process. Hence to give the title "educational supervisor" to a consultant will have little effect unless there is a profound change in the way in which consultants and hospital managers view the role of the house officer. Dedicated time for training, education, and study will be difficult to find in an environment where consultants feel they are being subjected to increasing pressure and juniors' hours are being reduced but the clinical workload is increasing.

Secondly, consultants receive no training in educational methods. Most would welcome it and would also appreciate an opportunity to meet with other trainers. This will require funding.

Thirdly, there is a feeling of frustration and powerlessness among consultants. At a time of increasing demands for clinical work, audit, management, and financial responsibility the GMC seems to be imposing a further requirement for the preparation, provision, and assessment of structured education and involvement in the professional and personal development of house officers.

The GMC's appeal for the goodwill of consultants to

underwrite the improvements in house officer training, which are envisaged in its 1992 recommendations on general clinical training, comes at a time when this commodity is losing ground under pressure from other competing demands.

The appointment of clinical supervisors and the introduction of structured education and training will be effective only if there are profound conceptual changes in the understanding of the purpose of the preregistration year, if there are contractual agreements to enable the educational supervisor to fulfil the role, and if there is financial provision for the training of trainers and regular formative assessment of the trainees.

I thank the five members of Yorkshire Health Associates who conducted the interviews and all the consultants who took time to respond to questions and reflect on their role as trainers.

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Medical Education

The preregistration year

Stella Lowry

This is the seventh in a series of articles examining the problems in medical education and their possible solutions

In Britain basic medical education ends with a year as a preregistration house officer in approved hospital posts that provide the general clinical experience required before full registration with the General Medical Council. In theory the preregistration year is an integral part of basic medical education, which is reflected in the fact that the universities have statutory responsibility for this year. But this is also the first time that a young doctor takes on daily clinical responsibility for patients' care, and in reality the service element provided by preregistration house officers underpins the medical care provided in many of our hospitals.

The long hours worked by preregistration house officers, the high service commitment, and the low rating given to the educational aspects of the job have led to numerous criticisms of this part of medical education. Many reports have drawn attention to high levels of dissatisfaction among junior doctors. One survey, conducted in 1986, found that nearly half of the doctors who had graduated in 1981 regretted their choice of career.¹ A recent report by the BMA has confirmed that stress and disillusionment are common among young doctors,² and various reports have pinpointed the preregistration year as a time of considerable unhappiness, up to half of preregistration house officers suffering from clinical depression during the year.^{3,4}

A common criticism levelled at the preregistration year concerns the long hours of work. Despite recent government initiatives most preregistration house officers still work over 72 hours a week. What causes most distress, however, is not the total number of hours but the inappropriate work expected of junior doctors during this time.⁵ Recent studies have confirmed that large parts of a house officer's week are spent on routine tasks like taking blood, filling in forms, arranging beds for routine and emergency admissions, and filing laboratory reports.⁶ The GMC has acknowledged these criticisms in its most recent set of guidelines on what the preregistration year should provide.⁷ Universities are supposed to ensure that all

posts approved by them for general clinical experience meet the GMC's recommendations. In this article I shall look at what has been proposed by the GMC, whether this can or should be implemented, what the interested parties think about the recommendations, and whether there are any other ways of ensuring that newly qualified doctors are not put off their careers completely before they have properly begun.

What the GMC recommends

In the introduction to its latest guidelines the GMC states that the preregistration year should be "an enjoyable and profitable experience" and calls on the universities to "exercise greater control than hitherto over the duties undertaken . . . , the supervision of house officers, the general education provided and the monitoring of house officers' progress." The document sets out various skills that should be mastered during the year and also states that time should be set aside for education, including protected time within the working week for private study. House officers should have named educational supervisors, usually their consultants, who ensure that the educational objectives of the year are met and help with any personal problems that may arise. The educational supervisor is supposed to ensure that the house officer is not "overwhelmed by clinical commitments, overburdened by responsibilities inappropriate to the experience acquired, or undertaking an excessive on-call commitment." The supervisor is meant to undertake, and not delegate, various tutorial functions, including the induction of the new house officer, regular monitoring of progress and assessment of competence, encouraging participation in educational activities, and giving careers advice.

Can it be done?

These may all be worthy aims, but they are so far removed from the reality of most house officers' experiences as to be laughable. How is a consultant physician or surgeon in a busy hospital supposed to

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The preregistration year should be an enjoyable and profitable experience. But does it come up to scratch for educational value?

