Scenes from Postgraduate Life

Service versus training

The National Health Service (NHS) exists, those of us who work in it are constantly reminded, to treat patients. While such a bald statement may be open to qualification – enlightened general practitioners, for example, might argue that increasingly their function is to prevent their clients from *becoming* patients – it is still broadly true of hospitals. Educationists, of course, will tell you that hospitals have an equally important role in training medical students and graduate doctors. Since junior doctors in training provide most of the service to patients, the potential for conflict at many levels is considerable.

The Department of Health and Social Security (DHSS), for instance, is said to regard senior registrars as supernumerary to service needs yet everyone knows how heavy is their workload. It is good to see the increasing insistence of colleges and faculties on adequate time for research and study in senior registrar posts. Since most of the holders will be spending 25–30 years as busy consultants I have always felt that they should be encouraged to do their own thing in those precious four years; they are unlikely to get a second chance.

The DHSS supports postgraduate education in principle: has it any statutory obligation to do so? According to the draft recommendations of the General Medical Council (GMC) regarding general clinical training:¹ 'Responsibility for provision of resources and facilities is accepted by the National Health Service (NHS) in principle, in accordance with its statutory duty. Health authorities must therefore take account of the balance between fulfilling service needs and providing the necessary facilities for general clinical training.'

When I pressed a Regional Medical Officer (not unsympathetic) too hard about the provision of educational facilities in district hospitals, he retorted by asking if I thought them more important than a patient's laundry. And at a local level the workload of most junior doctors is often so horrific that it is a wonder they ever manage to pass examinations. Is it possible to reconcile the educational needs of doctors in training with a first class service to patients, especially when restrictions have to be imposed on the numbers of juniors in order to produce an equitable career structure? I believe it is – with a bit of goodwill – by altering the way we work the service and by putting on attractive training programmes.

Many years ago an imaginative colleague suggested two innovative measures the consultant body in our hospital might take. At a time in the 1960s when appointment of additional consultants was a reality (and not a forlorn hope as at present) he proposed that each firm (headed by two consultants) should be strengthened by a third. In this way each consultant would be 'off service' in turn for a period of 3–6 months, freed from routine outpatient clinics and emergency takes, so that he or she could oversee the duty rotas of juniors, assess their progress, organize teaching and audit, and carry out research. Needless to say the proposal, while acceptable in principle, was too radical to be implemented.

The second idea was not new: to have an educational afternoon each week, much as the services have a recreational afternoon, during which all routine clinics, ward rounds and operating sessions would be suspended. Rumour had it that the surgeons were antagonistic because of loss of theatre time: the idea was quietly dropped. A pity in my view and some sort of arrangement will have to be accepted eventually. The excellent half-day release courses organized for general practice trainees are frequently opposed by consultants because they say they need their senior house officer (SHO) for hospital duties. General practitioners have a statutory duty to provide vocational training, and they will no doubt insist on proper training posts if they cannot get them by voluntary agreement.

Time for education can be made available with careful organisation. I recently took part in a Faculty Study Day at Liverpool where preclinical and clinical activities were suspended so that students in all five years as well as faculty could attend a day-long symposium on alcohol and the National Health Service. Several hundred people attended and it was adjudged a success worth repeating.

The other side of the coin is the type of teaching to be provided. On the whole, preregistration housemen do not want formal education (they have had five or six years of it), however much they protest the opposite. When rounds or talks are arranged few people turn up, even when (as I have experienced) the initiative is taken by one or two of the housemen themselves. At the moment SHOs, planning to take the first part of their specialist examinations and therefore most in need, are often obstructed by the

heavy burden of service. It is no longer possible to get a job which allows time for study, although most district hospitals are still able to be generous (for how much longer?) with study leave.

The GMC has recently suggested that the first year of the SHO grade should consolidate undergraduate teaching. If it then consisted of generalist (one year) and specialist (a two year rotation) components it should be possible to plan viable courses in terms of numbers of trainees along the more formal lines of the American boards. Very successful rotations lasting 3–4 years already exist in psychiatry where individuals advance from SHO to registrar during their training. Apart from the advantages of security, such schemes would enable trainers to plan a proper syllabus, as is done in psychiatry and general practice. A further year or two as a registrar, doing research or more specialized training before becoming a senior registrar, would mean that the time to consultant appointment would, in general, be shorter than at present.

Overall organization of medical training would be in the hands of the clinical tutor. It is certainly not possible at the moment to provide the ambitious programmes and surveillance of careers envisaged here; future appointments would require dedicated sessions and/or the type of consultant post mentioned earlier. In parenthesis I like the idea of a basic five session clinical contract with other sessions negotiable for further clinical work including private practice, administration, teaching, research, etc; I suspect that one reason why consultants 'moonlight' is that after 20 or more years, clinical work becomes increasingly

more demanding but less challenging – if that is not a contradiction.

Tutors in most specialties are already available and their help is vital. This does not mean that junior staff would be entirely passive receivers of education. They can, and do, help themselves by forming their own groups, for example for Membership and Fellowship teaching, and by asking consultants to give seminars on special topics, especially such technicalities as interpretation of electrocardiograms and CT scans. With the permission of consultants they could also keep a central list of 'interesting cases' which their colleagues could go and see.

Much as one would like to see a broadening of educational approaches it has to be said that junior staff at this stage are really only interested in examination-orientated teaching. Many hospitals have already grasped this fact and put on successful courses, including mock examinations. An educational component which needs strengthening is medical audit; carried out by a firm or department such an exercise would help to imprint the practice of self-criticism and continuing education after the immediate need for examinations has passed. It will only succeed, however, if it becomes part of those very examinations.

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Reference

1. General Medical Council Education Committee. Draft Revised Recommendations on General Clinical Training. December 1986.