

Becoming the medical registrar: a qualitative study of a professional transition as a transformative learning event

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Abstract

Background: The medical registrar is a daunting role to take on for the first time. While studies have explored how preparedness can be improved through simulation, less has been written about how doctors learn to be registrars through clinical practice.

Method: Doctors working as medical registrars were invited to participate in semi-structured interviews. The qualitative data collected underwent thematic analysis.

Results: The clinical environment was considered fertile ground for transformative experiential learning, but opportunities for debriefing and guided reflection were rare. Participants felt they needed additional support from supervisors after difficult experiences and mistakes, but this support was not always forthcoming.

Conclusion: Acute physicians involved in supervising new medical registrars must facilitate meaningful independent practice to encourage the next generation of medical generalists.

Keywords

Medical Registrar, Training, Transition, Supervision

Background

In UK hospital medicine, the medical registrar is thought to have a particularly challenging job, co-ordinating acute admissions, supervising junior doctors and acting as a senior clinical decision-maker out-of-hours.¹

Doctors in the UK typically become registrars approximately 4-6 years after graduation and work at this level until they become consultants. While there are multiple routes to become a medical registrar, the most common for UK graduates was to undertake two years of Core Medical Training (CMT). CMT was replaced by Internal Medicine Training (IMT) in 2019. Unlike CMT, IMT includes a third, transitional year (IMT3) to better prepare doctors for the more senior role.²

This change is of particular interest to acute physicians, as IMT3 doctors will spend much of this year working on Acute Medical Units (AMUs) under their supervision. This study sought to determine how acute physicians can best support new registrars.

Literature Review

A literature review was conducted to explore our existing knowledge of medical registrars' education. A PubMed search was performed for the phrase "medical registrar", returning 167 results. These papers were filtered to exclude those that did not address education and training. 19 studies remained,

all of which were relevant to learning that takes place on AMU. As IMT is still new, existing studies referred only to CMT.

These studies suggest that junior doctors often misconceive medical registrars as all-knowing beings.^{3,4} Authors stressed the importance of debunking this "superhero" myth and reimagining medical registrars as well-supported members of a wider team.^{5,6} While practical skills were considered important, authors generally agreed that new registrars should focus on developing excellent non-technical skills.⁵⁻⁸

Less is known about *how* new registrars develop these skills, but many felt CMT prepared doctors poorly for their new role.^{3,9-11} CMT doctors only took on registrar-level responsibilities to cover rota gaps, often without any additional support.^{7,9} Supervised step-up shifts were highly-rated, but these require a senior clinician present to provide feedback if the shifts are to be truly educational.^{11,12} Authors agreed that a paucity of constructive feedback hindered CMT doctors' development.^{9,10,13}

Several authors suggested simulation-based medical education (SBME) as a possible solution to this problem. In SBME, new registrars can compare practice and learn from their peers in an unthreatening environment.^{8,14,15} Unfortunately, high-fidelity simulation is expensive and only available sporadically, limiting its utility.^{7,13} Furthermore, authors' focus on SBME meant clinical experiences were underexplored.

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The existing literature leaves some intriguing unanswered questions about registrars' education "on the job" and how new registrars experience the transition. Many papers evaluated educational interventions by taking serial measurements of doctors' confidence under the assumption that good training would result in more confident registrars.^{16, 17} This may give an incomplete picture of the learning experience.

Methods

Building on gaps in the literature, this study sought to answer the following questions:

- What learning processes take place in the clinical setting during the transition to the medical registrar role?
- What stages and experiences are common during the transition and do these follow a particular order?
- How can AMU supervisors best support doctors through this transition?

The population of interest comprised doctors working as medical registrars. A purposive approach was taken to sampling. IMT3 doctors and doctors in higher specialty training (HST) were included as it was felt their perspectives would be broadly representative of medical registrars. Potential participants were approached at training days and booked for remote interviews via Microsoft Teams.

