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Original Communication

Training of Assistant Forensic Medical Examiners in London, UK

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ABSTRACT

The overall aim of this pilot study was to evaluate the quality of current practical training in London with a view to improving future training as part of faculty development.

New trainees in clinical forensic medicine (CFM), Assistant Forensic Medical Examiners (AFMEs), were interviewed to gather their views of their recent training experience and to attempt to identify problems with implementing the training as it stands.

An overwhelming theme emerged that there should be a more formal structure to the training of newly appointed FMEs. Each trainee should have a named clinical and educational supervisor during the training period. Furthermore it should be mandatory for educational supervisors to undergo training and review of performance.

1. Background

Doctors training and practicing in the field of clinical forensic medicine (CFM) in London, UK, are working in the independent sector, outside the formal regulation of the National Health Service (NHS). Currently forensic and legal medicine is not recognised as a speciality in the UK. However, good practice suggests that any training programme should be at least as good as that available for doctors working within the NHS. The General Medical Council is clear that doctors should recognise and work within the limits of their competence and keep their knowledge and skills up-to-date being familiar with relevant guidelines.[1]

In July 2008, the Postgraduate Medical Education and Training Board issued guidance on the standards that must be applied when postgraduate medical education and training takes place.[2] This stipulates that trainers must provide a level of supervision appropriate to the competence and experience of the trainee and those trainees should have sufficient practical experience with accessible supervision and regular feedback.

The reference guide for speciality training in the UK, the 'Gold Guide',[3] provides guidance to postgraduate deans and covers all speciality training, including general practice. The Gold Guide requires that each trainee should have a named clinical supervisor for each placement, usually a senior doctor, who is responsible for ensuring that appropriate clinical supervision of the trainee's day-to-day clinical performance occurs at all times, with regular feedback.

For some years prior to January 2009, a doctor wishing to work in the Metropolitan Police area as a forensic medical examiner (FME, forensic physician, FP) shadowed an experienced doctor prior to being interviewed to ensure awareness of the type of work involved. After successful interview the doctor attended the five day theoretical training course run by the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London (FFLM) and the National Policing Improvement Agency (NPIA). The trainee doctor was then appointed to a group of doctors providing cover to an area in London with a Principal FME. The FFLM have produced a guide to the practical induction training in clinical forensic medicine, satisfactory completion of which leads to a 'Certificate of achievement of a standard of minimal acceptable competence in clinical forensic medicine' – the 'certificate'.[4]

The Principal FME (PFME) had a contractual requirement to supervise the 'needs and induction of' AFMEs. However research has shown that not all PFMEs have used the suggested FFLM programme of training and the methods by which PFMEs ensured that AFMEs were competent to work in police stations varied.[5]

At the end of two years' supervision, PFMEs are asked whether the AFMEs are 'suitable to be issued with an FME contract'. It was also recommended that an assessment by an independent senior FP should be carried out. This involved an interview where the doctor's original notes, statements and other relevant paperwork were examined by the senior FP, who would then advise the police on the doctor's suitability for progression to the post of FME.

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In January 2009, the MPS introduced a new contract for FMEs that removed the post of PFME and did away with the group structure under which FMEs had previously worked.

FMEs come from a variety of clinical backgrounds including, for example, general practice, emergency medicine, and psychiatry. As a consequence, AFMEs entering the specialty of clinical forensic medicine have varying qualifications and competencies and may be more or less well equipped to perform the role of an FME. Close supervision in the early days of practice is essential to support these doctors and address their differing needs.

The Postgraduate Hospital Educational Environment Measure (PHEEM) has been developed as a quality assessment tool of clinical teaching and learning for junior doctors.[6] This tool looks at perceptions of role autonomy, teaching and social support and was used to create a pro forma for the semi-structured interviews (available from MS).

It is essential in assessing any training programme to obtain the views of trainees/learners to aid future development.[7] Previous research has concluded that the level of supervision provided by supervisors is correlated with levels of stress and anxiety in junior doctors.[8] PMETB surveys trainers and trainees each year to assure the quality of postgraduate education and training.[9]

The overall aim of this study was to evaluate the quality of current practical training in London with a view to improving future training and, in particular, to assess whether the Assistant Forensic Medical Examiners (AFME) in London receive appropriate practical induction training following the theoretical training course.

