The relationship between pre-registration house officers and their consultants

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Context Previous studies have drawn attention to the importance of the trainee/trainer relationship in determining job satisfaction and motivation to learn.

Objectives To study the relationship between pre-registration house officers and their consultants through exploring an interpersonal exchange and the emotional context in which the exchange took place. To consider any association between the type of relationship implied and the trainee's attitude to their career.

Design Postal questionnaire covering a wide range of issues. This study focused on an open question about a significant or interesting exchange, followed by supplementary questions exploring the emotional context of the exchange.

Setting 336 hospitals throughout the United Kingdom.

Subjects A cohort of doctors were followed from the time of their application to medical school, and studied towards the end of their pre-registration year ($n = 2456$).

Results The response rate to the questionnaire was 58·4%. Responses were categorised as Support and supervision; Unreasonable behaviour; Consultant fallibility; Fair criticism and No exchange. Over half the responses described an interaction that made them feel positive. Trainees particularly appreciated positive feedback, clinical support, teaching, career advice, patronage, or social interaction. The importance of formal appraisal or review sessions in providing the setting for a positive exchange was confirmed. Positive interactions were associated with a positive view of medicine as a career. A minority described an interaction that was negative, involving unreasonable demands, criticism (whether perceived as fair or unfair), humiliation, or sexism. These were associated with a more negative view of medicine as a career, and of themselves as doctors.

Keywords Adaptation, psychological; cohort studies; consultants; Great Britain; interpersonal relations/ *psychology; *job statisfaction; medical staff, hospital; questionnaires.

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Introduction

The relationship with their supervising consultant is a crucial factor in determining whether young doctors are happy in their jobs.[1] The quality of that relationship can make the difference between a post that is rewarding and one that is demoralising. For doctors in their first year, that could make the difference between setting out positively on their career or making the decision to leave medicine. In the UK system, the pre-registration year follows graduation from medical school, and precedes full registration as a medical practitioner. It usually consists of two six month posts, one in surgery and one in medicine, although commonly each will be divided into two three month parts. Each post will have an educational supervisor, usually one of the consultants that the house officer will be working for. Frequently the house officer will change hospitals half way through the year, and will have to get to know a new set of seniors, a factor that may itself be a source of stress.[2]

We know something about what makes an effective educational supervisor. Good supervisors create an educational climate within the team or unit; give constructive feedback; assess the trainees' progress and their learning needs; and keep up to date as a teacher.[3]

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Key learning points

The majority of house officers described their consultants offering support and supervision.

These house officers were less likely to regret their career choice, more likely to feel they would make good doctors and more likely to be satisfied with their posts.

Appraisal sessions offered a common setting for positive feedback

Many house officers found it difficult to guess what their consultants felt about them.

House officers who described their consultants making unreasonable demands, criticising them or exhibiting poor behaviour or clinical skills were less confident about their careers.

Poor supervisors essentially neglect their role as trainers, overlook their trainees' educational needs and may be in conflict with others.[4] A supervisor's competence as a clinician is also important to the trainee;[5] the worst supervisors may be clinically incompetent or even maltreat their patients.[6]

That first year as a doctor is a time of particular vulnerability to emotional stress. Although most trainees find their senior colleagues supportive,[7] newly qualified doctors are often upset by lack of sensitivity shown by their supervisors to their patients,[8] and are likely to be dissatisfied with their training if they observe unethical or unprofessional conduct.[9] A structured educational dialogue with a supervisor has been shown to be a key to job satisfacton.[10,11] A survey in 1993 revealed that few consultants offered much more than rudimentary feedback to preregistration house officers.[12] Since then, although there have been attempts to improve consultants' supervision, for example with encouraging regular two-way feedback,[13] consultant supervision has remained variable and dependent on the commitment of individual consultants and on their natural aptitude and sensitivity to the educational needs of their trainees. Considering the importance of the trainee/trainer relationship, relatively little is known about it and about how to help both parties to foster a good relationship, given the limited duration of a placement, the pressures inherent in both roles, and the fraught environment in which they work.

