Scenes from Postgraduate Life

The senior house officer (SHO) grade – service and education

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The remorseless tendency towards increasing specialization in medical practice has led many over the years to warn the profession of the continuing need for doctors to develop and sustain broad medical knowledge and clinical skills. Not only is such an approach necessary for the doctor to continue to be able to assess, treat and refer to others as necessary the diseases that concern him but it recognizes the importance of an holistic approach to many such diseases. It also enables doctors to respond to common medical emergencies whatever their nature when necessary, albeit in the form of first aid. Such training in the early stages of medical education can also enable the doctor to remain optimally pluripotential for as long as possible. Nevertheless, specialist excellence is obviously also essential and a balance needs to be struck. In the United Kingdom recognition of the importance of initial generic training along with special emphasis on the importance of clinical skills has long prevailed¹ (Recommendations on Basic Medical Education, Education Committee, General Medical Council 1980). In Europe a similar emphasis has recently arisen through promotion of the concept of the common trunk of early specialist training (European Community Recommendation on Specialist Training, 1986).²

The Education Committee of the GMC has statutory responsibility for all stages of medical education in the UK. This has been the case in respect of basic medical education for very many years and in this context the Committee issues relevant Recommendations, periodically enquires of, visits and inspects medical schools and their final professional examinations and mounts educational conferences. The Committee's responsibility for postgraduate education is more recent, dating from 1979 and enshrined in the Medical Act of 1983. In this respect it is required to co-ordinate all stages of medical education and to ensure high standards of training and practice. It has also for long held the right to inspect

examinations of those Royal Colleges and Faculties whose postgraduate diplomas it registers. The Colleges, Faculties and Joint Higher Training Committees in the UK have been involved for many years in developing their specific postgraduate specialist educational programmes and establishing related standards through such processes as entrance, intermediate or exit diplomas. These activities have widespread recognition and respect. The Joint Higher Training Committees have occasionally been perceived as placing too much emphasis on specialism and of setting up training requirements that are too rigid. This is one expression of the debate concerning the respective merits of generalism versus specialism.

None of these postgraduate educational bodies requires additional general training following full registration to practice (although such general training characterizes medical education in the UK up until this point) prior to entry to their specialist training programmes although the situation is unclear in respect of medicine itself. Thus, the Royal Colleges of Physicians in the UK regard specialization as only starting at senior registrar level and following conferment of membership (MRCP) of one or other of their Colleges feel strongly that the period of training required for entry to MRCP examinations is properly qualification apart from those very closely linked to the Royal Colleges of Physicians themselves. These Colleges feel strongly that the period of training required for entry to MRCP examinations is properly called 'general professional training'. However, it is not 'general' in the sense of being suitable in itself for preparation for entry to other forms of higher specialist training, such as surgery, pathology, psychiatry, obstetrics and gynaecology. All such other specialties as these have their own training requirements at this stage of the doctor's career.

However, the Colleges responsible for training in these latter specialties have also in the past always used the term 'general professional training' to describe this period of early specialist training. Meanwhile, the Education Committee of the GMC, in the early stages of discharging its new responsibilities and after lengthy discussions with all those concerned, eventually concluded that this period of training was better called 'basic specialist training', that is preparation for

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higher specialist training, but that, paradoxically, it should be kept as truly 'general' as possible.

The terminology is less important than the validity of the concept. The Committee's recently published *Recommendations on the Training of Specialists* (1987)³ endorse this view, emphasizing the importance of breadth and flexibility of training at this level, thus permitting maximum interchange as well as the desirable breadth. A great deal of this greater breadth is seen as consolidation and maintenance, that is continuing medical education at this early stage, rather than atrophy of existing generic competence acquired during basic medical education. The Committee has also attempted to illustrate the fast track to independent practice within a table published in its *Recommendations* and reproduced here (Table I). Of course, the concept of 'fast' is relative! There are those who believe that basic and higher specialist training could profitably be compounded and shortened overall. Such a step would also bring those of us in the UK more in line with our North American and European counterparts.