The aim here was not to prove a hypothesis about the transition, but rather to explore the complex social phenomena that underpin it. Accordingly, an interpretivist approach was taken. Semi-structured interviews were employed, with topics explored as they arose mid-conversation. Interviews were recorded and subsequently transcribed. An inductive approach was taken to coding, with codes identified as they emerged and then grouped into themes.

Ethical issues were carefully considered, but the risk to participants was considered negligible. Full approval was granted by the relevant ethics committee.

Results

Seven participants took part in interviews:

- Four IMT3 doctors working at a district general hospital (IMT3¹⁻⁴)
- One IMT3 doctor working at a teaching hospital (IMT3⁵)
- Two HST doctors in Acute Medicine (ST5 and ST7)

After analysis, six key themes emerged and are discussed below. Quotations from participants are used throughout.

Regarding terminology, doctors working at the grades between Foundation Year 1 (FY1) and registrar are referred to as Senior House Officers (SHOs), as this was the term used by participants.

Theme 1: Defining the medical registrar role

Participants began by defining what made the registrar role unique. Medical registrars must have an "eagle eye" view of the acute take, with responsibility for patients they may never meet. This caused some trepidation: participants had spent their early careers being detail-orientated but would now rely on others for critical information, while in turn being relied on for expertise and guidance.

Participants found it more difficult to define the role of the medical registrar when *not* on-call. On AMUs with a strong consultant presence, they saw registrars performing similar tasks to more junior doctors. Participants felt consultants' presence as decision-makers left less room for registrars to practise independently.

"When [the registrar] is on the ward, [they] follow around a consultant. [They don't have] their own plans, their own patients or people they review." – IMT31

Theme 2: Experiences of the transition

As FY1s, participants were dependent on medical registrars for instruction and support. As they gained confidence during their SHO years, this dependence diminished. Several even began to feel they had "outgrown" the SHO role and wanted more responsibility. Despite this, participants recalled being apprehensive about registrar-level duties.

"When you start as the Med Reg, you come across lots of situations you've never come across before. You do sometimes feel like you're floundering." – ST5

In contrast to the self-belief they had as SHOs, new registrars grappled with self-doubt. Participants felt they became more risk averse and were more likely to escalate questions to consultants. They lamented this sudden drop in their confidence.

Several participants shared stories about the first truly unpleasant experience they had as registrars, typically a mistake or unexpected death. One participant described the warm, unconditional support they received after a traumatic cardiac arrest. Others described supervisors who were cold, indifferent or even hostile.

Theme 3: Quality of supervision

Participants wanted supervisors to be accessible without preventing meaningful independent practice. AMU consultants are rarely in the hospital overnight but often see every patient on the ward round, leaving fewer decisions for registrars to make. As a result, participants felt they vacillated between under-supervision on-call and over-supervision in-hours.

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“For me, good supervision is having someone who trusts you. Who lets you exercise your autonomy [and] lets you make decisions.” – IMT34

Feedback was considered crucial. Participants valued feedback that was honest and constructive, provided it did not publicly undermine them. Some participants wondered whether feedback should be more formal, but others said they found feedback “appointments” so intimidating they avoided them at all costs.

Theme 4: Useful learning activities

Supervised step-up shifts for senior SHOs were highly valued. All participants had done at least one step-up shift before becoming registrars, but staffing issues meant there were rarely senior registrars supervising them. More commonly, participants had stepped up to fill a rota gap.

As registrars, participants felt the most important learning was experiential:

“I don’t think you fully understand [the role] without having done it.” – IMT3¹

Participants would reflect after busy shifts and experiment with different approaches. They might spend one shift seeking out referrals, another waiting for referrals to come to them. Similarly, participants found they learned a great deal by comparing practice with their peers. Unfortunately – as medical registrars rarely work in pairs – opportunities for this were limited.

Theme 5: Redefining the medical registrar role

Participants’ understanding of the medical registrar role changed significantly during the transition. Post-transition, they no longer viewed registrars as “lonely heroes”, but as important players in a broader team. They realised their role was often to signpost rather than answer questions and that a reliance on others was vital to safe practice.