While the attitude and behaviour of the consultant is a central factor in determining the quality of the trainer/trainee relationship, the attitude and aptitude of the trainee also plays a part. In order to gain better understanding of this relationship from the trainee's point of view, we asked house officers to tell us about any significant or interesting interpersonal exchanges with their consultants. We went on to ask them to comment on their feelings both about the exchange and about the consultant, and to speculate on how the consultant felt both about the exchange and about them. We were especially interested in finding out whether empathy or emotional intelligence in the young doctors – as evidenced by the ability to imagine what was going on in the mind of the consultant – was in any way related to their confidence and commitment to a career in medicine.

Methods

The study began as a prospective cohort study of medical student selection, looking at applicants to UK medical schools in Autumn 1990 for admission in October 1991.[14] The detail of how they were surveyed at the end of their pre-registration house officer year is reported in a companion paper in this issue.[15]

The main focus of the present report is the question which asked *Could you please briefly describe an exchange that you have had with one of the consultants you have worked for that seems to you in any way interesting or significant*? A 2·5 × 11 cm box was provided for the response.

The questions then went on to ask *What was your predominant emotion? Which adjectives most clearly describe your impression of him or her? What was his or her predominant emotion? Which adjectives most clearly describe his or her impression of you*? In formulating the questions we drew on the Relationship Episode Questionnaire described by Hale and Hudson.[16]

Other questions used in this analysis were *Have you ever regretted your decision to become a doctor*? *Now that you have practised medicine for nearly a year, do you think you will make a good doctor*? *How would you describe your current post to a friend thinking of applying*?

Classification of the consultant exchanges was carried out by two of the authors, EP and SH. The analysis of recurrence of descriptive words was carried out using the word search facility of Microsoft Word. Statistical analysis was carried out using SPSS version 8.

Results

Response rate

Questionnaires were sent to 2456 house officers of whom 1435 (58·4%) sent usable replies. The response

rate was slightly higher in females (62%; 787/1266) than in males (55%; 628/1151; Chi-square = 14·4, 1 d.f., $P < 0.001$). Comparison of respondents and non-respondents on baseline measures suggested, as in previous studies, that there were no significant differences between the two groups. The 1435 respondents worked in 336 hospitals throughout the United Kingdom. The question under study was left blank by 384 (26·8%) respondents.

Classification of responses

Most respondents understood our term 'exchange' to mean a single interpersonal interaction between the consultant and themselves. A few referred to a more general behaviour pattern, either directed at themselves or others. In most cases it was clear that the consultant concerned was their educational supervisor, but in a few cases the relationship was more distant. The coders independently identified 12 themes in the exchanges described: positive feedback, clinical support, teaching, career advice, patronage, social interaction, unreasonable demands, clinical criticism, conduct criticism, public humiliation, consultant fallibility, sexism, being ignored or belittled. However, there was a good deal of overlap between these, and many responses included more than one of these themes. The coders were unable to allocate the responses to single categories with acceptable agreement. The categories were therefore reduced to five: Support and supervision; Unreasonable behaviour; Consultant fallibility; Fair criticism; and No exchange (Table 1). The coders achieved good agreement (kappa 0·92) with this classification.

The exchanges

Support and supervision

This was the largest category, with 615 (58·5%) respondents describing an exchange where they were praised or thanked, taught, given career advice or support, recognised socially, or offered a good role model.

Praise or thanks. In 245 (23·3%) cases, the house officer described being praised or thanked. Nearly half of these exchanges took place in a planned appraisal session (also referred to as review, assessment, or end of job interview). Often these occasions provided the only indication for the young doctor that their performance had been acceptable. Praise or thanks at the time of extra effort was much appreciated.

Table 1 Responses by category of consultant exchange

Category	Number (%)
Support and supervision	615 (58·5%)
Unreasonable behaviour	234 (22·3%)
Consultant fallibility	77 (7·3%)
Fair criticism	64 (6·1%)
No exchange	61 (5·8%)
Total responses	1051 (100%)
No answer	382
Grand total	2456

'My assessment with my medical consultant – he said I was one of the best house officers he'd had and it boosted my confidence.'