The problem is compounded by several other issues:

1. The manpower situation. This is better balanced in the UK than anywhere else in the West but it is still imperfect. Not enough consultant posts exist within the National Health Service to accommodate graduates coming through into postgraduate training. The acute specialties, in particular, engage doctors at Senior House Officer (SHO – an immediately post registration training grade) level, and a grade they construe as non-specialist in its training goals, who also often nevertheless undertake the burden of first on-call specialist as well as generalist duties out of hours.
2. Not all doctors know what they want to specialise in and deliberately choose to try out a variety of posts at SHO level hoping such further experience may ultimately count towards their subsequently chosen specialist training.
3. Not all doctors can gain entry into the specialist training programme of their choice at the first attempt or even thereafter.
4. Some specialist training programmes, such as anaesthetics and psychiatry have come to embody SHO posts within their framework. This was not recognized within the 'Achieving a Balance' proposals.

Such matters have led to a large pool of SHO posts and the view, framed within 'Achieving a Balance' that, in the foreseeable future, doctors may need to spend two to three years at SHO level before entering specialist training programmes.⁴ A few, at the end of this period, may go on directly to sub-consultant staff grades but which permit relevant continuing medical

education thereafter. Meanwhile, it is clear that proper training of doctors within this SHO pool is sometimes very unsatisfactory.⁵

The training needs at SHO level are unclear. The posts exist only within specialist fields of practice and yet the training requirements are clearly for a more general training provided that the doctor in post concurrently adequately fulfils the elementary specialist tasks required of him under specialist supervision. The more general training needs may not be within the educational training compass of any one Royal College or Faculty. Such training, as Table I has shown, is not regarded as essential but the Education Committee in its *Recommendations* on the Training of Specialists³ recognizes it as occurring for some but not all trainees. Under those circumstances the Committee has recommended that as much such training as possible should subsequently be recognized by Colleges, Faculties and Joint Higher Training Committees as relevant to their specialist training programmes and in the interest of the greater breadth of knowledge and skill to which reference has already been made.

The Education Committee addressed the matter of such additional training at SHO level through its revised *Recommendations on General Clinical Training*.⁶ General clinical training is the term used to describe training primarily in the pre-registration year. This pre-registration training also inevitably occurs within specialty settings but its necessary general nature is spelled out in detail within the *Recommendations* (see Appendix 1). Within the pre-registration year the newly fledged doctor is initiated into responsible medical practice under close supervision. In the new *Recommendations on General Clinical Training*, the Education Committee considers that training at SHO level should be essentially an extension of this process but with the doctor assuming that much greater responsibility and, of course, by then having the right to prescribe. The relevant section of these *Recommendations* reads as follows:

IN PREPARATION FOR SPECIALIST TRAINING

(i) In its *Recommendations on the Training of Specialists* (1987), the Education Committee suggests in paragraphs 41–48 how trainees should be able to build on the foundations laid by basic medical education by obtaining further broad experience after full registration.

(ii) As paragraph 47 of these *Recommendations* indicates, some trainees may choose to achieve this in part by acquiring further general experience at SHO grade before beginning basic specialist training. Many of the Education Committee's recommendations in paragraphs 3–25 above about the content and processes of general clinical training during the

pre-registration year should also apply to such a period of general training after full registration. There will of course be some modifications, to reflect the changed position following full registration in respect of the wider variety of content of training available, the different arrangements for approval of training posts and the need for educational supervision to be adapted to the growing professional experience of the trainee.

(iii) Post-registration general experience might be obtained in specialties such as anaesthetics, community medicine, general practice, obstetrics and gynaecology, pathology, paediatrics, psychiatry and radiotherapy, which provide experience that is not normally widely available during the pre-registration year. The Recommendations on the Training of Specialists also contain further suggestions about posts which would be suitable for this purpose.

