Original articles

Induction for senior house officers. Part II: The departmental programme

Simon J Ward, Paula Stanley

Summary

This study was designed to examine the content and usefulness of departmental induction programmes to senior house officers (SHOs) and to explore perceptions of the usefulness of a range of topics to these trainees. A total of 64 SHOs, in five hospitals in the Anglia region, participated in semi-structured interviews up to 3 months after starting their post. The interviews investigated the content of any induction received and also examined what the trainees would have liked to have received. Almost half (29) of the SHOs also completed a questionnaire which examined the perceived usefulness of various induction topics for a trainee starting a new post. The results showed that, although a departmental induction programme is considered important and highly valued, a substantial minority of SHOs had not received one. Of this minority, 75% would have welcomed an induction. Where an induction had taken place, the focus was primarily upon timetables, tours and meeting people, however, a quarter of the questionnaire sample had not received a service timetable, a third had not met any consultants, two-thirds had received no introduction to clinical management, and two-thirds had received no information about how their consultants manage their patients. Thus, although many trainees receive an induction, important information may not be covered. A staged approach to departmental induction is recommended, using a short, high-quality, and comprehensive induction programme. Flexible and timely programmes, supported by comprehensive written information, will contribute to meeting the needs of trainees in an efficient and effective way.

Keywords: induction; training; education

School of Education,
University of
Cambridge,
Cambridge, UK
S J Ward
P Stanley

Correspondence to
Simon J Ward, 40 Rodwell
Road, East Dulwich, London
SE22 9LE, UK

Accepted 20 January 1999

the department and the handover of patient care, as well as allowing trainees to be more competent more quickly. Although some effort is required to design and deliver such a programme, the potential returns over the ensuing months can be enormous, with reductions in variations from standard practice and enhanced service delivery.

Despite its obvious importance, no published research investigates departmental induction. Research has either focused on induction to the whole hospital or has failed to separate hospital from departmental induction.¹ This lack of clarity of definition and provision can result in confusion, gaps or overlaps between hospital and departmental programmes.²

We investigated the content and perceived usefulness of departmental induction programmes for senior house officers (SHOs). Whilst many trainees may remember discovering peculiarities about a post that they wished they had known at the start, this research aims to draw together some of this knowledge to inform practice across departments.

Methods

Trainees starting a new post in August 1996 or February 1997, in one of five hospitals in the Anglia region, were invited to contribute to the study. There was a 55% response rate. The study was undertaken in two phases. In the first phase, 35 SHOs from 10 specialties in three hospitals were interviewed, using a standardised semi-structured schedule. SHOs were asked to describe their departmental induction, how useful it was and how satisfied they were with it. They were also asked to describe the content and style of their preferred induction.

From the data obtained in this first phase, a self-completion questionnaire was designed for use in addition to the interview. This questionnaire listed a range of topics which might be included in an induction programme. Trainees were asked to indicate which they had or had not received and which, if they had been offered, would have been useful. In total, 29 SHOs from nine specialties, in three hospitals (two hospitals being changed from the first phase), took part in this second phase.

Qualitative data were categorised and coded. All data were analysed using Microsoft SPSS. Frequency counts, Chi-square, and Mann-Whitney U tests for non-parametric data were employed.

Results

Sixty-four SHOs from 10 specialties were interviewed, of whom 29 completed the questionnaire. One-quarter of the trainees were in their first ever SHO post and 80% were in their first SHO post in the department concerned. Two-thirds of the sample received a departmental induction programme. These programmes were delivered by various grades of staff (box 1).

Three-quarters of the inductions were planned and one-quarter arose opportunistically. Almost all of the inductions (93%) took place during week one of the post. The varying lengths of the programmes are shown in box 2. Box 3 details the results of the questionnaire responses ($n=29$), describing what was covered in the induction programmes and how useful this was to the trainees.

Departmental inductions focused primarily upon timetables, tours and meeting people. Although two-thirds received an induction, many received only a limited range of information. Most notably, one-quarter did not receive a timetable of service commitments and one-third did not meet any consultants. Two-thirds received no introduction to clinical management and two-thirds received no information about how their consultants manage their patients.

Nearly all the topics that were provided were rated by trainees either as of 'much use' or of 'some use'. The only exception was for 'meeting other new doctors' which was viewed as being of 'no use' by 7% of the SHOs. These findings were supported by satisfaction levels. Of those who received an induction, 65% were

Providers of induction programmes

One or more consultants: 33%
Outgoing post-holder: 23%
Specialist registrar: 19%
Nursing staff: 2%
Individuals of different grades: 23%

Box 1

Length of induction programmes

One hour or less: 35%
Between one hour and half a day: 42%
One day or more: 18%
Spread over a few days: 5%

Box 2

'satisfied' or 'very satisfied' with it, 16% had 'mixed views' and 16% were 'dissatisfied' or 'very dissatisfied'. Thus, although inductions are not universal or comprehensive, where they are provided, most trainees find them useful.