'At 3 month review he finally said I had worked hard and he'd appreciated my effort. At no point before had he acknowledged me!'

'On a busy stressful firm we did a full week on call which was very tiring – my consultant took me aside and thanked me, said, "You're doing a very good job." It somehow gave me strength to continue!'

Teaching. Teaching in a clinical setting was described by 135 (12·8%) respondents. Several respondents described support provided by consultants following the death of a patient.

'Interesting discussions re patients. My opinion has been listened to and my questions answered.'

'Patient death that was surrounded by strong family resentment and a probable litigation case – consultant sat me down and explained/reassured me what the situation was. Relieved all my anxiety.'

Career counselling. Supportive career counselling was the topic of 92 (8·8%) exchanges. The consultant was described as providing information, advice, support and practical assistance. This occasionally went so far as a promise of patronage.

'I applied for and was interviewed for an SHO job, but I did not get it. Consultant took time that evening to give feedback, discuss questions and answers and advise for future.'

'Being told that I had done a good job as a house officer and that if I needed a reference he would give one and moreover ring the people concerned and get me the job!'

Social. Forty-two (4·0%) respondents described a social exchange with their consultant. The recurrent theme in these was the reduction in the professional gap between house officer and consultant, and the mutual recognition of each other as people.

> 'On a ward night out on a canal boat, sitting at the bow of the boat and rolling him a cigarette, talking about painting, artists and our careers.'

Role model. In 21 (2·0%) cases, instead of an exchange, respondents described an occasion when the consultant's clinical behaviour excited their admiration.

> 'Dealing with young patient who was dying of cancer on a Saturday evening and the consultant on call was there throughout terminal process.'

> 'Once when a particularly aggressive alcoholic patient was admitted, just watching him control the situation, make his examination and treat a patient no one else could control.'

Unreasonable behaviour

The exchange described by 234 (22·3%) respondents involved unfair criticism, bullying, unreasonable demands, disrespect, sexism, or sexual harassment.

Unfair criticism. Unfair criticism was the largest group, with 107 (10·2%) respondents describing occasions when they felt they were blamed for problems that were not their fault. In several instances the respondent was caught between warring seniors.

> 'A colleague had failed to check a blood result which could have resulted in cancellation of surgery. I was blamed because the patient was under my care despite the fact that I was not on duty.'

> 'Blamed for a mistake about a patient's antibiotic as I took the message from a consultant microbiologist who gave the wrong advice.'

Bullying. A striking feature was the intemperate behaviour of some consultants. Criticism was often delivered in a raised voice and in front of patients or colleagues.

> 'Consultant phoned me in pre-clerking clinic, ordered me to ward and screamed and hollered at me and was generally rude and nasty for forgetting to give first dose iv antibiotic (it was written up and nurses hadn't asked me). This was the worst mistake I made.'

> 'Consultant radiologist shouted at me and threw a packet of X-rays in my face and ordered me to get out of her sight in front of a large room of doctors after I requested a scan as instructed by my Prof.'

> 'Working with emotionally unstable consultant surgeon who had tendency to explode if jobs not done to his design despite failing to express his intentions.'

> 'Orthopaedic consultant wanting to know what I've done as not in clinic. Explained I had ill patients (after weekend on call). 'Not acceptable'. Told him the way he spoke and his attitude not acceptable.'

Unreasonable demands. Fifty-nine (5·6%) respondents reported unreasonable demands over hours or intensity of work, holiday or sick leave.

> 'Complaining to consultant in surgery who drew up our rota that I had been given two weeks of nights in a row and would end up working three weekends in a row. She refused to change it.'

> 'Senior consultant said he would not employ someone in the future if they had heard about the New Deal and were concerned about their hours.'

> 'Consultant refused me annual leave despite my having booked 2–3 months previously and having another house officer to cover for me. Holidays were booked and paid for.'

