

# Educational supervision of pre-registration house officers

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## SUMMARY

*An annual survey of the educational supervision of pre-registration house officers has been carried out since 1987 by the Northern Ireland Council for Postgraduate Medical Education and the Queen's University of Belfast. Educational supervision was considered by house officers to be unsatisfactory in 27% of medical posts and 52% of surgical posts. Regular teaching was provided at least weekly in 77% of the posts, but 50% of house officers wanted more experience of managing common medical emergencies. Over one-third felt administrative duties were excessive.*

*There is a strong argument that hospitals should designate within clinical units a consultant with responsibility for educational supervision of the pre-registration house officers. Creation of this hospital counterpart of the General Practitioner trainer — the educational supervisor — would enhance the educational value of the pre-registration year. This might avoid withdrawal of approval for training purposes from some pre-registration posts.*

## INTRODUCTION

In 1954 the General Medical Council made it a legal requirement that medical school graduates, in order to achieve full registration as medical practitioners, would have to undertake supervised hospital duties for one year. In recent years disenchantment with this apprenticeship-based hospital system has grown, with criticism of hours of work for the junior doctor, the specialised nature of some of the training posts and the failure of consultants to adopt an active approach to the training element of the pre-registration year. The Educational Committee of the General Medical Council produced guidelines dealing with basic medical training in 1986, which recommended that juniors should have a designated trainer and a close, more structured form of supervision. Nevertheless documented

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deficiencies in pre-registration training continue to surface, indicating that the GMC requirements have not been implemented.

A management efficiency study of the clinical workload of pre-registration house officers in Edinburgh Royal Infirmary resulted in the appointment of three extra pre-registration house officers.<sup>1</sup> In four Thames regions a postal questionnaire illustrated deficiencies in pre-registration training in terms of work pattern, and lack of education on important topics including resuscitation, pain control, and the breaking of 'bad news'.<sup>2</sup>

This study provides further information on the educational content of the pre-registration year based on the experiences of house officers in Northern Ireland.

## **METHOD**

The Northern Ireland Council for Postgraduate Medical Education carries out an annual survey of the 160 pre-registration house officers in conjunction with the Faculty of Medicine of the Queen's University of Belfast. Each house officer is asked to complete a questionnaire concerning the regularity and relevance of teaching, the degree of supervision, the size of clinical and non-medical workload and their confidence in managing medical emergencies. The data from the responses is categorised by hospital, specialty and unit, and forms the basis of a report to the Pre-Registration House Officer Committee, chaired by the Dean of the Faculty of Medicine.

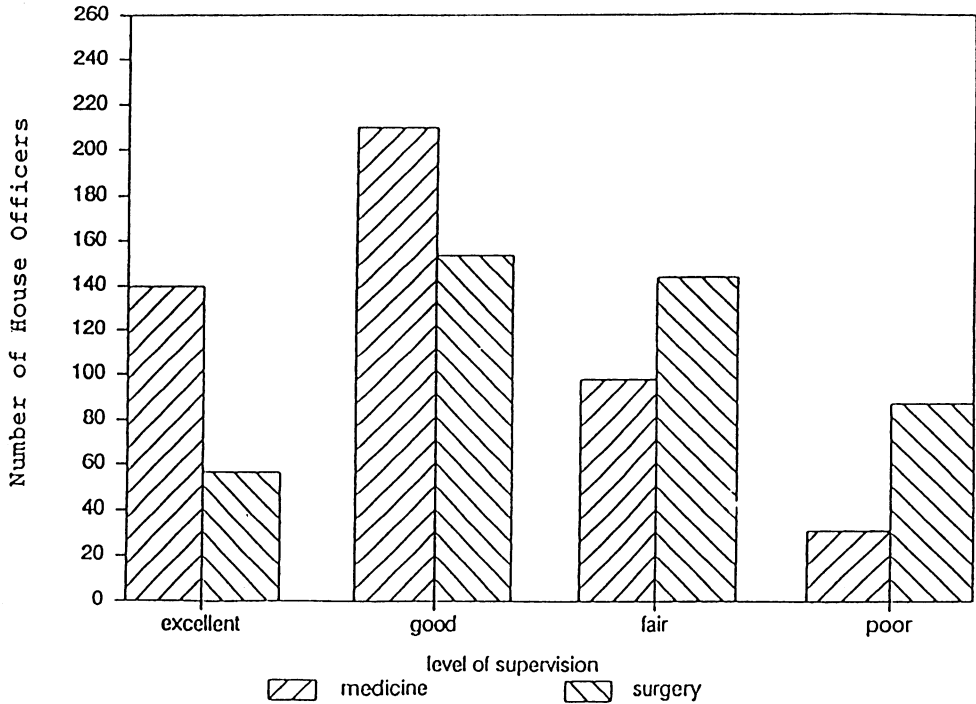
In 1990 a three year evaluation was carried out for the years 1987 – 1989. House officers were asked to assess the level of supervision which they had received using a scale of 1 – 4, where 1 was interpreted as being poor and 4 excellent. For the purposes of this paper the results are categorised into either medicine (including paediatrics) or surgery (including gynaecology). A chi-squared test was performed for the two groups to test the null hypothesis that there was no difference in the level of supervision between the two major specialty groups.