Participants were surprised to find they enjoyed the autonomy of the role and the opportunity to create a supportive environment for others. They remembered registrars they had worked with who were obstructive or inaccessible and aspired to be a better kind of supervisor.

However – as they began to confront the realities of the job – participants realised that creating a positive atmosphere is tiring. They became more conscious of their own wellbeing and a need to keep their workload manageable. While they enjoyed the job, they recognised the detrimental impact it could have.

“It’s always such a contradiction being the Med Reg. I love it and I hate it.” – ST5

One participant mentioned a friend who disliked the role and ultimately changed specialty. It stands to reason that – for some doctors – redefining the role means leaving the role behind.

Theme 6: The IMT3 programme

IMT3 participants expected to have greater levels of supervision to “soften” the jump to registrar, but this was not forthcoming. While consultants were supportive, rota issues meant there was never a second-on registrar, as was initially planned. Elsewhere, the lack of clarity around the new role meant some consultants assumed IMT3 doctors were still SHOs.

“I don’t think anyone really appreciated what an IMT3 was and that that equalled reg.” – IMT35

The distinction between IMT3 and HST registrars was similarly problematic. Participants feared departments would prioritise more senior trainees, expecting IMT3 doctors to manage ward activities so HST registrars could pursue educational opportunities elsewhere. Some were concerned the new programme had inadvertently created a sub-class of junior registrars.

Discussion

We can think of the transition to medical registrar as a transformative learning event: an unfamiliar challenge that forces learners to change their beliefs and behaviours.¹⁸ Doctors accustomed to working independently must become co-ordinators, inherently reliant on others. The concept of the all-powerful lone registrar is no longer helpful, as their purpose is to empower colleagues in pursuit of a shared goal. Ultimately this leads to a permanent change in behaviour, as they learn to manage, delegate and defer.

Participants felt their clinical jobs were fertile ground for experiential learning, but experience only leads to transformation if accompanied by reflective practice.¹⁸ Opportunities for guided reflection are rare and this is the void that SBME often fills. However, clinical experiences could just as easily be used as the substrate for reflection and discussion.¹⁹ Simulation may be unnecessary if we can make registrars’ working lives more educational.

Educators often evaluate teaching programmes by measuring learners’ confidence before and after an intervention, but this is an unreliable gauge of educational benefit. A loss of confidence may be an important transitional step. We need a more nuanced understanding if we wish to improve the quality of training we offer on AMU.

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Key Stages of the Transition

To construct a conceptual framework of the transition, eight key stages were identified from participants' descriptions of their training experiences, spanning from FY1 through HST. A visual representation of how confidence changes as registrars progress through these stages is included as Figure 1. Each stage is described in detail below.

Stage 1 – Insurmountable task

“I remember being an F1, looking at the Med Reg in awe of the responsibility they have for the whole hospital.” – ST7

As novices to clinical practice, FY1 doctors are dependent on medical registrars for support and instruction. Registrars are therefore often misconceived as infallible superheroes, a role the novice believes themselves incapable of taking on. Foundation doctors need to see that registrars are formidable, but fallible. The best way to ensure this is to invite them to actively participate in the acute medical community of practice.²⁰ By clerking patients under the supervision of a supportive medical registrar, FY1 doctors can gain a more realistic understanding of the role.

Stage 2 – Master of one world

“You’re really good at being an SHO. You’re brilliant at being an SHO. And actually, you’re itching to have [freer] reign.” – IMT35

This stage is characterised by confidence, earned over years of practice. Despite this confidence, many senior SHOs find themselves frustrated by a lack of satisfying, challenging work. This may be because – in hospital medicine – the role of the SHO is often indistinguishable from that of the FY1.^{3, 11} Doctors at this stage need to be supported to take on higher-level responsibilities. Step-up shifts can deliver this, but appropriate supervision and feedback must be provided.