> 'I took 1 day off sick and my surgical consultant admonished me saying that in his career he had never taken a day off sick!'

> 'Told consultant I couldn't cope with busy medical firm on my own with no SHO, 60 patients and absent registrar and needed more senior support. He just said I had to be a man about it.'

Disrespect. Thirty cases (2·9%) dealt with being ignored or snubbed. Consultants not knowing their names, even after several weeks or months, was a recurrent theme.

> 'First day on new unit I introduce myself to consultant who has ignored me all day. He nods and walks away. I slave for him for next 3 months.'

> 'In assessment when he said something wrong, then said "all house officers blend into one".'

Sexism. Twenty-two (2·1%) respondents described sexist remarks or behaviour. These mostly concerned negative assumptions about the capacity of women to succeed in their careers, especially if they were contemplating surgery. One case each concerned unwanted sexual advances, consensual sex and homophobic remarks.

'Consultant did not believe in women in medicine except paediatrics, anaesthetics, dermatology and sometimes psychiatry. Women are unable to make decisions about male patients especially if life and death decisions!'

'Young married male consultant with children. Stands too close to female staff. Made himself my tutor. Said loudly in front of other staff and patients, "Time for our hot date, babe" and put arm round my waist.'

Consultant fallibility
In 77 (7·3%) responses, the consultant was viewed as demonstrating incompetence, insensitivity or negligence. Poor communication skills on the part of the consultant, particularly when breaking bad news, were described by several respondents. Excessive investigation or treatment of terminally ill patients was another recurrent theme.

'Working with one consultant who had little confidence in himself or his junior staff. Not letting any decisions be made and referring too many problems inappropriately.'

'Consultant telling a woman she had metastatic breast cancer. Awful to watch. Talked about "we can keep you out of pain" without explaining – didn't even sit down. She was completely bewildered. I was cringing – "No, listen to her!"'

'Consultant wanting to do a liver biopsy on elderly lady dying of pancreatic cancer as they had no tissue diagnosis. I felt this cruel.'

Fair criticism
A small but interesting group of 64 (6·1%) described what appeared to be fair criticism by the consultant for an acknowledged error or omission. Sometimes what seemed to us to be fair criticism evoked a negative response from the respondent. Several respondents simply described their error, leaving the exchange with the consultant to the imagination.

'After I made a clinical misjudgement my consultant took me aside, made his views known, but then asked me how I felt and how the situation could have been avoided.'

'At my appraisal, my consultant told me that his only complaint was that I wasn't as organised as I could be. I wasn't able to defend myself.'

'I had to tell him I had made a mistake in a prescription.'

No exchange
Sixty-one (5·8%) respondents reported that no interesting or significant exchange had taken place. While most wrote a simple *No*, or *Haven't had one*, several added comments such as, *No. Is that in itself interesting or significant?*

Medical and surgical consultants

We did not ask during which post the exchange had taken place, but in 272 (25·9%) responses it was possible to identify the specialty of the consultant concerned. Of these, 90 (33·1%) were medical and 182 (66·9%) were surgical. The preponderance of surgeons reflected the textual clues presented by references to theatre and operations. Within this group, there were marked differences between physicians and surgeons (Table 2). Medical consultants were more often described offering Support and supervision. Surgical consultants were more likely to be described exhibiting Unreasonable behaviour, Fair criticism or Consultant fallibility.

The emotional context of the exchange

We classified responses to the follow-up questions about the emotional context of the exchanges into 'positive', 'negative', 'neutral or ambivalent' and 'unable to say'. The results by type of exchange are summarised in Table 3.

What was your predominant emotion?
Those who described an exchange in the category 'Support or supervision' were likely to feel positive about it. Positive feedback was usually greeted with *surprise* or *delight*, teaching with *respect*, and support with *gratitude*. Negative feelings in this category mostly related to difficult clinical circumstances in which the exchange took place. Respondents describing an exchange in the category 'Unreasonable behaviour' described mostly negative emotions. *Anger* and *frustration* were the two most frequently used descriptive words. 'Consultant fallibility' evoked similarly negative reactions. Here the words most used were *contempt* and *disbelief*, as well as *anger* and *frustration*. Those in the category 'Fair criticism' spoke most often of *embarrassment*, *shame* and *anger*.