(iv) Those Royal Colleges and Faculties which currently offer 'general professional training', and others which decide to offer general clinical training at Senior House Officer grade, will be jointly responsible with the Regional Postgraduate Deans and Clinical Tutors for this period of training. They should, in collaboration with local employing authorities, consider how to provide suitable posts and/or combinations of posts for further general experience as a prelude to specialist training.

(v) The principal beneficiaries of such programmes would be the trainees, who would become informed about the varieties of specialized medical practice, and adaptable to career opportunities including the possible need to change career goals because of lack of opportunities in the preferred specialty. They would also be equipped to proceed to basic specialist training in any one of a number of disciplines, with at least some of their postgraduate general clinical experience recognized retrospectively as acceptable for this purpose.

To explore in detail the aims and content of such training one can turn to earlier paragraphs in the Recommendations (Appendix 1). These initially emphasize the importance of breadth of training (paragraph 4). This is as true for post-registration as for pre-registration in general clinical training. For instance, such breadth includes the ability to undertake cardio-pulmonary resuscitation (paragraph 6), to communicate effectively with patients including those from ethnic minorities, those who are mentally handicapped, those in pain, those who are dying and those who need counselling (paragraphs 7 and 8), to promote health (paragraph 9), to work in a team (paragraph 10) and to evaluate the quality of care (paragraph 11). Subsequent sections (e.g. Section C) and paragraphs in the Recommendations outline the relevant processes for such education and training with emphasis on the apprenticeship model allied to elements of formal teaching by educational supervisors, clinical tutors and others.

In the long term it is surely unnecessary to be rigid regarding terminology. The concept of general clinical

training, applied more widely, fits comfortably with what is required at SHO level. As a concept it leads naturally, sooner or later, on to basic specialist training and then to what is currently the separate and final phase of higher specialist training. Subject to statutory constraints the term 'general professional training' could equally be applied instead, both to the pre-registration period of training and to the kind of SHO training described above, but it would require modification of the current Medical Act by Parliament for those changes of terminology to be possible. However, we must surely try and keep our understanding of the situation clear in the meantime.

The thorny question of the governance of training at SHO grade (over and above the concluding statement in the *Recommendations on General Clinical Training* referred to above) remains to be considered. Clearly, the Colleges will have an abiding interest in those SHO posts within their respective medical practice domains. However, their specialty interests will need to be tempered by those with greater experience in securing standards for general clinical training. This would involve the Regional postgraduate system of Postgraduate Deans and Clinical Tutors. Hopefully, it can be a truly joint enterprise devoid of the sparring that has sometimes characterized such matters in the past. It is in the interest of the public and of our juniors and of our relationships with them that this be so.

Conclusions

Training at SHO level is sometimes an educational no-man's-land. For many of the specialties such training is not a requirement and the posts often exist because of manpower and service needs. They also inevitably exist within specialist areas of practice but need to offer further broad training in addition to carrying the supervised specialist responsibilities that such young doctors must also discharge when appointed to them. This further general training, when it arises within the SHO framework, should be similar in its content to that provided at pre-registration level, which also inevitably occurs within specialty practice, but compatible with the increasing maturity and responsibilities of the trainee, who by this time is a fully registered medical practitioner. The new *Recommendations on General Clinical Training* produced by the Education Committee of the GMC in 1987 address this matter of relevant educational content and process. It is suggested that its governance is best undertaken as a joint enterprise between the Colleges and Faculties on the one hand and the Regional Postgraduate Deans and Clinical Tutors on the other hand.

