviewing a patient, it's like they are a different person – they become a doctor again' [FY8]*

There was also disparity between how medical registrars were perceived in different work environments:

*'A reg on their ward job can look quite different to a reg when they are on call' [FY7]*

### Transition into the role

### Responsibility

Medical registrars were viewed as having a key role in supporting less experienced colleagues:

*'They are a kind of safety blanket for juniors' [FY1]*

More junior trainees had a skewed, sometimes inaccurate, understanding of the responsibilities of the medical registrar,

particularly overnight; this appeared to contribute to junior trainees being fearful of the role:

*'My experience of the med reg was they are the person that ran the hospital at night – they were on their own and had the whole hospital, ICU and CCU to look after – I just thought, what a terrifying role' [FY9]*

When overnight on-call shifts were considered, there was a perception that medical registrars were the final step in the support hierarchy with limited peer or senior support:

*'When you're the reg overnight in the hospital, you're the last port of call' [CMT5]*

*'You don't have that other person to confirm things or to get reassurance' [CMT10]*

While some participants described the availability of consultant support via the telephone, they also recognised a reticence to access this support:

*'You do have that consultant, but you're not going to call for every single thing, you don't want to be that registrar who always needs support – I think that's my biggest fear about how I try to make the transition' [CMT10]*

### Clinical experience

Increasing breadth and depth of clinical experience was identified as a key factor in the transition into the medical registrar role. Trainees nearer to making the transition described both specific and more general gaps in their knowledge and experience, but did not always feel empowered to address these:

*'My worry is the things you've not been able to experience during core training. The idea that I'm never going to do a respiratory job before I become a med reg – which seems such a large part of medicine – is fairly terrifying' [CMT5]*

More junior trainees took a different view: gaps in clinical experience often rendered them 'helpless' and hence the idea of being more like their medical registrar colleagues was a motivating factor:

*'One of the frustrations of being a junior doctor is the feeling of being helpless – not having knowledge and skills. I really don't like that feeling – you want to do more…it would be nice to have the skills of a med reg' [FY4]*

Junior trainees had insight that to acquire these skills necessitated working in on-call environments which, while challenging, are rich environments for learning:

*'Most people in medicine are quite geeky – they secretly want more knowledge and skill. The prospect of on-call is really daunting but I imagine just through doing it, that is a way to acquire that knowledge and skills' [FY7]*

More senior trainees demonstrated insight that development of non-technical skills complemented clinical experience and thus was an important part of training; however, some perceived to have had insufficient training in this area:

*'It makes a difference how much time management skills you've got [sic] – that's part of the juggling of med reg-ing isn't it? I don't think we learn that at Foundation level' [CMT6]*

### Climate

Among junior trainees there was negativity in relation to the training experience during the CMT programme:

*'People are saying CMTs are just service providers and (there's) not much training compared to other trainees' [FY2]*

Some CMTs echoed this:

*'There has to be more distinction between CMT and Foundation Training – I don't feel like I am any different from an FY1' [CMT9]*

However, there were positive aspects of the CMT learning environment:

*'Doing CMT alongside them [medical registrars], you see a lot more, you see the times when they are unsure and when they're bouncing ideas off each other' [CMT1]*

It was described that training as a medical registrar was going to be both lengthy and challenging. The difficulties of balancing this role with life outside of work were a recurring issue:

*'How does that fit in with having a family and a normal life? It makes it very difficult – five years is a long time' [CMT3]*

There was evidence of negativity towards the specialty of hospital medicine – for some this was disenfranchising and made them less likely to opt for a career in the field; for some, however, this acted as a powerful motivation:

*'A lot of specialties see medicine as a dumping ground – this is not the way it should work. This is why I want to be a med reg – to change the culture' [CMT12]*

## Discussion

Our work builds on existing literature to inform a deeper understanding of how junior doctors perceive the medical registrar role. The description of the medical registrar as a 'superhero' is an important finding: the belief that a medical registrar must be all-knowing and omnipotent was a powerful deterrent to assuming the mantle. Debunking the 'superhero' myth may represent one way to help make general internal medicine a more realistic career option in the eyes of junior doctors. Periods of explicitly shadowing medical registrars could be considered earlier in training to facilitate first-hand experience of how it is that ordinary people – medical

registrars – cope with high demands in often very mundane and human ways.

Junior doctors identified clear differences between the behaviour of medical registrars when on call compared with when working in their parent specialty. This should serve as a reminder to medical registrars of how role-modelling influences career choices in junior colleagues. Externalising and venting grievances while on call may be affecting junior colleagues in a lasting way. It has been described that perceived lack of approachability can lead to a loss of team perspective[14] and may inhibit escalation of clinical concerns from more junior colleagues.[15] The possibility of pushing junior colleagues away from general internal medicine should also serve to focus colleagues on the important ambassadorial components of their job at the front line of the medical specialties.

Our findings in relation to perceived high workload are concordant with previously published survey work[2] and highlight this as a potent deterrent to becoming the medical registrar. Providing junior doctors with formal training in non-technical skills, such as effective delegation, is key to them developing the confidence and competence in managing high workload. The relevance of training in 'non-technical skills' to modern medicine is increasingly recognised.[16] Simulation focusing on human factors is one possible way to provide training for future medical registrars in this domain.[17]

The role of the medical registrar was perceived as being an isolated one, particularly overnight. Apprehension about being in this situation seems to be a powerful deterrent to junior doctors becoming medical registrars. A cultural expectation that medical trainees should strive to work independently in clinical practice has previously been described.[18] There is potential to use 'to call or not to call' debates, which doctors of all grades frequently grapple with, as a focus for teaching. Consideration should also be given as to what training new and existing consultants receive to enable them to fulfill the role of on-call supervisor.[19]

In addition to exposing junior doctors to the registrar role and providing them with the skills to perform as a registrar earlier in their careers, there are also important considerations about how the medical registrar role is structured. The observations here, about perceived excessive workload, lack of support and levels of dissatisfaction among specialty trainees when faced with the unselected take, support previous observations about the pressures associated with the medical registrar role.[7,20] These should add further impetus to the projects already being undertaken by the Royal Colleges to better support doctors working with the acute take and to establish a better balance of training and service provision when performing within that role.

Our work identified that junior doctors held some positive perceptions in relation to the medical registrar. Possessing the skillset of the medical registrar was something that junior doctors aspired to, particularly when they considered how impotent they at times felt in the face of clinical problems. In addition, a sense of vocation and 'mission' was identified as positive: junior colleagues wanted to be a medical registrar to make a difference as part of a specialty that underpins much of the core working of acute hospitals. It is critical that the positive aspects of the medical registrar role are championed: there is great need to nuture and harness enthusiasm for the specialty, and the power of positive role-modelling from senior colleauges cannot be understated.[21]

### Study strengths and limitations

The use of separate focus groups for participants at different stages of their careers enabled us to compare and contrast perceptions of the medical registrar role at differing levels of seniority. Rich data were obtained and prolonged engagement with this, alongside triangulation between researchers, provided methodological rigour. The main limitation of our work relates to potential biases introduced by the sample. Participants were recruited at a geriatric medicine conference and thus the study reflects the views of doctors interested in one of the more general medical specialties. The views of doctors intending to embark on narrower medical specialties were therefore not heard. However, given the centrality of such trainees to the current and future delivery of acute general medicine[22] their perspectives are crucially important. While we did not seek to achieve representativeness with sampling (in line with phenomenological research principles), the gender distribution of study participants in our work (15 female and 6 male) is comparable to recent estimates of the gender distribution among CMTs (58% female)[3] and geriatric medicine registrars (56.7% female).[12]

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