Learning Medicine

Qualification and the year as a preregistration house officer

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Qualification as a bachelor of medicine and surgery (MB BS or equivalent) after five or six years is not the end but a beginning. Now at last you can learn all the time by doing, a process which continues throughout life: now you are a medical practitioner and can earn your own living. Examinations are not finished and uncertainties about the future are no longer speculations but realities, but at least your first foot is on the ladder. The first rungs are the same for everyone—the preregistration house officer posts, six months in medicine and six months in surgery (or, in one experimental scheme, four months each in medicine, surgery, and general practice). These posts must be satisfactorily completed under supervision before a doctor can be fully (rather than provisionally) registered with the General Medical Council and be formally recognised as entitled to embark on postgraduate training. There are preregistration house officer posts in all medium sized and large general hospitals in the United Kingdom.

Whatever else you do or do not do, it is important to complete preregistration posts at the appointed time. It is permissible but most unwise on passing the final MB to wander off to the Himalayas for transcendental meditation or even to East Cheam to have a baby. Returning after a break to complete preregistration house officer training is not easy and part time completion of the requirements is almost impossible.

The qualifications

Most students pass the final MB examination at the first attempt; roughly 10% have to resit all or part of the examination six months later. Very few fail more than once. Candidates who fail the final MB examination or who are ineligible (because they have not undertaken their preclinical studies at a British university) often try to save time at this stage by obtaining a non-university qualification to practise. There are two of these in England, the MRCS LRCP (Member of the Royal College of Surgeons and Licentiate of the Royal College of Physicians), better known as "conjoint," because it is organised by the conjoint board of these two Royal Colleges, and the LMSSA (Licentiate in Medicine and Surgery of the Society of Apothecaries, London), and two in Scotland, set by the Colleges of Physicians and Surgeons in Edinburgh and Glasgow.

The standard required to pass these examinations is similar to that needed to pass university MB examinations. The only advantage for candidates who have failed the MB is that these examinations can be taken section by section and the Apothecaries' examination is held monthly. The conjoint examination is held every six months as are the university examinations.

House jobs

Medical schools have each built up a pool of preregistration house jobs, partly posts at the central teaching hospital and other university hospitals in the vicinity and partly posts in hospitals throughout the country, often where graduates of the school are consultants. Applications for these house officer posts are handled centrally by each school; some make a more or less random selection by computer, others match consultants' and students' choices as far as is possible. Not all schools have enough posts for all their graduates nor do all their graduates seek posts in the local scheme, as some prefer to find their own posts. There are enough posts for all United Kingdom graduates, and when the number of graduates has increased the number of preregistration house officer posts has been and doubtless will continue to be increased.

Students tend to choose posts at hospitals where they have worked happily as students and to look for consultants who teach conscientiously, take a personal interest in guiding their house officers ("housemen") in their careers, and are pleasant to work for. Sometimes posts are chosen because they are near home or near sailing or some other attraction. On the whole, general experience and responsibility are greater away from the large teaching centres but there is more teaching in the latter.

The amount of supervision, teaching, and experience provided by every preregistration post is assessed formally by the regional postgraduate dean every five years to ensure that it is educationally acceptable. Not all consultants are pleasant to work for (but most are), duty rotas vary considerably, and the standard of both ward facilities and doctors' accommodation is variable, often poor, and sometimes dreadful. The most attractive posts generally go to the applicants who not only apply themselves best to their studies but also use their initiative in discovering which are the best jobs.

Some consultants may prefer a man to a woman (or vice versa) as their house physician or house surgeon, just as some consultants may prefer serious characters to jolly ones. Men and women are equal as house officers: both are "housemen" and they have identical duties. The only difference in name is between house physicians, who are all "Dr," and house surgeons, who at most hospitals are "Mr," "Mrs," or "Miss." House surgeons sometimes resent losing their hardwon title of "Dr" so soon but their surgical pride soon gains the upper hand.

Kingpin of the firm

Housemen are the continuity men (or perhaps the "dogs-bodies" if truth were told). They are the kingpins of their firms, people who examine all the patients as they arrive day by day, keep the notes, arrange the initial investigations and treatment, prescribe for each minor symptom, keep the intravenous infusions going, and are called by the nursing staff when patients develop new symptoms, signs, or whims, day or night. Housemen also talk to patients' relatives to amplify the history of the

illness and to answer the initial anxious questions as well as they can at this early stage of investigation. All those small but essential details are the houseman's lot. House surgeons assist at their patients' operations and perform a few operations under supervision, such as appendicectomies and stripping varicose veins. They also have their own operating list for minor operations such as the removal of lumps in the skin.