In a second question, house officers were asked if they thought that there were too many administrative duties involved in their posts. A chi-squared test was applied to test the hypothesis that there was no difference in the amount of non-medical work existing between the two major specialty groups.

To assess the relevance of teaching, the house officers were asked if they felt confident in dealing with common medical emergencies. In response to the question on confidence in dealing with common emergencies, 46% reported that they felt fully competent and 50% thought that although they felt competent, they would have preferred more experience. Over 4% claimed that they had been given insufficient opportunity to gain first-hand practical experience of such emergencies.

## **RESULTS**

Over the three year period 57% of the pre-registration house officers responded to the questionnaire, covering all the hospitals and units in the Province. The Figure illustrates the replies to the level of supervision question, indicating a marked difference between the medical and surgical specialties, particularly at the extreme ends of the scale. Twenty-seven percent of house officers in medical



$$\chi^2 = 73.2 \text{ (P=0.01)}$$

Figure. Level of supervision as perceived by pre-registration house officers 1987-1989.

posts and 52% of those in surgical posts thought that the level of supervision was only fair or poor. The difference between the two groups lie at the extreme ends of the supervision levels; surgical posts were much less likely to offer 'excellent' supervision and were nearly three times as likely to yield reports of poor supervision. One in five of all surgical posts reported supervision of a poor standard.

Over one-third of the house officers in both major specialties felt that the amount of administrative duties was excessive. There was no difference regarding non-medical duties (Table I).

TABLE I

*Administrative duties carried out by house officers*

<i>Too many duties</i>	<i>Medicine</i>	<i>Surgery</i>
No	310 (64%)	307 (63%)
Yes	172 (36%)	176 (36%)

The regularity of teaching, including teaching ward rounds, as perceived by junior house officers is shown in Table II. Seven percent had rarely received teaching and a further 7% were too busy with clinical or administrative duties to attend, even if teaching was available.

TABLE II  
*Teaching content of post*

Frequency of teaching	
More than once weekly	88 (38%)
Weekly	90 (39%)
Every 2 – 3 weeks	14 (6%)
Monthly	7 (3%)
Seldom/never	16 (7%)
Lack of time to attend	16 (7%)

## DISCUSSION

The results of this study indicate that house officers in Northern Ireland during 1987–1989 considered educational supervision unsatisfactory in 27% of medical posts and 52% of surgical posts, and that over one-third felt administrative duties were excessive in both posts. Half would have preferred more experience of common medical emergencies. These results and the studies from Edinburgh<sup>1</sup> and elsewhere suggest that there is scope for improving the pre-registration year experience with regard to the nature of work involved, the personnel management role of the consultant physician or surgeon and the content of formal training. The difference between medical and surgical posts might partly reflect the different nature of the work in the two specialties, surgeons being absent from wards for longer periods due to operating theatre commitments.