The specific aims of this study were:

- To gather the views of the AFMEs' on their training experiences.
- To identify problems with implementing the training as it stands.
- To assess whether AFMEs received the 'certificate' of competence on completion of their practical induction programme.

It was hoped that recommendations could be made to the FFLM regarding standardisation of practical training programmes in the future.

2. Methodology

Training of new doctors in this field varies throughout the country, within different constabularies, and there is no central register of trainees so as a pilot project the focus for this study was London.

There are 18 PFMEs who were contacted to establish if there were any members of their group of doctors who had undergone practical training as AFMEs in London over the past 2–3 years – 'purposive sampling'. These AFMEs were initially contacted by telephone by MS to establish whether they would be interested in taking part in a short telephone interview using a semi-structured pro forma. If so, an appointment was made for MS to telephone at a mutually convenient time. Verbal consent was given to the interview, which was audiotaped. A semi-structured interview pro forma was used. A semi-structured interview of the independent senior forensic physician was also carried out and taped.

A telephone interview was chosen as a relatively quick, inexpensive and easy option to gain information about the trainee's experience, as opposed to a face-to-face interview or a focus group. This method had the benefit of allowing the trainee to speak confidentially, which may have been more difficult in a focus group made up of peers with a wide variation in positive and negative experiences of training.

Quality issues were addressed by returning the transcribed interviews to each of the interviewees by email for them to check accuracy of the transcript (reflecting their experience) and to allow further comments. The transcribed interviews were also sent to a peer (GN) to read and to independently look for themes – 'investigator triangulation'.[10] The themes highlighted in the AFME interviews were compared to those identified in the interview of the external assessor.

During the research an unexpected opportunity arose to interview an FME face-to-face from a constabulary outside London who had undergone a completely different training process. This was felt to be a useful opportunity to consider the experience outside London.

3. Results

The 18 PFMEs contracted to the Metropolitan Police Service (MPS) (excluding MS) were contacted and five indicated that they had no trainees in recent years. The remaining 13 Principals identified 18 doctors as possible candidates for interview.

One doctor categorically refused to be interviewed. Nine interviews were completed in the time available. The remaining doctors were not contactable in the first instance or did not return calls. The audio-taped interviews (lasting between 10 and 20 min) were transcribed by MS, including the interviews with the external assessor, and the doctor working outside London. Therefore, a total of 11 transcribed interviews were available for analysis.

The transcripts were sent to the interviewees – 10 out of the 11 responded and confirmed the content of the transcripts. The transcripts were analysed for themes and then sent to the peer (GN) for independent thematic review and comment, thus decreasing the potential for investigator bias.

4. Summary of interviews – initial training and shadowing

Eight out of the nine AFMEs interviewed had been on the Faculty/NPIA initial training course about 2–6 months before starting work. One doctor was advised at interview that attendance on the Faculty/Metropolitan Police Service development training courses and the South East and London (SEAL) course was sufficient. This doctor was not interviewed by a PFME. The doctor working outside London (OL) did not attend any theoretical training course before starting work as an FME. One of the MPS doctors, who had worked in a different constabulary, also had not attended a training course before starting to work as an FME in that constabulary. One of the London doctors felt that they did not need formal training as they were only working as a locum and did not have a regular slot on the rota.

All doctors had shadowed either the Principal in the area they were going to work in or another Principal and/or Senior FMEs. The doctor working outside London had also shadowed an FME before starting work. Four doctors were not aware of the existence of the Good Practice Guidelines for FMEs within the MPS (GPG).[11]

5. Clinical supervision

All AFMEs stated that there were experienced FMEs to assist them on the phone when they started work. However, it was not always their allocated Principal but other doctors from the group.

One Principal actually supervised the AFME in the police station observing the doctor doing an assessment. In another group the Principal had given the AFME a shift to do and was readily available to come to the police station if required. The doctor working outside London had no clinical supervision on starting working.

One doctor commented that the quality of care provided by colleagues was very variable and expressed concerns that shadowing could be inadequate as a learning experience if colleagues are not working to the same guidelines and standards.