Scenes from Postgraduate Life

Medical education 2000

Five years ago I predicted, half tongue in cheek, that acute hospitals as we knew them would disappear in 50–100 years, made obsolete partly by financial constraints and partly by further triumphs in preventive medicine. At that time there were, of course, rumours of psychiatric hospital closures, although ours (over 2000 beds) had already reduced its size owing to the drug revolution, as, perhaps more surprisingly, had our geriatric hospital (2000 beds) by altering the ratio of chronic to acute cases in favour of the latter and by improving services in the community as well as long-stay facilities.

Today we live under the threat of closure of all those vast Victorian psychiatric institutions which seem to have been a part of our professional lives for so long, and for which those of us who have had associations with them have a respect and admiration in spite of sometimes sensational reports in the media. This is not to say they should be preserved (though I suspect one or two might be worth 'listing' for the edification of future generations), though surely we shall need some form of institutional back-up for the community services when the doors finally close. I may say that I am a firm believer in breaking down, physically if necessary, the walls that surround hospitals and letting out not only patients but more particularly consultants who regard hospitals as places, like monasteries, where they can escape from the clamour of the outside world.

My concern, however, is with a spin-off of these closures which, along with other trends in hospital practice, may have unforeseen effects on postgraduate medical education which must be recognized in good time. Many large psychiatric hospitals, often in association with teaching hospitals, have built up excellent junior staff rotations, in which there may be ten, twenty or more participants. Provided assessments are satisfactory and examinations are passed, trainees progress from senior house officer to registrar over a period of approximately four years, at the end of which time they should have passed the MRCPsych. Apart from the benefit of security, such schemes allow each trainee to participate in a variety of specialized options, like child psychiatry, drug abuse, psychogeriatrics, as well as general psychiatry, depending on local availability; because of the complexity of programmes it is usual to appoint a tutor to keep a watch on the training. (In parenthesis it is worth noting that adult psychiatry and general surgery are now following general medicine in encouraging the

appointment of consultants with an interest.)

If psychiatric institutions are to be replaced by community care the close-knit tutorial system will be dispersed. Questions are beginning to be asked about how trainees will be taught and where they will meet for peer group activities, which are reminiscent of the early days of training for general practice. Or will training in future be taken on by teaching hospitals, where presumably there will still be a residue of patients (highly selected) needing institutional care and study? Will tomorrow's trainees get the wide range of experience at present on offer?

The problem goes beyond psychiatry. The recent green (in reality blue) paper on primary health care makes two points relevant to the present discussion: firstly that general practitioners must take full responsibility for prevention, and secondly that they must be prepared to manage those chronic diseases – diabetes, rheumatoid arthritis, hypertension are three examples – which are traditionally dealt with in hospital out-patient departments. Both actions constitute threats to the practice of acute district general hospitals and to the training of medical students and postgraduates, but in my view should be welcomed on behalf of patients.

With their greater and more diverse work load, general practitioners will themselves have to alter their practice. They could, for example, provide special waiting rooms where patients could weigh themselves, check their breathing with a peak flow meter, measure pulse and blood pressure, and record an exercise electrocardiograph – with appropriate instructions on what to do about the results. If technical help were available, breath, blood and urine tests could be done, as well as more specialized screening tests if thought to be desirable. This is not all. The advance of technology will increasingly make it possible to treat people with serious illness outside hospital – home dialysis and enteral feeding are but two current examples.

All of which is bad news for acute teaching and district hospitals, especially those in metropolitan areas already being squeezed by financial cuts. For some time teachers have been grumbling that medical students see fewer patients than they used to. Medical schools complain that diversion of money from the acute to the priority services – mental illness, mental handicap, and the elderly – deprives students of exposure to the commoner acute conditions. A year's preregistration experience may not be enough to remedy the deficiencies, particularly if the job is in the

teaching hospital, where it is increasingly difficult to provide six months each of general medicine and general surgery. Restriction of acute services and increasing specialization mean that a doctor may not be as well trained generally as he or she should be. The General Medical Council's look at basic specialist training reflected this anxiety by suggesting that more general experience of patient management might have to be provided after registration.

But that is not all. Fewer hospitals and fewer patients mean smaller numbers of junior medical staff, and the trend might have a salutary effect on the career structure. Present failure to fill senior house officer posts in certain specialties and in some parts of the country has forced health authorities to look abroad for staff. But an alternative response might be to see if the work could be shifted elsewhere; we all know that a good deal of hospital casualty work could be done in general practitioners' surgeries – and no doubt will be

in the future by a greatly enlarged workforce. To retain hospital beds because they have to form the basis of medical teaching is neither economic nor humane.

General practice is increasingly popular as a career choice for present graduates, who regard with despair the narrowness and competitiveness of hospital specialization. If a fixed retiring age is introduced for general practitioners there could well be a further substantial increase in graduates opting for general practice. The specialty has already introduced monitoring and evaluation into its training schemes, both by trainers and trainees, including practice inspections and multidisciplinary teaching, which are much more sophisticated than anything to be found in hospitals. Perhaps they will be able to provide the necessary expertise for medical training when hospitals, like dinosaurs, have succumbed to the pressures of evolution. After all, over half a million patients attend doctors' surgeries every working day.

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