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find time for the formal educational supervision suggested, much less the pastoral aspects? Who is going to train consultants in the necessary counselling and facilitating skills? Who will provide the cover for house officers attending their education sessions? Is it realistic to expect junior house officers to admit to their consultants that they are overburdened when their career progression depends on getting a good reference? Unless some of these problems can be overcome the GMC's recommendations will be impossible to implement.

A recent survey of 33 consultant staff in Yorkshire found little enthusiasm for the GMC's proposals.⁸ Although almost all of them enjoyed supervising house officers, they admitted that there was little formal teaching (as opposed to learning by apprenticeship) and that they had not been trained to provide such teaching. They also thought that pressures from other commitments meant that it would be impossible to provide the sort of supervision recommended or free the house officers to take advantage of the scheme. A typical comment was, "Will somebody tell me who is going to do the work?"

What about a two year preregistration period?

Recently a new proposal for improving the lot of preregistration house officers has been suggested by the Council of Deans of United Kingdom Medical Schools and Faculties.⁹ Under this proposal the preregistration period would be extended to two years with first and second year house officers working in pairs, sharing the on call commitment, and providing cover for each other to attend specially structured education programmes. So that the training is not unduly prolonged the deans suggest that the undergraduate course could be shortened to compensate for the extra time spent as a house officer.

Like the GMC's recommendations the deans' suggestion may seem superficially attractive, but it too lacks any semblance of realism about how it might be implemented. No detailed proposals about how the education programmes might be set up are suggested, although the deans concede that they would require "careful thought" and "ingenious timetabling." The additional burden that this would place on other staff is casually dismissed as "to some extent... offset by a smaller number of clinical medical students." The NHS is assumed to benefit financially from reduced extra duty payments and reduced medicolegal costs as

junior doctors would be "better supervised and less exhausted." This assumption of improved supervision is put forward as a great strength of the proposals, but in fact what is being suggested is that the first year house officers would receive supervision from second year staff who are not yet fully registered.¹⁰ There is no discussion about who should provide the improved supervision to the second year staff.

Junior doctor abuse

A recent report from the South Western district based on in depth interviews with 12 preregistration house officers and the staff who had supervised them during their house jobs identified many of the problems with our present system.¹¹ The report confirmed that house officers spend much of their time on inappropriate tasks—either those that are beyond their competence and for which they cannot hope to provide optimum care (like providing the main source of symptom control to inpatients, the sole medical cover to surgical patients, and explaining complicated procedures to patients and relatives) and others that could be done just as well by non-medical staff (like filing reports, taking routine blood samples, and arranging beds).

LACK OF EDUCATION

There was hardly any educational element of the job, and most of the consultants interviewed admitted that they had not read the GMC's recommendations on this. Those who were familiar with them thought that they were unworkable, given the huge volume of other responsibilities on consultant staff, their lack of training in educational methods, and the absence of support services in most hospitals.

Many of the house officers were working long hours without proper medical supervision. They were very isolated from other members of the team because they were essentially ward based, while the more senior staff spent much of their time in outpatient clinics and operating theatres—often in different hospitals. In fact, much of the day to day supervision and emotional support of house officers was provided by the senior nurses on the wards where they worked, yet this role of the nursing staff receives no official recognition. A combination of long hours, isolation, inappropriate work, and poor working conditions adds up to what Dr Sue Dowling (one of the authors of the report) describes as "a syndrome of junior doctor abuse."

STOPPING TINKERING

Dr Dowling thinks that it is time that we stopped "tinkering at the edges of the problem" of the preregistration year and totally rethought our responses to it. She suggests that there are two elements of the job—the educational and the service—and that neither has been properly thought out. She suggests that the educational infrastructure does not exist at all in our present system but could be provided. The universities could coordinate distance learning packages for their graduates in various hospitals, although this would have funding and manpower implications.

Total rethink

The service elements of the job fall into two categories—those that are routine and mundane and do not need a doctor to carry them out, and those that are essentially the front line services for health delivery in our hospitals. People who challenge the assumption that much of what a house officer does could be done just as well by someone without a medical qualification may be surprised to learn that in Taunton and Cheltenham nurse practitioners are already

working as house officers on two surgical firms (box).