When comparing the responses of sub-samples of SHOs there were no statistical differences in the information provided according to time in post or experience of working in the hospital. Statistical differences were, however, apparent between SHOs who had worked in the specialty before and those who had not. Trainees who had worked in the specialty before were less likely to be provided with a number of topics and these are shown in box 4. These differences suggest some informal adaptation of programmes according to experience of the specialty but not to experience of working in the hospital or to time spent as an SHO.

Overall, one-third of trainees did not receive an induction and of these, three-quarters would have welcomed one, whilst the remainder would not. This latter point was because the SHOs had either worked in the department, or with members of the team, before, or the department was so small that a formal induction was viewed as unnecessary.

With regard to the trainees' wishes for induction programmes, consultants and juniors feature heavily in perceptions of who should provide the induction. Four-fifths of trainees thought that it should be provided, or contributed to, by consultants, including some who said it should be the Clinical Director. This proportion includes one-third who thought that a mixed team of consultants and juniors should provide the programme. One-fifth thought that the induction should be provided by a team of juniors.

Although, as intuitively expected, most trainees (79%) considered that induction was best provided on the first day of their post, a substantial minority suggested providing it before the start of the post, or spreading it out over the first few days. Two-thirds suggested that the induction could be delivered in half a day or less; indeed, one-third considered that one hour or less would be sufficient. Of the remaining third,

Trainees' questionnaire responses ($n=29$) to what was covered in their inductions and its use to them

	Covered (%)	Of 'much' or 'some' use (%)
Before, or on starting, your post did you:		
• shadow a trainer or trainee	10	10**
• overlap with the outgoing trainee	18	18**
• discuss the post with the outgoing trainee	65	65
• meet other new doctors	71	64*
Did your induction cover:		
• pastoral support available	14	14**
• examples of completed forms	17	17**
• identity of individuals you will meet	17	17**
• departmental research/audit	25	25**
• clinical patient management	32	32
• experiences the post will offer	34	35
• consultant preferences and practices	38	38
• tests available and how to organise them	43	43
• department's expectations of you	50	50
• admission/discharge policies	50	50
• departmental protocols	52	52
• useful telephone numbers/bleeps	52	52
• guided tour	54	53
• senior medical support available	59	56**
• meet the department's non-medical staff	59	59
• meet department's consultant staff	68	68
• on-call/rota/shifts/cover arrangements	71	72*
• meet department's other medical staff	72	72*
• timetable of service commitments	74	74*
• educational activities (eg, timetable/ study leave/supervisor/training plan)	76	79**

Chi-square: ** $p<0.01$, * $p<0.05$

Box 3

Topics less likely to be provided to SHOs with specialty experience

- guided tour*
- meet department's consultant staff*
- meet department's other medical staff*
- tests available and how to organise them**
- clinical patient management**

* $p < 0.01$; ** $p < 0.05$

Box 4

half (17%) considered it better to spread the induction over the first few days, some (11%) felt that the length did not matter as long as everything which needed to be covered was, and the remainder (6%) wanted their induction to span their first day. One interpretation of this variety is that it is the quality of the induction that is important rather than its quantity.

Most trainees would find it useful to have the information and/or opportunities listed in box 5 made available to them. For 17 of the 24 topics (71%) more than half the sample said they would be of 'much use' to them. Only two topics were viewed as of 'no use' by a salient minority of SHOs and these were 'shadow a trainer or trainee' (22%) and 'pastoral support available' (29%).

For most variables there were no significant differences between sub-samples of SHOs, suggesting little diversity in needs according to experience. The exceptions to this were that those in their first post rated information about

on-call arrangements, rota and shift patterns ($p < 0.05$) and about where to get pastoral support ($p < 0.05$) as more useful than those in their subsequent posts. Another exception was that trainees new to the specialty rated information on clinical management as more useful than those in their subsequent posts in the specialty ($p < 0.01$).

Pre-post discussions and/or contact via telephone or letter with the out-going post-holder proved to be an important source of information. Where trainees made contact before starting their post, information such as consultant practices and preferences was imparted; more than 80% found such contact to be very useful. A similar proportion thought that such a discussion would be very useful to them in a future post. In one specialty an SHO wrote a highly praised short booklet of information for new trainees which included advice on how to manage everyday conditions/problems and consultant preferences concerning treatment and medication. In another, the in-coming post-holder received a similarly praised letter from the out-going post-holder containing important "how to..." information.

The overall findings suggest that the content of departmental inductions varies considerably, and also that the needs of trainees vary. Although levels of satisfaction with current provision are high, the information provided fails to meet the range of trainees' needs: trainees want more information made available to them. Trainees would welcome greater consultant involvement in their induction, together with some junior input. However, a programme that lasts more than half a day would not be welcomed. To be effective, programmes must convey a wide range of information over a short period.

With regard to timing, most introductory sessions take place on the first day of a post; a time when most trainees consider it appropriate. However, the findings raise two questions. First, whether it would be better to provide the induction in a staged approach, so integrating it within service, and second, whether it is best provided before or after the hospital induction. These questions could usefully be assessed by further research.

