Medical Education

The Safety Net and preregistration posts

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Summary and conclusions

The Safety Net is a clearing system that collects and distributes information about preregistration posts remaining unallocated after as many doctors as possible have been placed by local efforts. Provided that the local systems operate in the final year, the Safety Net should ensure that each student has a post allocated to him before he sits the final examination.

Introduction

The working group set up by the DHSS to advise on ways of ensuring adequate preregistration posts accepted that there would be enough in 1977, though the margin might be narrow. As expected, the margin was small and a few doctors could not find posts where they wanted them. Arrangements were complicated by the change in 1977 in graduation dates for three London medical schools: St George's, University College Hospital, and Westminster; similar changes in graduation date occurred in 1978 (Guy's, Middlesex, St Mary's, and St Thomas's) and more are due in 1979 (Charing Cross, King's, the London, the Royal Free, and St Bartholomew's).

If regional targets set by the DHSS (table I) are achieved—as seems likely—enough posts should be available to meet future needs and still leave some for doctors who qualify outside the UK. Students approaching qualification may therefore be assured that there will be posts for all of them,¹ though each new graduate may not be able to find one exactly where he wants it. Many new doctors now find their posts through matching schemes run by medical schools. Although some prefer to find posts outside these schemes, others are forced to, because the schemes do not always have enough posts linked to them to meet the demand.

Preregistration posts may be divided into two groups: those that are linked to a medical school (or a matching scheme) and those that are not.

Linked posts are those that a medical school, a health authority, and a consultant agree will be filled by a graduate from the medical school. In some schools the dean of the faculty or the postgraduate sub-dean is responsible for the arrangement, whereas in others it is the regional postgraduate dean. In some schools students are left to apply for posts from a list displayed on a notice board; sometimes the dean, the subdean, or

the preregistration committee tries to match consultants' preferences with students' choices; and in a few regions a computer-based scheme does the matching.^{2 3}

Unlinked posts are advertised in the medical press or filled by private negotiations between the consultant in charge of the post and the student seeking it, or through personal contact between the consultant and a medical-school teacher willing to recommend a suitable student.

After the linked and unlinked posts have been filled some regions have surplus posts and some have unplaced doctors; a few may have some of each, but generally the unallocated posts and the unplaced doctors are in different regions. On the advice of its working group, the DHSS asked the Council for Postgraduate Medical Education in England and Wales to plan and run a national clearing scheme for preregistration posts. The Council accepted the invitation and in 1977 began to run the Safety Net.

The Safety Net

In essence, the Safety Net is not unlike an emergency bed service. It collects information about unallocated posts and makes it available to those concerned with helping graduates to find posts. It is meant to augment, not to replace, existing regional, medical-school, or private arrangements and, being a clearing-up operation, it functions after local systems have filled as many posts as they can.

COLLECTING INFORMATION

The Safety Net depends on employing authorities for information about unallocated posts. These authorities are the only source of information about both linked and unlinked posts. The DHSS has asked area medical officers to arrange for the Safety Net to be notified of posts remaining unallocated after local efforts have failed. The posts are clearly defined by specialty (medical or surgical), consultant, hospital, and area; the name and telephone number of the person to contact about the post is also given. If the system is to work efficiently, employing authorities must also inform the Safety Net as soon as they fill a post previously notified as unallocated.

With the completion of local placing operations and attempts to fill posts the appropriate medical-school officer (table II) should inform the Safety Net of the names of students still unplaced and of whether they are seeking a medical or a surgical post or can accept either. When a candidate finds a post it would be helpful if, in addition to his name, details of the post he has taken were reported to the Safety Net by the medical school, even though the filling of the post should also be reported separately by the employing authority.

