Senior house officer training in medicine

SUMMARY OF RESULTS OF A SURVEY BY THE STANDING COMMITTEE OF MEMBERS OF THE ROYAL COLLEGE OF PHYSICIANS

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There has been a great deal of concern about the lack of formal training for doctors undergoing general professional training (GPT), in particular at the senior house officer (SHO) grade. This was highlighted recently in an article by Grant and colleagues in the BMJ [1]. This has also been alluded to in a document from the Council for Postgraduate Medical Education in England and Wales in 1987 entitled Proposal for district medical educational structure. In the latter document the training of SHOs was discussed. Amongst other things, it was recommended that clinical tutors should formulate a core curriculum, the trainers should be trained, and there should be two-year rotational posts with a half-day release programme. The latter would reduce the need for study leave. Furthermore, SHOs should have regular career guidance and the educational content of these posts should be included for GPT implications.

The paper by Grant et al [1] attempted to provide some facts on the type of training received by SHOs in the South East Thames region. It revealed that there was no systematic approach to teaching, and that 47% of SHOs did not feel that consultants were their main teachers. Most of them said that registrars and senior registrars were the best teachers because they understood their training needs better and also often had more time.

To obtain the views of the SHOs in the regions in which the members of the SCM work, both in teaching hospitals and district general hospitals, the SCM sent out questionnaires directed primarily at identifying the existing format of the teaching, and also to find out what type of teaching SHOs would prefer to have.

The survey

A total of 200 individuals were contacted and overall 179 (89.5%) replied, although not every section of the questionnaire was completed by all respondents. Their average age was 26.7 years, 62% were based at teaching hospitals, 28% at a large DGH and 10% at small, peripheral hospitals.

Formal teaching was available to 85.5% of respondents, but only 31% were satisfied with it; no formal teaching was available to 20% of those who expressed their dissatisfaction. Further details are shown in Tables 1-3.

Discussion

Approximately two-thirds of the SHOs balloted were dissatisfied with the teaching they received in their hospitals (Tables 1–3). Written comments revealed that their dissatisfaction stems from the lack of time to attend teaching sessions even where they are provided,

Table 2. Details of who performs the teaching (formal and informal)

|                      | Satisfied (%) | Not satisfied (%) |
|----------------------|--------------|------------------|
| Consultant           | 32.7         | 37.2             |
| Consultant + senior registrar | 29.3       | 21.6             |
| Consultant + registrar | 5.8        | 8.8              |
| Consultant + senior registrar + registrar | 25.8   | 15.7             |
| Senior registrar     | 1.8          | 1.9              |
| Senior registrar + registrar | 1.8        | 8.8              |
| Senior registrar + senior house officer | 1.8     | 1.0              |
| Registrar            | 3.6          | 4.9              |

Table 1. Satisfaction with teaching received and average hours of teaching.

|                          | Satisfied (%) (n = 55) | Hours/week | Not satisfied (%) (n = 110) | Hours/week |
|--------------------------|------------------------|------------|----------------------------|------------|
| Teaching hospital        | 50.0                   | 5.0        | 68.1                       | 2.4        |
| Large city DGH           | 34.6                   | 4.1        | 24.5                       | 2.2        |
| Peripheral DGH           | 15.4                   | 4.3        | 7.2                        | 2.2        |
Table 3. The differences in the teaching format between those who found it satisfactory and those who did not.

| Teaching Format                                | Satisfied (%) | Hours/week | Not satisfied (%) | Hours/week |
|-----------------------------------------------|---------------|------------|-------------------|------------|
| Routine consultant ward round                 | 47.2          | 3.5        | 31.5              | 2.8        |
| Selected case ward round                      | 52.7          | 3.1        | 26.1              | 1.2        |
| Seminars/tutorials                            | 89.1          | 1.9        | 55.9              | 1.5        |
| Half-day release programme                    | 18.2          | 4.8        | 15.3              | 3.5        |
| Outpatients clinic                             | 21.8          | 1.4        | 34.2              | 0.9        |
| Journal club                                  | 16.4          | 1.8        | 19.8              | 1.1        |
| Other (MRCP part II session, pathology, clinical meetings, X-rays, case presentation, clinical slides, viva session) | | | | |

and in some cases from the failure to provide any teaching sessions at all.

There is therefore a need for protected time to attend formal teaching sessions, with cover for patient care provided by other members of staff. Formal protected sessions have resource implications, and with the reduction of registrar numbers proposed by JIPAC the onus for teaching will increasingly fall on consultants. The sessions must be part (or all) of the SHO’s study leave. Based on this survey, it would seem that an average of 3–4 hours per week is achievable for most hospitals and would result in a satisfactory education programme if a practicable rota system is organised which includes consultants and registrars from medicine, geriatrics and medical specialties such as dermatology and rheumatology. Also, if radiologists, ophthalmologists, pathologists and microbiologists were included in the teaching programme, it should be possible that no one consultant in an average DGH needs to participate in more than one session every month or two.

The format of teaching sessions must be left to the individual hospitals. However, the results of the survey give a guide to the content of a core curriculum as perceived by SHOs (Tables 4 and 5). They prefer an emphasis on selected case ward rounds and seminars/tutorials containing practical clinical skills, and advice on diagnostic methods: interpretation of laboratory and other results is also seen as desirable. About 50% would prefer a half-day release programme.

This survey has highlighted some of the problems of SHO training that need to be addressed. Senior house officers are the future consultants. To continue to attract high calibre doctors into hospital medicine they must be encouraged and supported at all stages of their career. Otherwise they will vote with their feet and go for softer and better paid options rather than the long specialist training with its uncertain job prospects in hospital or academic medicine.

Reference

1 Grant J, Marsden P, King RC. Senior house officers and their training. Br Med J 1989;299:1265–8.