Discussion

How can departmental induction be improved? Based on the findings presented, a model of a staged approach to departmental induction is proposed (boxes 6–8). This staged approach is based on the educational principle of assessing trainees' actual needs rather than organisational perceptions of their needs. This approach would convey a wide range of information with minimal disruption to service, and place fewer demands upon anxious trainees. To provide a fully co-ordinated approach, this model needs to be integrated with the hospital induction programme. Stage one, on day one, provides essential service information, sufficient to ensure that trainees are equipped to deliver their first few days of service and to respond competently during their first period on-call. This short intro-

Responses ($n=29$) to the question "how useful would the following information/ activity be to you when starting a post in a new specialty?"

	Of 'much' use (%)
How useful would the following be to you before, or on starting your post:	
• discuss the post with the outgoing trainee	82**
• shadow a trainer or trainee	56*
• overlap with the outgoing trainee	50*
• meet other new doctors	48
How useful would the following information be to you on starting your post:	
• department's expectations of you	86**
• on-call/rota/shifts/cover arrangements	86**
• tests available and how to organise them	82**
• timetable of service commitments	79**
• useful telephone numbers/bleeps	79*
• departmental protocols	76**
• admissions/discharge policies	74**
• consultant preferences and practices	69**
• clinical patient management	69*
• educational activities (eg, timetable/ study leave/supervisor/ training plan)	65
• senior medical support available	63
• experiences the post will offer	59
• meet department's other medical staff	59
• guided tour	52
• meet department's consultant staff	48*
• meet the department's non-medical staff	38*
• examples of completed forms	25*
• departmental research/audit	21**
• identity of individuals you will meet	21*
• pastoral support available	14*

Chi-square: ** $p < 0.01$, * $p < 0.05$

Box 5

Stage I: An introduction to service*Timing*

- day 1

Aims

- familiarisation with people and post
- equip trainees with general information to deliver service with support

Content

- rota, service and educational timetables
- meet senior staff
- service knowledge required immediately (eg, emergencies, investigations, useful numbers, admissions and discharge policies)
- consultant expectations of trainees
- sources of medical support and advice

Format

- face-to-face meetings and discussions supported by written guidance

Providers

- consultants and trainees

Box 6**Stage II: Understanding the service role and responsibilities***Timing*

- week 1 onwards

Aims

- provide detailed and specific service information
- equip trainees to work without supervision where appropriate
- provide specialty-specific skill training
- develop specialty-specific knowledge

Content

- departmental protocols
- consultant practices and preferences
- clinical management of various conditions
- specialty-specific knowledge and skills

Format

- group/individual discussions supported by written materials

Providers

- consultants

Box 7

ductory session includes any 'unofficial' knowledge which the previous post-holders may have acquired. Once trainees begin to feel that they can cope with the basic demands of service, detailed service information can be conveyed. Thus stage two, beginning up to a week into the post, begins a more in-depth introduction to service, building the knowledge and skills to enable trainees to work increasingly without direct supervision. Stage three, beginning in week two or later, focuses on clinical education and training as well as focusing on specialty-specific knowledge and skills. From the findings of this study a number of 'take-home' practical guidelines can be suggested on organising departmental induction programmes (box 9).

Stage III: An introduction to clinical education and training*Timing*

- week 2 onwards

Aims

- develop trainees' education and training role, responsibilities and skills

Content

- training plans and educational supervision
- educational opportunities and how to take advantage of them
- giving and getting feedback

Format

- face-to-face discussions

Providers

- consultants/educational supervisors

Box 8**Practical guidelines for organising a departmental induction**

- provide comprehensive information and advice
- use written as well as oral advice
- ask existing trainees to write, and keep up-to-date, a short advice sheet on what trainees new to the specialty need to know
- advise trainees at interview to meet with their outgoing post-holder to get a detailed picture of the post
- encourage out-going post-holders to write a summary of useful information for the in-coming trainee
- use a staged approach, concentrating on service in the early stages and education and training later on
- involve juniors and consultants, building the programme around people as well as information
- monitor, evaluate and adapt the programme to meet changing needs over time

Box 9

In summary, the results confirm that departmental induction programmes for SHOs are important and highly valued, but a substantial minority of trainees do not receive one. Trainees want more information, of a practical nature, and they want more consultant involvement. An effective induction programme can do much to smooth a trainee's entry into a post. By providing a well-designed and timely programme, trainees can receive the information they need, at a time when they need it. By removing many initial anxieties, trainees can move quickly and comfortably into making an effective contribution to service and quality patient care, while profiting from the training provided.

We acknowledge Professor DH Hargreaves for his advice and guidance, and Dr JS Biggs for his support.

This research was funded by the Anglia Postgraduate Medical and Dental Education Committee as part of the Project on the Training of Doctors in Hospital, University of Cambridge.

- 1 Gale R, Jackson G, Nicholls M. How to run an induction meeting for house officers. *BMJ* 1992;304:1619–20.
- 2 Committee of Postgraduate Medical Deans (COPMED) and the UK conference of Postgraduate Deans. *SHO*

training: tackling the issues, raising the standards. Discussion paper. London: COPMED, January 1995.