The Safety Net does not normally accept applications for posts from individual UK students. Candidates for posts are expected to apply to the appropriate person in the medical school or region that they prefer. The Safety Net will normally deal directly only with graduates who have no connection with a school in the UK, such as overseas doctors who have qualified through non-university licensing bodies or EEC candidates seeking preregistration posts. A few students who have not yet reached the final year are already applying to the Safety Net for posts that they will not need for a year or two. The

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TABLE I—Medical-school output* and target numbers of preregistration house-officer posts, according to region. (Figures supplied by DHSS)

Region	1978†		1979		1980		1981	
	Output	Target	Output	Target	Output	Target	Output	Target
Northern	120	170	100	180	120	180	120	180
Yorkshire	125	190	120	200	120	200	120	200
Trent	155	200	155	220	255	220	275	240
East Anglia	80	80	50	90	50	90	80	100
Thames (combined)	1295	980	1310	990	1165	990	1170	1000
Wessex	75	140	105	140	95	140	120	150
Oxford	65	110	70	110	70	110	100	120
South-western	110	160	120	170	110	170	120	180
W Midlands	145	260	150	270	150	270	150	280
Mersey	140	150	145	150	140	150	135	150
North-western	250	230	250	240	260	240	250	250
Totals:								
England	2480	2670	2575	2760	2535	2760	2640	2850
Wales	115	145	115	145	135	155	135	155

*Output figures are based on intake figures five years previously, on the assumption of 9% wastage, rounded. Trent output figures combine Leicester, Nottingham, and Sheffield graduates. East Anglia and Oxford figures include only students who complete medical training at Oxford and Cambridge. Thames output figures are for all London medical schools.

†The target for 1978 is firm; targets for subsequent years will be reviewed annually, the next review being in summer 1978. The DHSS has asked regions that already exceed their target not to reduce the number of available posts.

TABLE II—Members of staff responsible for helping students to find preregistration posts, according to region

Region	Responsible officer	Contact	Thames region	Medical school	Postgraduate subdean	Contact
Northern ..	Professor P Rhodes	Dr A G Leishman	North-west	St Mary's	Dr P H Sanderson	Miss P Diamond
Yorkshire ..	Professor D R Wood	Mrs J Mackenzie		Westminster	Dr J Gleeson	Miss F M Packman
Trent ..	Mr R Nicholson	Dr K J Gurling		Middlesex	Dr K B Saunders	Mrs M Williams
	(Administrator, regional postgraduate committee)	(Nottingham); Professor G N C Crawford (Sheffield); Mr K F Wood (Leicester)	South-west	Charing Cross	Mr H B Holden	Miss S Blanchfield or Miss P Macdougall
East Anglia ..	Mr C Parish	Miss Linda Carter	North-east	St George's	Dr P Richards	Miss J Elliott
Wessex ..	Dr R Moore	Mr Craig Duncan		London	Dr A D M Jackson	Miss J Jeffery
Oxford ..	Mr J M Potter	Mr J M Potter		St Bartholomew's	Dr M L Clark	Miss Dora Hampton or Miss M G Scaal
South-western ..	Dr J Cates	Dr J Cates	South-east	University College	Dr L Watson	Mrs P Sykes
West Midlands ..	Mr P Bevan	Mr P Bevan		Royal Free	Professor K Hobbs	Miss G Clack
Mersey ..	Mr A S Davidson	Dr Brian McGuinness		King's College	Dr B S Cardell	Mrs W Chilcott
North-western ..	Professor J H Kellgren	Mr H R Bennett		St Thomas's	Mr R W Lloyd-Davies	Miss S Brackpool or Miss Rosemary Cains
Wales ..	Dr D H Makinson	Dr D H Makinson		Guy's	Mr P Schurr	
				Council for Postgraduate Medical Education:		Mrs Rosemary Marks

Safety Net cannot help with such proleptic arrangements, since it is designed to be a clearing-up scheme.

Lists of all unallocated posts notified to the Safety Net are distributed to the dean or his nominee (table II). This information needs to be exchanged as rapidly as possible, so the nominated contact must be directly in touch with those seeking the posts. The Safety Net does not propose to send the lists to each doctor. When most of the doctors have found posts the Safety Net is prepared, at the request of medical schools, to communicate directly with the few remaining unplaced candidates.

FILLING PREREGISTRATION POSTS WITH EXPERIENCED DOCTORS

Preregistration posts should not be filled with experienced doctors until all those needing them for registration purposes have been placed. Employing authorities should not appoint an experienced doctor to a preregistration post until the DHSS has declared that there are no doctors requiring such posts for registration purposes. If the authority is in doubt the Safety Net should be consulted. If posts are filled with experienced doctors they should be made available again for provisionally registered doctors on the usual starting dates for preregistration posts: 1 August and 1 February.