Table I Estimated minimum duration of training

TRAINING PHASES	BASIC MEDICAL EDUCATION					SPECIALIST TRAINING										CONTINUING MEDICAL EDUCATION				
	UNDERGRADUATE COURSE					GENERAL CLINICAL TRAINING	GENERAL PROFESSIONAL TRAINING/BASIC SPECIALIST TRAINING (ix)					HIGHER SPECIALIST TRAINING (viii)					15	16	17	UNTIL RETIREMENT OR BEYOND
	1	2	3	4	5	6	7	8	9	10	11	12	13	14						
YEARS						↑														
PSYCHIATRY						↑														
ANAESTHETICS (i)						↑														
OBSTETRICS/ (ii) GYNAECOLOGY						↑														
PATHOLOGY (iii)						↑														
RADIOLOGY/ RADIOOTHERAPY						↑														
GENERAL SURGERY/ SURGICAL SPECIALTIES (except as undernoted) (Eng)						↑														
SURGERY/SURGICAL SPECIALTIES (except as undernoted) (Edin)						↑														
GENERAL SURGERY & SURGICAL SPECIALTIES (Glasg)						↑														
ORAL/MAXILLO-FACIAL SURGERY (Edin)						↑														
OTOLARYNGOLOGY/ PLASTIC SURGERY						↑														

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2. Commission of the European Communities. *Third Report and Recommendations on the Conditions for Specialist Training* adopted by the Committee at its meeting on 18 and 20 June 1985. III/D/538/84-EN.
3. Education Committee; General Medical Council. *Recommendations on the Training of Specialists*. October 1987.
4. Department of Health and Social Security. *Hospital Medical Staffing: Achieving a Balance. The "Plan for Action" in brief*. A digest of the report issued in October 1987 on behalf of the UK Health Departments, the Joint Consultants Committee, and Chairmen of Regional Health Authorities. JC/2483a/1.
5. University Hospitals Association of England and Wales. *The Early Postgraduate Years*. An enquiry by the University Hospitals Association into the progress and career perceptions of doctors within 6 years of graduation. Available from the Executive Secretary of the University Hospitals Association (Professor D.R. Wood, c/o Department of Pharmacology, Worsley Building, University of Leeds, Leeds LS2 9JT, UK) 1989.
6. Education Committee; General Medical Council. *Recommendations on General Clinical Training*. October 1987.

Appendix 1

A: The aims of general clinical training

1. Medical education is a continuous process in which each stage is not an end itself but permits progression to the next stage. General clinical training should provide the trainee with opportunities to consolidate, apply and extend knowledge acquired during the undergraduate medical course, and to develop further and refine the range of general professional skills and the attitudes appropriate to the practice of medicine. Supervised in-service, general clinical experience, with increasing responsibility for the care of patients, should predominate and be directed towards this end. However, some time should also be provided for private study and for attending courses of instruction on topics relevant to this stage of education.

2. General clinical training should enable the house officer:

- (a) to understand the nature and implications of, and to make an appropriate initial decision about, each problem presented to him or her as a doctor;
- (b) to plan and carry out, under appropriate supervision, the investigation, treatment or management of and rehabilitation after acute and chronic illness, and to participate in programmes for promotion of good health;
- (c) to apply knowledge of science and of logical method to the assessment of clinical problems and to continue to develop the ability to assess the reliability of evidence;
- (d) to develop knowledge and understanding of disease processes;
- (e) to maintain attitudes appropriate to the practice of medicine, which include respect for the dignity of the patient and concern for the relatives, awareness of the legal and ethical aspects of medical practice, together with appreciation of the importance and implications of professional confidentiality;
- (f) to be aware of the limitation of his or her own knowledge and skills and to be ready to seek help;
- (g) to continue to develop the capacities for self-education and self-audit;

- (h) to learn effective and economic use of laboratory and other diagnostic and therapeutic services;
- (i) to learn safe practice in relation to radiation protection, blood products, body fluids and tissues in the ward and laboratory, and to have regard at all times to the safety of patients and health care workers, and
- (j) to gain experience in teaching others, effective teamwork, the management and administrative aspects of medical practice and the work of those bodies which plan, advise and assist with the organization and provision of health care in the community and in hospital.