Stage 3 – Crossing the threshold

“I think the thing that makes you the Med Reg is being the Med Reg.” – IMT35

While IMT3 is intended as a transitional period, medical hierarchies are notoriously rigid. At some point, doctors stop being SHOs and become registrars. This is typically when they join the registrar rota, often at the start of IMT3. However, IMT3 doctors are a heterogeneous group and new registrars will vary in confidence and supervision

needs. Their status as registrars must be recognised, but supervisors must tailor their supervision to suit each trainee.

Stage 4 – Strange new world

“At the end of the day, when you start [as a registrar], you’re starting from scratch.” – IMT33

The first few months as a registrar can be disorientating, as new, unfamiliar experiences force doctors to change the way they see the clinical environment and their place within it.¹⁸ New registrars may struggle with a sudden dip in confidence as they tackle new challenges, but they are no less competent than they were as senior SHOs. They have simply become aware of the skills they now need to develop, entering a state of conscious incompetence.²¹ Positive feedback and encouragement are crucial.

Stage 5 – Embodying the role

“It felt really good to finally [feel] you’ve established yourself within your training. That you finally are the medical registrar.” – IMT31

This stage is characterised by renewed confidence as registrars settle into their role. Registrars are now able to perform proficiently, albeit only with focus and concentration.²¹ The first few shifts serve as mastery experiences: by performing the role successfully, registrars begin to believe themselves capable.²² While the medical registrar role must be experienced to be understood, vicarious learning is also important. These new experiences are less daunting once registrars realise their anxieties are shared by their peers. As Harrington, Watmough and Lovell described, group

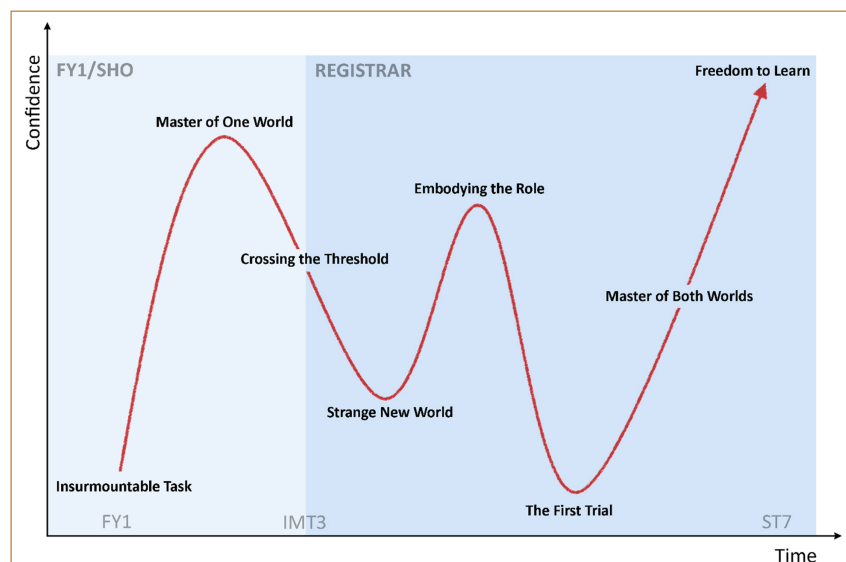


Figure 1. Key Stages of Transition

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debriefings can help registrars reach this important realisation.⁷

Stage 6 - The first trial

“I needed an adult to tell me that nothing more could have been done.” – ST5

Despite rising confidence, it is only a matter of time before new registrars must confront their first genuine trial, often a mistake or unexpected death. While they will have made mistakes before, mistakes made as a senior decision-maker have more significant ramifications. While distressing, this is a critical rite of passage. Vulnerability is key to transformative learning, but disconcerting for doctors keen to be seen as confident leaders.¹⁸ Supervisors must gently persuade registrars in distress they are still capable.²² Registrars will likely experience several such trials during training but for participants here, the first was the most arduous.