TIMETABLE OF EVENTS

The desirable timetable is shown in the appendix, which also summarises the arrangements. The dates shown should be regarded as the *latest* that would allow time for the Safety Net to work; an extra two to four weeks should preferably be allowed.

The Safety Net is most active from about mid-May to mid-June, but continues to operate throughout July until all doctors have found posts. It may also be active from mid-November for those doctors who were not given two posts earlier in the year and for those who qualify in December. Although the mechanism is quiescent at other times it is available for those who need it.

Discussion

The Safety Net depends on schools and authorities to place as many candidates as early as possible. Most students prefer to know before the final examination what their appointment will be if they are successful, not least because the young doctor wants to be sure of starting his post without delay. It is hard to understand why early allocation is not universal. Some schools already make their allocation of posts well before the final examinations, and some consultants, relying on the student's record in earlier parts of the course, offer appointments as much as a year ahead. Other consultants, however, wish to know how students perform in the final examination before choosing a house officer, and some schools find it difficult to make early appointments even though the final cohort of students may not change greatly between the beginning and end of the final year. The reallocation of posts freed by failure in the examination should not be a major problem, provided that the freed posts are immediately notified.

In regions that are not self-sufficient in posts, some new doctors may be seriously inconvenienced if allocations are delayed until the examination results become available because there may not be time to place them in posts by 1 August. It seems strange, therefore, that any school faced with a shortage of posts for its students should be among those opposed to early allocation. If regional schemes were advertised from about November to January and completed by about the end of April, the Safety Net would have adequate time to see that by about the end of June everyone had the offer of a post starting on 1 August. The Safety Net does not restrict advertising of pre-registration posts for doctors needing them for registration purposes, but it does insist that preregistration posts should be reserved for preregistration candidates until all new doctors have been placed.

Although there are enough posts to meet the demand, the

number of posts in a region does not always match the output of doctors from schools in that region (table I). The greatest deficiency is in the Thames regions, where the number of graduates exceeds the number of posts by over 300. Some London graduates must therefore be prepared to move to other regions, where they will find that the clinical opportunities compare with those in London. Similarly, graduates from schools outside London should not expect to find posts in London. The Safety Net seemed to work reasonably well in 1977 and 1978 and it is hoped that, with the co-operation of medical schools and employing authorities, especially in the early allocation of posts, it will be even better in future years.

The Safety Net is a modification of a system devised by the late Dr J D F Davies. I thank Miss Beryl Brown and Dr Michael Essex-Lopresti, my colleagues at the Council, for their enthusiastic support, and I am particularly indebted to Sir John Richardson for his encouragement and to Dr John Brothwood and Dr Robert Lowe for many helpful suggestions. It is a pleasure to acknowledge the ready co-operation of health authorities in notifying vacant posts and of medical schools that have been able to allocate posts before the final examination.

Appendix

The Safety Net in outline: suggested timetable of events

PHASE 1: LOCAL ATTEMPTS AT PLACING STUDENTS

Nov-Dec—Publicity for local arrangements (matching schemes and others) by advertisements, notices, letters, etc.

Jan-April—Local schemes place as many students as possible, aiming at being complete by about end of April or early May.

10 May—Completion of phase 1—all students of the medical school who can be placed have been allocated a post.

15 May—Safety Net is notified (a) by medical school contact—names of unplaced students; (b) by AHAs—details of unallocated posts (area, hospital, consultant, specialty; name and phone number of contact).

Posts to be offered only to doctors requiring them for preregistration purposes.

PHASE 2: SAFETY NET ACTIVITY

Mid-May to mid-June—(a) Safety Net compiles lists of unallocated

posts showing area, hospital, consultant, specialty, name, and phone number of contact; (b) lists distributed frequently to named contacts in medical schools (table II) with unplaced students; (c) medical schools advise candidates in the choice of jobs for which they should apply.

Early July—(d) Final results available and provisional allocations confirmed. Medical schools to inform employing authorities of students who have failed examinations and cannot take up posts allocated to them. AHAs notify Safety Net about posts falling vacant. (e) Safety Net continues to exchange information; Safety Net needs to be told about filling of any post previously notified as being available and any unplaced graduate who accepts a post.