Which adjectives most clearly describe your impression of him or her?
In the category 'Support and supervision' these were overwhelmingly positive, with recurrence of the words *admiration*, *respect*, *considerate*, *caring*. Half of those

Table 2 Category of exchange by consultant specialty

	Support and supervision	Unreasonable behaviour	Consultant fallibility	Fair criticism	Total
Medical	69 (76·7%)	15 (16·7%)	3 (3·3%)	3 (3·3%)	90 (100%)
Surgical	91 (50·0%)	52 (28·6%)	24 (13·2%)	15 (8·2%)	182 (100%)
Total	160 (58·8%)	67 (24·6%)	27 (9·9%)	18 (6·6%)	

Chi square 18·827 d.f. 3 $P < 0{\cdot}0001$.

Table 3 Emotional context of exchange

	Support and supervision	Unreasonable behaviour	Consultant fallibility	Fair criticism	Total
Respondent's predominant emotion					
Positive	498 (84·0%)	4 (1·7%)	6 (8·1%)	12 (18·8%)	520 (54·0%)
Negative	64 (10·8%)	224 (96·6%)	66 (89·2%)	50 (78·1%)	404 (42·0%)
Neutral or ambivalent	31 (5·2%)	4 (1·7%)	2 (2·7%)	2 (2·7%)	39 (4·0%)
Chi square 626·721 d.f. 6 $P < 0{\cdot}0001$					
Respondent's impression of consultant					
Positive	527 (91·5%)	10 (4·4%)	5 (6·8%)	31 (50·8%)	573 (61·0%)
Negative	24 (4·2%)	203 (89·0%)	60 (81·1%)	26 (42·6%)	313 (33·3%)
Neutral or ambivalent	25 (4·3%)	15 (6·6%)	9 (12·2%)	4 (6·6%)	53 (5·7%)
Chi square 670·780 d.f. 9 $P < 0{\cdot}0001$					
Consultant's predominant emotion					
Positive	376 (70·8%)	22 (9·7%)	10 (14·1%)	16 (26·2%)	424 (47·7%)
Negative	49 (9·2%)	157 (69·5%)	48 (64·8%)	34 (55·7%)	286 (32·2%)
Neutral or ambivalent	46 (8·7%)	9 (12·8%)	11 (15·5%)	6 (9·8%)	92 (10·3%)
Unable to say	60 (11·3%)	18 (8·0%)	4 (5·6%)	5 (8·2%)	87 (9·8%)
Chi square 377·152 d.f. 9 $P < 0{\cdot}0001$					
Consultant's impression of respondent					
Positive	372 (69·5%)	20 (8·8%)	10 (14·1%)	12 (19·7%)	414 (46·3%)
Negative	33 (6·2%)	148 (65·2%)	34 (47·9%)	35 (57·4%)	250 (28·0%)
Neutral or ambivalent	72 (13·5%)	32 (14·1%)	18 (25·4%)	9 (14·8%)	131 (14·7%)
Unable to say	58 (10·8%)	27 (11·9%)	9 (12·7%)	5 (8·2%)	99 (11·1%)
Chi square 395 780 d.f. 9 $P < 0{\cdot}0001$					

describing 'Fair criticism' were positive, using words like *fair* and *understanding*. The negative words in this category included *arrogant* and *unsympathetic*. Those describing 'Unreasonable behaviour' did not mince their words. *Bastard, idiot, fat-head, rude, arrogant, greedy, selfish, senile* and *pompous* all recurred. In the category 'Consultant fallibility' the word *arrogance* recurred most often, followed by *weak*, *indecisive*, *unconcerned*.

What was his or her predominant emotion?