What action should be implemented by hospitals with responsibility for pre-registration house officers? We would suggest that hospital medical staff should designate within each clinical unit a consultant with responsibility for educational supervision of the unit's pre-registration and senior house officers. The pre-registration house officer joining a hospital unit should receive an initial briefing by the designated consultant which should encompass the clinical organisation of the unit and what is expected of the house officer. Specific advice should be given about resuscitation, discharge letters, practical procedures, autopsies and any other protocols special to the individual unit. The educational supervisor should conduct a monthly interview with pre-registration house officers lasting approximately 30 minutes during which the opinion of the house officer should be sought regarding adequacy of training and supervision, and feedback should be given on individual performance. The house officer should be encouraged to keep a career journal; this could prove helpful as it requires the house officer to document the training received in an individual post, his/her opinion of the training, and also the supervising consultant's opinion on the house officer's performance.

The house officer's career intentions should also be explored and basic guidance given by the educational supervisor. Parkhouse and Ellin<sup>3</sup> have shown that career choice and change of choice is mainly determined by domestic circumstances, awareness of promotion prospects and self-evaluation of aptitude and ability.

Preliminary career advice to the pre-registration house officer should therefore aim to assist in assessment of his/her potential for a given career, and provide basic information about career prospects in the declared field of interest. Other appropriate advice might include information on local short-listing criteria for senior house officer posts and what to expect at interview for these posts. For detailed career advice and counselling the individual house officer should be referred to the specialty advisor or clinical tutor with access to relevant information including DHSS census data, regional strategic plans etc. Educational supervisors should ensure that formal training and/or hospital induction courses cover topics relevant to the tasks of the pre-registration house officer,<sup>1, 4, 5</sup> should give adequate attention to communication skills,<sup>6, 7</sup> and ensure that the house officer can recognise and initiate emergency treatment of common conditions. (Table III).

TABLE III

SUGGESTED ROLE OF THE EDUCATIONAL SUPERVISOR
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To provide for pre-registration house officers —

Initial briefing covering clinical organisation of the unit.

Specific advice about any protocols special to the unit (autopsies, practical procedures etc).

A monthly interview to assess adequacy of training being received and to give feedback on performance.

Encouragement to keep a career journal.

Basic career advice and information.

Information on senior house officer posts and guidance on interview techniques.

Formal training including management of common medical emergencies, pain relief and communication skills.

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In conclusion, although some have expressed misgivings about the General Medical Council recommendations for basic medical training,<sup>8</sup> the findings of this study strengthen the case for extending the trainer/trainee system from general practice to hospital medicine, accepting that this could not be on the one-to-one basis that pertains in general practice. The trainee (the pre-registration house officer) needs to have a model of good practice, adequate supervised clinical experience, time for study, regular feedback on performance and preliminary career guidance.<sup>9</sup> Ways need to be explored of minimising the clerical/administrative component of the pre-registration house officer workload. The hospital counterpart of the general practitioner trainer — the educational supervisor — could fulfil a valuable role which would enhance the educational value of the pre-registration year. This might help the difficult problem of reconciling the competing needs of clinical workload and continuing medical education, thus avoiding the spectre of some pre-registration house officer posts having approval for training purposes withdrawn.

**REFERENCES**

1. Leslie PJ, Williams JA, McKenna C, Smith G, Heading RC. Hours, volume, and type of work of preregistration house officers. *Br Med J* 1990; **300**: 1038-41.
2. Dent THS, Gillard JH, Aarons EJ, Crimlisk HL, Smyth-Pigott PJ. Preregistration house officers in the four Thames regions: I. Survey of education and workload. *Br Med J* 1990; **300**: 713-6.
3. Parkhouse J, Ellin DJ. Reasons for doctors' career choice and change of choice. *Br Med J* 1988; **296**: 1651-3.
4. Astill JL, Watkin DFL. What does a house-surgeon on call for the wards do? *Lancet* 1987; (i): 1363-5.
5. Saunders KB. How our house physicians live now. *Br J Hosp Med* 1987; **38**: 399.
6. Cybulska E, Rucinski J. Communication between doctors. *Br J Hosp Med* 1989; **41**: 266-8.
7. Irwin WG, McClelland R, Love AHG. Communication skills training for medical students: an integrated approach. *Med Education* 1989; **23**: 387-94.
8. Saunders KB. The GMC and education of doctors. *Br J Hosp Med* 1987; **37**: 97.
9. Permanent Working Group of European Junior Hospital Doctors. Policy Statement on Postgraduate Medical Education. 1988, Munich. (Unpublished).