PHASE 3: FILLING RESIDUAL POSTS WITH EXPERIENCED DOCTORS

1 July onwards—Advertisements for unallocated posts. Posts may not be filled with experienced doctors until all those needing them for preregistration purposes have been placed. The DHSS will tell AHAs when this has been achieved. If in doubt consult the Safety Net.

Posts start 1 August. If an experienced doctor is appointed to a preregistration post starting after 1 August he should give it up on 31 January so that the post remains in phase with preregistration timings.

PHASE 4: SAFETY NET DORMANT

The Safety Net will be available to help the occasional doctor who qualifies at a different time of year through a non-university licensing body or who is granted temporary registration for preregistration purposes.

For rapid contact with the Safety Net telephone 01-323 1289 and ask for Mrs Rosemary Marks.

Address of Safety Net: Council for Postgraduate Medical Education in England and Wales, 7 Marylebone Road, London, NW1 5HA.

References

- ¹ Yellowlees, H, *British Medical Journal*, 1978, **1**, 654.
- ² Doig, A, and Munday, G, *Lancet*, 1969, **1**, 1250.
- ³ Leishman, A G, and Ryan, R P, *Lancet*, 1970, **2**, 459.
- ⁴ Royal Commission on Medical Education 1965-68, *Report*, para 69, p 45. Cmnd 3569. London, HMSO, 1968.

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Is it true that hysterectomy with conservation of the ovaries often results in a diminution of ovarian function and the development of menopausal symptoms? If so, what advice should be given to young women recommended hysterectomy for dysfunctional uterine bleeding? Should hormone replacement therapy be offered to them and for how long?

It is not true that hysterectomy with conservation of the ovaries causes a diminution in ovarian function. There is therefore no routine requirement for hormone replacement in such cases. Climacteric symptoms (a woman who has had a hysterectomy has a menopause though not a climacteric) should be treated just as they would be in a woman who has her uterus. In fact the decision to treat a woman who has had a hysterectomy with oestrogens is easier since there will be no untoward effects on the endometrium, which are the main reasons for hesitation in prescribing them more widely.

How effective is ultraviolet sterilisation for instruments in a GP's surgery?

Although ultraviolet light is effective for surface sterilisation of objects, the quantum of energy it radiates is small, so its lethal activity is often of a relatively low order and its powers of penetration are much smaller than those of other radiations. Ultraviolet light rays travel in a straight line, so objects in the light beam's path cast a shadow with resultant lack of irradiation in the shadowed areas. The method is thus effective only for the flat surfaces of solid objects

and instruments must be turned to expose all surfaces to the rays. Although bacteria may be killed by irradiation with ultraviolet light for a sufficient time at an effective intensity, certain bacteria have grown after exposure to supposedly lethal radiation.¹

Remington's Pharmaceutical Sciences,² in discussing the use of ultraviolet rays for reducing the bacterial content of areas for the preparation of sterile pharmaceutical products, states that it is generally assumed that an irradiation intensity of 20 $\mu\text{W}/\text{s}/\text{cm}^2$ is required for effective antibacterial activity but Sykes³ quotes doses of from 830 to 6400 $\mu\text{W}/\text{s}/\text{cm}^2$ as being necessary for various common bacteria. Nevertheless, he states that since the irradiation from even a 15-watt lamp at 30 cm distance is about 400 $\mu\text{W}/\text{cm}^2$ exposures of up to a maximum of about 16 s should be adequate to effect 90% kill in most cases. It would be wise, however, to extend this to about 15 min to give as wide a margin of safety as possible. Opinions differ on the relative susceptibility of bacteria and viruses to ultraviolet irradiation. It has been stated that the smaller the organism the more susceptible it is to ultraviolet radiation, and theoretically this would seem quite plausible. Sykes³ quotes several examples of experiments showing viruses to have similar susceptibility to that of vegetative bacteria and others demonstrating that they are extremely resistant. He concludes that such contrasting observations may be attributed in part to the divergent characteristics of viruses generally and in part to different experimental working conditions.

¹ Weatherwax, R S, *Journal of Bacteriology*, 1956, **72**, 329.

² *Remington's Pharmaceutical Sciences*, ed E W Martin, 13th edn, p 508. Easton, Pennsylvania, Mack Publishing Company, 1965.

³ Sykes, G, *Disinfection and Sterilisation*, p 138. London, E and F N Spon, 1958.