Induction for senior house officers. Part I: The hospital programme

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Summary
The study was set up to examine how an induction programme can be designed to meet the needs and expectations of senior house officers (SHOs) beginning a new post in a hospital. A total of 63 SHOs, in five hospitals in the Anglia region, participated in standardised structured interviews up to 3 months after starting their post, by sorting a list of 38 possible induction topics in order of priority. Trainees' early induction needs were found to centre on day-one service activities, ie, information that enables them to undertake their service work efficiently and effectively, is particularly valued and required early. Information related to clinical education and training is also valued, but many trainees prefer it to be provided after they have been in post for a week or two. Much induction information can also be effectively conveyed in writing, with little or no need for additional formal presentation. We conclude that first-day induction programmes which strive to satisfy the range of trainee needs in one session fail to take account of the different priorities that trainees attach to induction information. Trainees do not want all information at once. Information of prime concern to clinical tutors, namely education, training and generic skills, is generally favoured after a week or two. To ensure that trainees' hospital induction needs are met in an efficient and effective way, programmes must be flexible and timely, and supported by comprehensive written information.

Keywords: induction; training; education

Hospital induction programmes integrate trainees into hospitals as quickly as possible, aiding smooth running, and reduce levels of anxiety, allowing trainees to feel more competent more quickly.1 Induction programmes are strongly recommended in a number of reports and by postgraduate deans.2–7 Indeed, they are now mandatory for pre-registration house officers.8

Although most hospitals now run an induction programme, there is great variety in their content and style. This may be due to different published lists of suggested topics3 8 or to lack of systematic research in this area. Most programmes are chosen by seniors, rather than by trainees as advocated;1 8 consequently, they may not meet the needs of trainees. Programmes often consist of short didactic presentations,2 3 which may not be the optimal adult learning method.9 Also, trainees may have a diverse range of experience, giving rise to different needs and expectations, which may or may not be fulfilled by an induction programme. This programme may be repeated regularly in the same format, irrespective of changing needs, whilst the programme's usefulness is rarely evaluated.1 Special induction problems also exist for trainees who are not synchronised with the main rotation times, and for other European and foreign graduates.

Published research discusses induction for pre-registration house officers3 5 or examines mixed grades of trainees.1 It does not concentrate on the 'lost and breeding tribe' of senior house officers (SHOs).12 13 This research takes SHOs as its focus. It examines how an induction programme may be designed to maximise the chances that it meets the diverse range of trainees' needs and expectations.

Methods
A total of 115 SHOs starting a post in August 1996 or February 1997, in one of five training hospitals in the Anglia region, were invited to contribute to the study. There was a 55% response rate. Each SHO sorted 38 induction topics, collated from the literature,1–8 in response to three questions:

Question 1: How valuable would each topic be to you if covered on an induction programme when joining a new hospital (of real value / of little value)?

Question 2: At what stage of your post would these topics best be provided (within the first few days / after a week or two)?

Question 3: In what form would the information be most appropriately conveyed (in writing only / in writing supported by spoken information) and in what style (formal presentation / group discussion / practical activity)?

The data were analysed using Microsoft SPSS. Frequency counts were performed and Chi-Square and Mann-Whitney-U tests for non-parametric data employed.

Results
Sixty-three SHOs from 10 specialties were interviewed. Most (75%) of the trainees were in their first SHO post in the hospital and 25% were in the first SHO post of their career.
Trainees were first questioned about the value of programme topics and their responses are detailed in table 1. Thirty-one of the 38 topics (82%) were rated ‘of real value’ by more than half the sample and only five (13%) were rated ‘of little value’ by more than half the sample (health and safety/fire drill, bereavement/breaking bad news, laundry/white coats, independent/pastoral advice, chief executive’s welcome), reflecting the breadth of topics upon which programmes could unusually valuably. For every topic, at least 10% of trainees gave a rating other than ‘of real value’, suggesting that whatever information is provided, it will be of little value to at least a small proportion of trainees. Topics to which fewer trainees attributed real value included those which contribute little to trainees’ immediate concerns about how to function successfully in their new post. No single programme will meet the needs of all trainees, therefore ways must be found of minimising the provision of unnecessary information.

Statistically significant differences in value ratings between samples were found in relation to a small number of topics. Trainees who had worked in the hospital before assigned more value to careers advice (p<0.01), P45/salaries and wages (p<0.05), and educational activities/timetable (p<0.05) than those who had not. Trainees in their second or subsequent SHO post were more likely to value information on housekeeping/accommodation (p<0.01), laundry/white coats (p<0.05), car parking/permit (p<0.05). Those in their first SHO post were more likely to value meeting the clinical tutor (p<0.05) and information on independent pastoral advice (p<0.05).

Although the number of topics that show significant differences between groups are small, these findings suggest differing needs among SHOs. Consequently, programmes need to be sufficiently flexible to allow trainees to select appropriate information.

Trainees were then questioned about programme timing and their responses are detailed in table 2. More than half the sample suggested that two out of three topics (63%) would be best provided within the first week and more than half suggested that three of the 38 topics (8%) would best be provided at a latter stage (study leave, sick leave/career and careers advice). The high proportion of trainees who had no strong views about the timing lends support to the view that there are topics that are not essential to provide during the first week, and could be provided appropriately later.

