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Original Communication

Principal forensic physicians as educational supervisors

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ABSTRACT

This research project was performed to assist the Faculty of Forensic and Legal Medicine (FFLM) with the development of a training programme for Principal Forensic Physicians (PFPs) (Since this research was performed the Metropolitan Police Service have dispensed with the services of the Principal Forensic Physicians so currently (as of January 2009) there is no supervision of newly appointed FMEs or the development training of doctors working in London nor any audit or appraisal reviews.) to fulfil their role as educational supervisors.

PFPs working in London were surveyed by questionnaire to identify the extent of their knowledge with regard to their role in the development training of all forensic physicians (FPs) in their group, the induction of assistant FPs and their perceptions of their own training needs with regard to their educational role. A focus group was held at the FFLM annual conference to discuss areas of interest that arose from the preliminary results of the questionnaire.

There is a clear need for the FFLM to set up a training programme for educational supervisors in clinical forensic medicine, especially with regard to appraisal.

1. Introduction

The overall aim of this research was to assist the Faculty of Forensic and Legal Medicine (FFLM) with the development of a training programme for Principal Forensic Physicians (PFPs) to fulfil their role as educational supervisors.

The Faculty of Forensic and Legal Medicine (FFLM) is the most recently formed Faculty of the Royal College of Physicians of London with the inaugural meeting having taken place on 13 April 2006.[1] The Faculty has been founded to achieve the following objectives:

- To promote for the public benefit the advancement of education and knowledge in the field of forensic and legal medicine.
- To develop and maintain for the public benefit the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity.

One of the aims of the Faculty is to establish a training pathway in forensic and legal medicine and achieve specialist recognition of the specialty. The specialty includes doctors working as forensic physicians in general forensic medicine and sexual offence medicine.

The Metropolitan Police Service (MPS) has approximately 150 forensic physicians (FPs) working in 19 groups in London. Each group is lead by a PFP[a] with duties including managerial responsibility and an educational supervisory role – specifically to:

Supervise the development training of all the FPs in the group, giving special attention to the needs of and induction of assistant FPs, and to undertake audit and appraisal reviews as appropriate.

Ensuring trainees are competent, supervising clinical practice within clinical teams, and undertaking audit is all part of clinical governance.[2]

The specific aims of this study were to identify:

- The extent of the PFP's knowledge with regard to their role in the development training of all FPs in their group, and the induction of assistant FPs;
- How these roles may differ;
- Perceptions of the training needs of the PFPs with regard to their educational role;
- How these might best be met.

There has never been any formal training for this supervisory educational role. Forensic physicians work in the independent sector where standards vary.

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[a] Since this research was performed the Metropolitan Police Service have dispensed with the services of the Principal Forensic Physicians so currently (as of January 2009) there is no supervision of newly appointed FMEs or the development training of doctors working in London nor any audit or appraisal reviews.

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Currently all doctors who wish to work in the MPS area are required to attend an approved five-day initial training course with the recommendation that this should be followed by a practical training programme.[3] For appointed doctors continuing medical education of 24 h each year is a contractual requirement, currently not enforced, and audit and appraisal are voluntary.

PFPs come from a variety of backgrounds with regard to experience and previous training and will vary in their strengths and weaknesses, and ability to cope with an educational supervisory role. It is hoped that through the survey questions the PFPs may reflect on their knowledge, experience, skills, and limitations with regard to this role.[4] Their responses will inform future training for an educational supervisory role. To diagnose learning needs it is useful to consider what competences, the PFPs currently have and what evidence there is in relation to their current practice in this area.[5]

2. Methods

An anonymised questionnaire with a supportive letter was sent to each PFP in February 2008 (copy available from the author) and following this a focus group was convened to explore and discuss areas of interest that had arisen from preliminary evaluation of the questionnaire results.