The senior house officer, registrar, or senior registrar is soon on the scene to check the houseman's findings, to agree initial treatment, to work out a strategy of investigation before the consultant's next visit, or to phone him to discuss the situation when matters cannot or should not wait.

Housemen work long hours, but shorter than they did; soon they will not be permitted to be on first or second call for a total

of more than 80 hours a week. Shifts are not worked as they are in many countries. The week is five days long for a start and is likely to include one night first on call for emergency admissions and one second on call. When first on call the houseman may be up for most of the night, but this gives no dispensation from the next day's work. One half day is supposed to be free for study or relaxation. One weekend in three the houseman lives in on first or second call. Two weeks' holiday are allowed in each six month post.

When two house jobs have been completed satisfactorily, as they almost invariably are, the first period of a doctor's training is complete and he or she can apply for registration with the General Medical Council. Now the first career decisions must be made.

Personal Paper

Polyhydramnios: threat of a handicapped child

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Consideration of the patient's emotional needs has been a feature of many of the leading papers on antenatal screening for neural tube defects, but few accounts have been written by patients. I do not pretend that my experience can be regarded as typical, and, since it happened in 1977, it is in many respects already out of date, but it may be useful and interesting to those concerned with such patients.

About 24 weeks into my second pregnancy I developed polyhydramnios. Neither my husband nor I (both doctors) was willing to recognise that anything was wrong until at 27 weeks our general practitioner, who was also a partner and friend, pointed out that I was 36 weeks' size and he intended immediately to convert "shared care" into "consultant only." The appointment with the consultant was arranged for the next day. Examination was followed by ultrasound scan, x ray examination, and a long and frank discussion with the obstetrician and radiologist. Polyhydramnios had always been a favourite question in our medical school, and I found to my horror that I could recite a list of causes and associated conditions under three headings—maternal, fetal, and miscellaneous. This was indeed a case of medical nemesis.

Polyhydramnios in a west coast Scot alerted everyone to neural tube defect. I particularly remember the kindness of the radiologist who carefully discussed the x ray film and frankly concluded that it looked normal but that a lumbar spina bifida could not be completely excluded. There seemed to be little to do but follow the ubiquitous antenatal regimens of rest and more frequent attendances at the clinic. Just as we were leaving, the consultant suggested sending blood to a laboratory in London

where he knew there was an experimental test for neural tube defect. It seemed a wonderful opportunity to put our minds at rest. I do not recall contemplating the possibility that the test could be anything but beneficial.

Discomfort for the patient

One feature that all my book learning on polyhydramnios had not mentioned was how uncomfortable it is for the patient. To reach term size 10 weeks early is very wearing. My girth was 45 in (115 cm) at 26 weeks, and as I am only 1.57 m (5 feet 2 in) tall I must have looked like a version of the Michelin man. Apart from the expected discomfort of legs, abdomen, and pelvis, it was difficult to sleep owing to pressure on the ribs. My most worrying symptoms, however, were those of hypotension. Lying down or even flopping into a chair brought on nausea, dizziness, and a feeling which I can describe only as a spinning into a vortex. Loss of consciousness quickly followed unless I rolled over on to one side. These episodes at their worst occurred several times daily and sometimes had no obvious precipitant. My practically minded 4 year old son calmly went for a neighbour whenever mummy fainted. Alone at home with a young child and having to drive to reach shops, etc, made the situation potentially dangerous. It was a great relief to be admitted to hospital and to give up the unequal struggle of "resting at home."

In the meantime, the first blood α -fetoprotein concentration had been reported as, "Almost undetectable levels—is patient pregnant?" a question that was really quite funny in view of my size. Nothing daunted, another sample was sent. This time the result somehow got lost and only after telephone calls were we told, "Just outside upper limits of normal". We were left with the worst possible situation of a substantial threat of abnormality at more than 30 weeks' gestation.

Surprisingly, our reaction was to stop trying to find out. We thought there was no alternative but to proceed with the pregnancy and to make the best of any handicap that resulted. That at least was my publicly expressed opinion. Privately, I remem-

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