Many respondents had difficulty in imagining what the consultant was likely to be feeling. Over 15% of those who described an exchange left this question blank, and another 10% said they did not know, sometimes adding a rider to the effect that they were not mind-readers. Those describing 'Support or supervision' used positive words like *satisfaction*, *concern*, *patience*, *interest*. Negative words like worry or regret reflected the clinical context of the exchange. *Anger*, *smugness* and *indifference* were words used to describe the emotions of those consultants exhibiting 'Unreasonable behaviour'. Those reporting 'Fair criticism' attributed negative emotions to the consultant. *Anger*, *irritation* and *disappointment* were the predominant words used. Positive words included *calm* and *amused*. Those in the category 'Consultant fallibility' were thought to feel *unconcerned*, if the respondent felt able to comment at all.

Which adjectives most clearly describe his or her impression of you?
Respondents had similar difficulty in judging the consultants' impression of them. Those most likely to judge this to be positive were in the 'Support and supervision' group, who used words like *reliable*, *hard-working* and *competent*. Negative words included *naïve* and *inexperienced*. In the 'Unreasonable behaviour' group, a number doubted whether the consultant had formed any impression of them: *He doesn't really seem to care. He treats all house officers with contempt.* Words that recurred included *lazy, incompetent, irresponsible* and *disorganised*. In the 'Fair criticism' group, recurrent negative words were again *incompetent* and *disorganised*, while positive words suggested they were normally considered *competent*. Respondents in the 'Consultant fallibility' group were likely to think the consultant neutral about them, though two used the word *upstart*.

Confidence and satisfaction with career

The responses to the questions *Have you ever regretted your decision to become a doctor? Now that you have practised medicine for nearly a year, do you think you will make a good doctor? How would you describe your current post to a friend thinking of applying*? by type of exchange are summarised in Table 4.

Those respondents describing 'Support and supervision' or 'Fair criticism' were least likely to regret their decision to become a doctor and those describing 'Consultant fallibility' were the most likely. Most respondents felt that they would make good doctors. The least confident were those who described 'Fair criticism.' Most were satisfied with their current post. The least satisfied were those describing 'Consultant fallibility' followed by 'Unreasonable behaviour' and 'Fair criticism'. Those who left the 'consultant exchange' section blank were not significantly different from those who offered the 'No exchange' response in terms of regretting entering medicine, confidence that they would make good doctors or rating their current post. Those who were unable to say what the consultant might have been feeling fell in the middle of the range (Table 5).

Discussion

The 'consultant exchange' question was answered by only 73% of respondents to the questionnaire as a whole. It is interesting to speculate on the reasons for this, given the evidence from previous research about the centrality of the trainee/trainer relationship in postgraduate medical education. The explanation might be that free text requires more effort than closed questions, that the question came towards the end when respondents were tired, or that they were anxious about confidentiality. However, a free text question about a stressful incident was answered by 94%, the final question was answered by 99%, and respondents were freely and frankly critical in other sections. A worrying possibility is that with reducing hours of work and an increasing size of firms, the relationship between house officers and their consultants is becoming quite distant. This was implied by those who suggested that their inability to recall any such exchange was in itself of interest.

Many of the exchanges reported took place in the setting of an appraisal. Regular appraisal is recognised

Table 4 Confidence in career choice and job satisfaction by type of consultant exchange

	Support and supervision	Unreasonable behaviour	Consultant fallibility	Fair criticism	No exchange	No answer
Regret decision to be a doctor?						
Never or occasionally	533 (86·8%)	186 (79·5%)	56 (72·7%)	55 (85·9%)	47 (77·0%)	319 (86%)
Often or very often	81 (13·2%)	48 (20·5%)	21 (27·3%)	9 (14·1%)	14 (23·0%)	52 (14%)
Chi square 16·234 d.f. 4 $P < 0{\cdot}003$						
Likely to make good doctor?						
Definitely or probably yes	602 (98·2%)	224 (96·6%)	73 (96·1%)	58 (90·6%)	59 (98·3%)	358 (97·3%)
Definitely or probably no	11 (1·8%)	8 (3·4%)	3 (3·9%)	6 (9·4%)	1 (1·7%)	10 (2·7%)
Chi square 13·567 d.f. 4 $P < 0{\cdot}009$						
Rating of current post						
Very good to good	444 (74·2%)	136 (61·8%)	36 (48·6%)	41 (66·1%)	41 (74·5%)	245 (66·9%)
Fair to very poor	154 (25·8%)	84 (38·2%)	38 (51·4%)	21 (33·9%)	14 (25·5%)	121 (33·1%)
Chi square 28·437 d.f. 4 $P < 0{\cdot}0001$						