Stage 7 - Master of both worlds

“You are running the ship. It’s the atmosphere you want to create for your team. It comes from you and not really from anyone else.” – ST5

This stage is characterised by autonomy. Having tried out different styles, registrars construct their own personal identity and begin to enjoy doing things “their way”. At the same time, they are now aware that their influence is limited. Shifts will get busier and patients more unwell, regardless of what approach they take. This need not be distressing; indeed registrars may even find it empowering, as all they can do is their best. While they aspire to excel in their role,

they recognise this is not always possible. Their own wellbeing is important too. While frustrating, this more balanced, realistic approach to the role is more sustainable.

Stage 8 - Freedom to learn

“I don’t think you ever get to a point where you’ve reached a threshold and cannot learn more.” – IMT31

In this final stage, registrars are confident enough to practise comfortably but recognise that learning is a lifelong process. They understand that they will never stop learning, even as consultants. However, many tasks and processes can eventually be done intuitively, allowing experienced medical registrars to focus on the complex or unpredictable aspects of their job. Ultimately, doctors at this stage will switch their focus to the next transition, as they prepare to become consultants.

The Importance of Supervision

New registrars need good supervision, but this does not necessarily mean *more* supervision. Adult learners enjoy solving problems and will become frustrated by passivity.²³ However, new registrars also dislike feeling *under*-supervised, particularly out-of-hours. Somewhere between these two extremes is a goldilocks range, where registrars can be guided to undertake tasks they would be unable to complete alone.²⁴ This is where the most important learning takes place.

Supervisors should therefore focus on “scaffolding” activities: activities that are not so complex as to be unachievable, but not so simple that new registrars can accomplish them alone. Examples of scaffolding activities are described in Figure 2.

Study Limitations

Time constraints meant only seven participants were interviewed. A larger study may capture phenomena unexplored here. The perspectives of HST registrars training in medical subspecialties (such as cardiology or gastroenterology) would be particularly informative.

Similarly, registrars who have left medicine were not included in this study. No conclusions can be drawn about what happens when the transition goes wrong, or how it could result in someone finding a more fulfilling career elsewhere. With record numbers choosing to leave medical training, this is a particularly timely avenue for further study.²⁵

Conclusion

After a historically challenging few years, new registrars need supportive seniors if they are to successfully navigate this complex, transformative learning event. Only through excellent mentorship and supervision

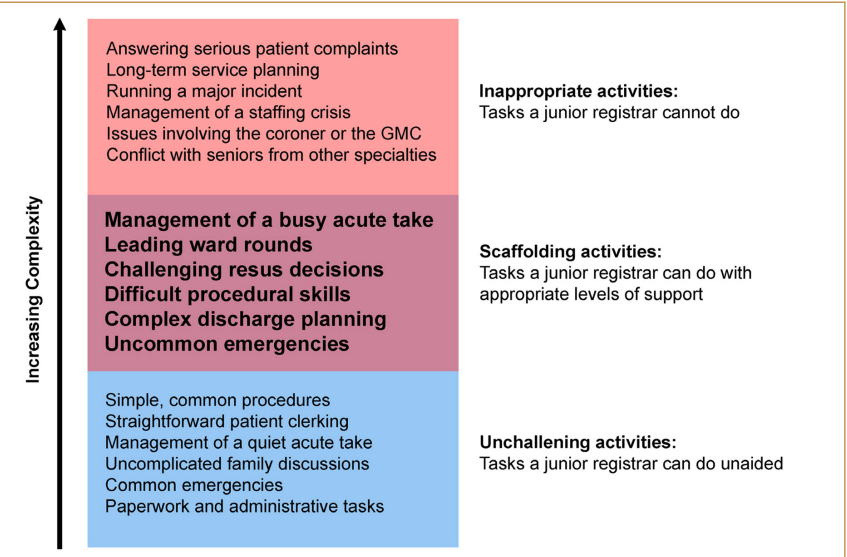


Figure 2. Examples of Scaffolding Activities

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can we enable this new generation of generalist physicians to thrive as medical registrars.

Acute physicians involved in training IMT3 doctors should:

- Facilitate meaningful independent practice
- Identify scaffolding activities
- Introduce regular peer-led debriefing sessions

- Provide additional support when registrars encounter their “first trial”

Conflicts of Interest

Nothing to declare

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