B: The content of training

3. Posts should offer breadth and diversity of experience but should always include a core of balanced general experience in medicine and in surgery. (This is the requirement at pre-registration level.) The care of patients with acute illness should form a major component of the experience. The gradual increase in responsibility for patient care should be of as varied a nature and in as wide a setting as may reasonably be arranged.

4. There are diminishing opportunities for trainees to gain experience in general medicine and in general surgery. Universities (the Universities are responsible for general clinical training at pre-registration level but of course not at the post-registration level being discussed in this paper) increasingly recognize posts in medical, surgical and other specialties, and this is acceptable, *provided that the posts afford good, general experience*. Each doctor under whose supervision the trainee may work should recognize that the trainee requires broad general experience which will provide an adequate foundation for subsequent specialist training in any field of medical practice.

Broad skills which should be developed during general clinical training

5. Some skills, which are generic to the practice of medicine and which were introduced in undergraduate medical education, should be developed during general clinical training. They include the consultation skills required for history taking and examination of the mental state, practical skills such as the procedures of physical examination and other elementary manual and invasive procedures, ability to recognize the indications for particular diagnostic and therapeutic tests, and good prescribing practice. Training at this stage should enable the doctor to consolidate his or her basic competence in such areas as:

6. *Dealing with common medical emergencies.* On graduation the trainee should already be proficient in first aid and elementary resuscitation procedures. By completion of general clinical training the trainee should have refined and augmented those skills particularly in cardiac and respiratory arrest and in dealing with shock.

7. *Communication skills.* These are fundamental to good patient care and include history taking, involving patients in decisions about themselves and giving treatment, advice, support and counselling. The introductory teaching in the undergraduate curriculum should be reinforced during general clinical training, and the assessment of trainees' performance should take account of their comprehension of cultural values, practices and constraints, and their ability to communicate effectively with patients (including children and the elderly) and patients' families, medical colleagues and others involved in patient care.

8. *Knowledge of social and psychological factors in health and disease.* Trainees should be able to understand how a patient's problems relate to home surroundings, family circumstances, work environment and other social factors, and to take into account the patient's personality. The following examples are not exclusive, but illustrate the opportunities for such training:

- (a) *Pain relief:* the period of general clinical training is the first occasion on which the trainee has some responsibility for attempting to relieve pain. Learning about the nature of pain and its relationship to personal

distress as well as to tissue damage, can remind trainees that good medical care should meet the patient's needs as a whole.

- (b) *Care of the dying patient:* trainees should learn, from both specific teaching and the good clinical example of their consultants or general practical principals, about the special aspects of the care of the dying patient. These include the ability to listen to the patient, a sensitive approach to the patient's family, bereavement counselling and ethical considerations where a question of organ transplantation arises.

9. *Prevention of illness and promotion of health.* The clinical setting is only one of several for these activities. Nevertheless trainees should be encouraged to recognize and take every opportunity for prevention of illness and promotion of good health, for example, by teaching patients about the social and medical consequences of sexual behaviour, and of the abuse of tobacco, alcohol or other drugs. Trainees should learn about the human life cycle, such as adolescence and ageing, and sexuality, to the prevention of illness and the promotion of health.

10. *Teamwork.* Trainees should learn to achieve good working relationships with medical and non-medical colleagues and to develop attitudes which contribute to the effective functioning of a multi-disciplinary team.

11. *Evaluation of the quality of care.* This involves activities such as assessment of the effectiveness of individual patient care, and in a wider context the commitment of health services resources. It can help trainees to recognize opportunities for making, when possible, a contribution to the progress of medicine and to new knowledge. Trainees should as far as is practicable, participate in such evaluation where it is undertaken by the team of which they are members and be involved in audit of their own activities including the assessment of their own progress and training programmes.

12. *Basic record keeping and information retrieval.* Trainees should learn how to keep records and transmit appropriate clinical information, and to be familiar with information storage and retrieval systems. The importance of professional confidentiality and the legal implications of data protection should be emphasized.