Table 5 Confidence in career choice and job satisfaction by consultant's emotion during exchange

	Consultant's predominant emotion			
	Positive	Negative	Neutral or ambivalent	Unable to say
Regret decision to be a doctor?				
Never or occasionally	365 (85·9%)	232 (81·1%)	70 (76·1%)	77 (82·8%)
Often or very often	60 (14·1%)	54 (18·9%)	22 (23·9%)	16 (17·2%)
Chi square 6·348 d.f. 3 $P < 0·096$				
Likely to make good doctor?				
Definitely or probably yes	417 (98·3%)	274 (96·5%)	85 (92·4%)	89 (96·7%)
Definitely or probably no	7 (1·7%)	10 (3·5%)	(7·6%)	3 (3·3%)
Chi square 9·568 d.f. 3 $P < 0·023$				
Rating of current post				
Very good to good	302 (72·9%)	168 (61·1%)	56 (62·9%)	63 (71·6%)
Fair to very poor	112 (27·1%)	107 (38·9%)	33 (37·1%)	25 (28·4%)
Chi square 12·268 d.f. 3 $P < 0·0007$				

as an important feature of any training post[17,18,19] and is now required in all house officer posts.[20] That an appraisal was the occasion for many of the positive exchanges underlines the importance of making sure that it takes place. However, the appraisal was also the setting for a few demoralising, ill-informed or inappropriate exchanges, highlighting the need for supervisors to be trained for this role.

Workplace bullying has recently been the subject of considerable attention inside and outside medicine.[21,22,23] Many of the exchanges fell within the definition of workplace bullying, e.g. public humiliation, belittling, shouting, threatening, unfair blaming, unreasonable demands. Clearly we only had the views of the house officers, and what they described might have been perceived as appropriately firm supervision by the consultants.

Sexual harassment has been identified as a common feature of life at medical school.[24] It clearly also occurs after qualification. It was disappointing to find that so many of the exchanges concerned consultants offering careers advice that discriminated inappropriately between the sexes in terms of their capabilities.

We were particularly interested in those house officers who were unable to imagine what was going through the mind of the consultant at the time of the exchange. We thought this group might represent those with less empathy or emotional intelligence, and that they might therefore feel less confident and satisfied in a career like clinical medicine, but our results (Table 5) did not support this hypothesis. Perhaps the inability to read the minds of the consultants reflected poor communication skills on the part of the seniors, or the distance of the relationship, rather than lack of skill on the part of the trainee.

Conclusions

Most respondents described a positive interaction between themselves and their supervising consultant, in keeping with previous reports. They particularly appreciated positive feedback, clinical support, teaching, career advice, or a social interaction that made them feel they were recognised as a person. Positive interactions were associated with a positive view of medicine as a career, and confidence in themselves as doctors. However many respondents described an interaction that was negative, involving unreasonable demands, criticism, humiliation, sexism, or frank bullying. Not surprisingly, these were associated with a more negative view of medicine as a career. Consultants should not be entrusted with the supervision of newly qualified doctors unless they are prepared to support, teach and respect them and to provide a good role model in their behaviour to patients and colleagues alike.

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Contributors

EP helped devise this part of the study, entered data, led the coding team and drafted the paper. ICM - devised the study. BW organised the survey and entered data. SH coded and helped with the drafting. FM helped devise the questions and helped with the drafting.

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