

## Formal development of teaching skills among hospital consultants

**Sir,**

Professional and higher education reforms have placed greater expectations on busy clinicians for undergraduate medical education. Doctors are accountable for providing structured, learner-centred teaching in a supportive environment (General Medical Council, 1999, 2006). A study was performed to establish whether application of teaching skills and educational accreditation was prevalent among consultants at Walsall Manor Hospital, a teaching trust of the University of Birmingham.

A questionnaire was sent to all 90 consultants, asking whether they held any academic or educational posts within the University or local Deanery, and whether they had any formal training or qualification in medical education. Further questions asked about teaching portfolios, membership of accrediting educational organizations and use of a variety of teaching methods. A total of 40 questionnaires were returned and analysed.

Consultants with less than 10 years' experience were more likely to teach students more than once per week (64% vs 50% with greater than 10 years' experience). Of respondents 85% had no formal teaching qualification and 94.8% were not associated with any educational organization; 92.5% planned their teaching sessions (90% considered learning outcomes), 82.5% evaluated their teaching (using feedback forms (75%), reflective practice (36%) or peer review (15%)) and 29% kept a teaching portfolio. Commonly

used methods were small group tutorials (62.5%) and bedside teaching (60%). Less widely used were lectures (25%), seminars (20%) and e-learning (4%).

The most popular bedside teaching method was the apprenticeship model (used by 50%), 12.5% of respondents delegated ward-based teaching to junior staff but 27.5% did not teach students on ward rounds. Of those who teach in outpatients 75% had a student sit-in but only 3.5% let the student see the patient independently.

A variety of teaching methods are used in inpatient and ambulatory care environments but formal development of consultants' teaching skills is not prevalent, despite their involvement in planning, delivering and evaluation of teaching. The authors aim to test the hypothesis that this does not reflect a lack of enthusiasm, but a conflict in priorities for professional development time and funding.

**Gareth Walters**

*Specialist Registrar in Respiratory Medicine  
West Midlands Rotation*

*Honorary Clinical Lecturer*

*University of Birmingham*

*Birmingham B15 2TT*

**Yi-Yang Ng/Steve Odogwu**

*Clinical Teaching Fellow/Clinical Sub-dean  
Department of Undergraduate Medical  
Education*

*Walsall Manor Hospital*

*Walsall*

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General Medical Council (1999) *The Doctor as Teacher*. General Medical Council, London

General Medical Council (2006) *Good Medical Practice*. General Medical Council, London

## Awareness of do not attempt resuscitation orders guidelines

**Sir,**

Resuscitation decisions carry difficult ethical and legal implications, and guidelines have been issued in the UK (General Medical Council, 2006; British Medical Association et al, 2007). A survey was performed to assess health-care professionals' awareness of the General Medical Council (2006) guidelines in three north

eastern university hospitals. A six-item questionnaire based on the following key points from the guidelines was distributed to around 700 health-care professionals in these hospitals.

1. A DNAR (do not attempt resuscitation) status should be documented for all seriously ill patients and those in very poor health with a foreseeable risk of cardiopulmonary arrest
2. Decisions about DNAR orders are combined decisions taken by the team, led by a consultant/GP in consultation with the patient or those close to them

3. If a competent patient refuses cardiopulmonary resuscitation, the doctor must comply with the patient's request and issue a DNAR order
4. If a competent patient wishes to have cardiopulmonary resuscitation, the doctor should try to comply with this request but he/she is under no obligation to do so if he/she considers it futile
5. The final authority to decide if a patient will not benefit from an attempted resuscitation rests with the consultant or GP in charge
6. A DNAR order has no bearing on any other treatment the patient may need.

A total of 240 completed questionnaires were returned. Only 25% of respondents answered all six questions correctly.

Of respondents 59.2% were unaware that a competent patient could refuse cardiopulmonary resuscitation. Only 64.2% of respondents were aware that if such a patient requests cardiopulmonary resuscitation, doctors were under no obligation to provide it if they think the effort is going to be futile. Approximately one third of respondents did not know that the final authority pertaining to resuscitation rests with the consultant or GP in charge. A significant 10% thought that a patient with a DNAR order is not fit for any operative treatment or intensive care.

This survey showed that health-care professionals' awareness of guidelines on DNAR in these three hospitals is suboptimal. This is likely to reflect the situation in other NHS trusts. Locally delivered formal awareness programmes are recommended.

**M Rookmoneea**

*Core Surgical Trainee*

*Department of Orthopaedics*

**K Mahawar/R Birla/YKS Viswanath**

*Specialist Registrar in General Surgery/ST2*

*in General Surgery/Consultant General and*

*Upper Gastrointestinal Surgeon*

*Department of General Surgery*

*James Cook University Hospital*

*Middlesbrough TS4 3BW*

British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2007) *Decisions relating to cardiopulmonary resuscitation – A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing*. British Medical Association, London: 7

General Medical Council (2006) *Good Medical Practice*. General Medical Council, London ([www.gmc-uk.org/guidance/current/library/withholding\\_lifeprolonging\\_guidance.asp#85](http://www.gmc-uk.org/guidance/current/library/withholding_lifeprolonging_guidance.asp#85) accessed 23 February 2009)