Dr Dowling suggests that front line medical services should not be provided by the most junior member of the team working without adequate supervision. She points out that in specialties where the quality of the front line services is a matter of life and death—such as intensive care medicine or accident and emergency work—they are not provided by preregistration staff. But she challenges the assumption that services like postoperative pain control or the provision of medical cover to surgical patients should be seen as less important. She believes that if patients and the purchasers who obtain medical care for them began to demand a better quality of front line service, then hospital managers would very quickly do something to improve the tasks undertaken by and supervision given to preregistration house officers.

Implementing change

One of the great problems in achieving any change in the preregistration experience is that no one seems to have the power and the will to do much about it. Although the GMC issues recommendations about what the year should provide, it does not have any means of enforcing these. The legal responsibility for the house officer year rests with the universities, which have shown few signs of willingness to rock the existing boat. (One notable exception is the University of London, which recently issued guidelines on what was acceptable in a house officer's post and warned that jobs failing to come up to standard would not be recognised.¹²)

The people with most interest in changing things are the house officers themselves, but individually they are in a very weak position because they all depend on references from their consultants for registration and career progression. Collectively, however, they have considerable power. Recently the junior staff at Southmead Hospital in Bristol found themselves in bitter dispute with the hospital management over the terms and conditions of their employment.¹³ By chance there were several mature graduates at the hospital, including one who was about to emigrate. These doctors, unlike so many preregistration house officers, were not prepared to be walked over, and a campaign of industrial action—including the threat that future students might boycott the jobs at Southmead—led quickly to remedial action.

Dr Dowling believes that part of the reason why house officers are often so impotent in hospital politics is that they are essentially migrant labour—rarely in one place for more than six months. Managers do not really see them as part of the assets of the unit. She believes that junior doctors could be empowered by longer contracts and proposes that house jobs should be arranged in one year (or even 18 month) blocks within single or closely linked units, so that the doctors felt and were recognised as an important part of the service provided. A scheme like this is now planned for Southmead Hospital.

Empowering the house officer

The first step in empowering house officers so that change can happen is to ensure that they know what they are entitled to expect from the job. Few house officers have any idea of the contents of the GMC's recommendations on general clinical experience. The GMC should ensure that all final year medical students understand what they can reasonably expect. Ideally there should be a central record of all approved house jobs, detailing the extent to which they meet the recommendations. Such a "good house jobs guide" is proposed in one recent report¹¹ and could be produced

Surgical nurse practitioner

Lou Jacobs has been a nurse for 17 years and has over 12 years' experience in intensive care units. She has been working as a nurse practitioner on a general surgical firm at the Taunton and Somerset NHS Trust since August. In previous years her job has been filled by a preregistration house officer.

Her duties differ from a preregistration house officer's only in line with the legal restrictions on nursing staff. She is not allowed to make diagnoses, initiate drug treatment, or certify death. She clerks patients, organises and attends ward rounds, requests investigations, draws up theatre lists, liaises with anaesthetic and nursing staff and general practitioners, helps in theatre, and does all of the other tasks undertaken by the medical house officers on the other firms at the hospital.

Ms Jacobs finds the job stimulating and admits to being surprised by how hard house officers are expected to work. She suspects that she may get rather more exposure to outpatient clinics and theatre sessions than her medical colleagues because they get bogged down on the wards with tasks that she is not allowed to do. She regards these sessions away from the routine work as some of the most interesting aspects of the job and does not think that the mundane elements of a house officer's post could be "dumped" on another person without some such perks to "relieve the boredom."

by the GMC or the BMA. House officers also need to know what to do if their job falls far short of the recommended standards. It is unreasonable to expect them to tackle problems through their consultants, although if they had independent supervisors this might be possible.

A better way might be for house officers to take collective action through their trade union representatives, and the BMA should take the lead in providing this service. Managers need to appreciate that house officers are a vital part of the service they provide and an asset that should be protected. Attaching doctors to single hospitals for both of their house jobs might be one way of making them a more obvious part of the system.

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Correction

From FPC to FHSA to... health commission?

A printer's error in this article by June Huntington (2 January, pp 33-6) resulted in the photographs of the practice premises being transposed (p 35). As published, the bottom picture shows the existing premises and the top picture shows the additional and independent premises, which was in fact built by the local authority at the request of one of the partners and for which the family practitioner committee/family health services authority has allowed a notional rent.