Topics which more trainees considered were best provided early, or about which they had no strong views, grouped around three themes: orientation: tour of hospital, mess/facilities and educational facilities; timetable of educational activities and events; administrative and ‘comfort’ requirements: bleeps/switchboard; keys/rooms/housekeeping; photo ID/badge; dining facilities/out-of-hours catering; car parking and permit; contract terms and conditions; laundry/white coats; P45/salaries/wages; essential knowledge and skills to practise from day one.
Chi-Square: all topics significant at p<0.01 except *p<0.05 (see text for explanation)

Table 4

<table>
<thead>
<tr>
<th>Stage</th>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>An introduction to service</td>
<td>An introduction to clinical education &amp; training</td>
</tr>
<tr>
<td>Aim</td>
<td>To equip trainees with the knowledge &amp; skills to maximise teaching &amp; learning opportunities (formal and informal)</td>
<td>Hospital-wide approach to education &amp; training and advice on how to create and use teaching &amp; learning opportunities (formal and informal)</td>
</tr>
<tr>
<td>Content</td>
<td>Hospital-wide services/information</td>
<td>Departmental services/information</td>
</tr>
<tr>
<td>Format</td>
<td>Written advice on all induction topics (service &amp; training)</td>
<td>Written advice on educational events, study leave processes</td>
</tr>
<tr>
<td></td>
<td>Formal presentations where necessary on service issues only, to support written materials</td>
<td>Group discussions with Clinical Tutor on how to get the most out of training opportunities</td>
</tr>
<tr>
<td></td>
<td>Practical activity on eg, CPR, use of computer system</td>
<td>Formal meeting with educational supervisor/clinical tutor/careers counsellor</td>
</tr>
</tbody>
</table>

Chi-Square: all topics significant at p<0.01 except *p<0.05 (see text for explanation)
original 38 topics (excluding those which could only be provided in one format, eg, a tour) according to the format which they considered the best. On only seven topics (27%) did more than half the sample suggest that presentation in addition to written format was required. Topics particularly amenable to group discussion included the generic skill topics of ethics/consent; communicating with GPs, and bereavement/breaking bad news. Those particularly amenable to practical activity included CPR and use of the hospital computer system.

Trainees who had worked in the hospital previously, as compared to those who had not, were more likely to want information presented to them orally as well as in writing in relation to: the hospital computer system (p<0.01) and paramedical support staff (p<0.05). This was also the case for trainees in their first SHO job as compared to those who were not, in relation to: a statement of training policy/practice (p<0.05), and how and when to transfer patients (p<0.05). Trainees in their second or subsequent SHO post were more likely to want information presented orally as well as in writing on: CPR (p<0.05); keys/rooms/ housekeeping (p<0.05), and the hospital computer system (p<0.05).

Thus, although trainees value information on a wide range of topics, much can be conveyed in writing. This written form has the advantage of being available as a reference source to be used as required and also allows the selection of information according to need, rather than requiring trainees to filter out irrelevant information as it is presented.

Discussion

How can hospital induction be improved? On the basis of these findings, a two-stage approach to induction is proposed (see Table 4). This approach would reduce disruption to service during the induction period and place fewer demands upon trainees at a time of great anxiety, allowing them to absorb information over time. This model integrates hospital induction with departmental induction, so providing a coordinated approach. Departmental induction is the subject of an ensuing article.

Stage one, on day one, provides essential service information. Stage two, provided after a week or two, focuses on education and training. The practical problem of getting SHOs together for stage two can be minimised by using established lunch-time education slots which trainees would ordinarily attend. Generic skills training, where required, could flow from stage two sessions.

From the findings of this study a number of ‘take-home’ practical guidelines can be suggested when organising hospital induction programmes (box). Induction programme organisers are faced with an increasing variety of suggestions and standards concerning information that may be appropriate for programmes to contain, eg, health and safety regulations. In addition, stakeholders other than the trainees, such as the coroner’s officer, infection control and fire officers, may well have differing views on the optimal programme content, timing or format. Thus it is important for organisers to note that some topics may be vital to provide, despite trainees attaching less value to them. At the same time, organisers face conflicting time constraints between service commitments and education requirements. Consequently, all of these factors have to be placed into the institutional contexts in which programmes take place. Variations between induction programmes are therefore inevitable because compromises will be necessary. To facilitate these compromises, collaboration and partnerships will be needed and this is especially important between trainee and trainer, eg, as learning contracts. Objective, as well as subjective, evaluations of the programmes and their value and effectiveness in ‘real-life’ clinical contexts, using validated outcome measures, is also essential. Well planned and efficient hospital induction may then allow enhanced trainee performance and maximise the quality of patient care provided.

Conclusion

Hospital induction programmes are important and highly valued. Programmes often consist of one-off, first day collections of didactic presentations which may not meet the diverse range of needs that trainees have, nor their preferences for style of presentation or timing. Flexible, timely programmes, supported by comprehensive written information, are needed. This research has led to the construction of a two-stage model for induction, based on the sound educational principle of assessing trainees’ needs. Stage one focuses upon trainee capability to undertake service work and to respond to emergencies from day one. Once trainees feel in control of the service responsibilities, stage two focuses upon clinical education and training. An effective induction programme does much to smooth the process.
of assimilation of new information. Where hospitals provide sound, well-designed and timely induction programmes, trainees receive the information they need, at a time when they need it, and in a format that makes the process valuable and interesting. Such programmes remove much of trainees’ initial anxieties enabling them to move quickly and comfortably into making an effective contribution to service and to profiting from training provided.

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