3. Results – questionnaire

There was a 100% response rate to the questionnaire ($n = 18$) (I excluded myself). One returned answers in a prose format; four by telephone interview at their request; and 13 completed the questionnaire and returned it by mail, fax, or email. No one remained anonymous and all were willing to discuss the issues further.

At the time of the research (February 2008) the PFPs had been working in the field of clinical forensic medicine (CFM) a mean of 22 years (range 11–43 years) with the length of time as the appointed PFP varying from 6 months to 21 years (mean 8 years).

Nine PFPs were fellows or members of the FFLM and one had joined as an affiliate. One third (6/18) were approved under the Mental Health Act 1983 as having special experience in the diagnosis and treatment of mental disorder. 12/18 had received training and previously worked as sexual offence examiners and child examiners but none were currently involved in acute cases. Eight PFPs had a number of higher qualifications including FRCGP, MRCGP (x3), FRCP, MRCP, FRCS (x2), MS, MD, FACBS, DRCOG (x2), MSc, MA(Med Ed), BDS.

3.1. Development training

Nearly all groups (15/18) met regularly at least 3–6 monthly; one group yearly and one group occasionally when required. One respondent stated that the group rarely met all together but the PFP met with group members and/or spoke and/or had email contact several times a week. With regard to the format of the meetings 14/17 had some educational input; two were business only and one business/social. Nine groups (9/14) applied for approved training hours for variable lengths of time (from 1.5 to 4 h).

Five replied that they had meetings with individual doctors to discuss their personal development plan; one did this by phone and one only with assistant FPs. Eleven PFPs encouraged and reminded members of the need to attend 24 h of approved medical educational training meetings over the calendar year as per the MPS current contract.

3.2. New members

All groups except one had appointed assistant FPs (AFPs) in the past 5 years. Eight PFPs had used the practical induction training programme produced by the Association of Forensic Physicians and revised in 2008 by the FFLM[3]; a further five were aware of the existence of the programme but had not used it and four were not aware of the document.

Even where the programme was used, all PFPs who had assistant FPs to train had ensured that they were competent to work in the police station by a number of methods:

- Monitoring their case work;
- Looking at original notes and entries on forms or national computer system (NSPIS);
- Feedback from colleagues, custody officers and other police officers.

Many (10/17) ensured that the assistant FPs had shadowed the PFPs and other experienced members of the group before starting work on their own, both before, and after the currently compulsory residential training course.

3.3. Appraisal in clinical forensic medicine (CFM)

Nine PFPs (50%) were trained appraisers but only two had been appraised in CFM specifically and these two had appraised members of their own group. With regard to who should be doing the appraisals, opinion was divided with a third of PFPs agreeing that they should appraise members of their own group and with one doctor commenting that a second opinion should be obtained if there were concerns. However one third felt that appraisals should be performed by an independent appraiser. Three doctors thought both systems would be satisfactory and one had no view. One PFP was unsure of the benefits of appraisal, feeling that it did not improve practice and was a waste of money, and another felt that further discussion was required on this issue.

3.4. Audit

Ten groups had been involved in audit and 14 examples were given of audits that had been carried out within groups:

- Response times.
- Calls per month.
- Percentage of detainees sent to hospital.
- Review of constant supervision requests by different doctors.
- Hospital admission rates and reasons.
- Case type.
- Regular reviews of workload.
- Drink drive examination.
- Analysis of smokers and illness.
- Analysis opiate substitution treatment.
- Time response for drinking driving cases.
- CS pray usage.
- Deaths in custody.
- Mentally disordered detainees arrested in a six moth period.

When asked about awareness of the contract requirement of PFPs (two PFPs did not answer this question):

15/16 were aware of the requirement to supervise the development training of all the FPs in the group.

15/16 were aware of the requirement to supervise the training needs of and induction of assistant FPs.

12/16 were aware of the requirement to undertake audit as appropriate.

9/16 were aware of the requirement to undertake appraisal reviews as appropriate.

50% of the PFPs felt that they met the contractual requirements above, however two of these commented that they did not