The lost tribes: finding our way out of the darkness

Sir,

The General Medical Council (GMC) recognizes the senior house officer (SHO) grade as 'doctors in training who, despite their educational needs, have service commitments to fulfill' (GMC, 1998) and, by the GMC's own admission, their training is an investment in both the health and care of our population.

Training the consultants of the future would seem a basic and obvious requirement of the NHS. The shortening of basic surgical training (BST) time since Calman has, however, tried to squeeze much into a paltry 2–3 years. The expansion in SHO numbers, expected to be mirrored by an equivalent but as yet unrealized rise in consultant numbers, has additionally led to the 'SHO bulge' — too many juniors chasing too few higher surgical training posts. The term 'the lost tribe' is apt indeed (Dillner, 1993).

Systematic and well supervised training as a SHO is a necessary step in the production of appropriately qualified additions to higher surgical training (Illott and Bunch, 1998). This has been discussed at length in the literature, but still deficiencies in the system are apparent and quantifiable.

Proud (1999) commented that the responsibility for training lies equally with the trainer and the trainee, yet most discussion has centred on the failings of the system from the trainer's standpoint and not addressed the fact that trainees need to take some control of their own education. This is hardly surprising, the grade is still seen as a stepping stone to higher things — the rite of passage being the MRCS examination — and not as a continuum of lifelong learning.

In an NHS culture which is essentially regional rather than national, it would appear to many that their employer has no interest in their career progression. Careers advice is scanty and haphazard, despite the GMC's feeling that careers guidance should be provided to assist personal and professional development. Large numbers of well-motivated and trained doctors will be lost to a system that allows individuals to make, sometimes, inappropriate decisions about their futures. The armed forces, industry and the commercial world would never function with such a system.

So whither the lost tribe? The basic/higher surgical training bulge will not vanish in an instant — every 6 months (Galasko and Smith, 1999) approximately 1300 junior doctors will come into an SHO post for the first time, of whom up to 700 will register a preference to pursue a career in surgery.

Educational supervisors are a mandatory part of BST, yet in a study by Bunch et al (1998) in the Yorkshire region, only 50% of general surgical trainees had an appointed supervisor. The concept of the 'educational contract' is surely to be encouraged — it promotes communication between trainer and trainee at an early stage in a post and gives direction to what otherwise may be a lost learning experience. Mentor–trainee relationships may help to give direction and encouragement to trainees. Mentors might be paid for their time and should represent a guiding force outwith the trainee's current post (Beckett, 2000). Such relationships may continue through BST and beyond.

Assessment and appraisal will become more obvious elements of modern medical practice (Hunt, 1998), so it seems appropriate to establish the process adequately at an early stage. There is a difference between the two, assessment being a one off, one way event which takes place at a set place and time, providing an objective measurement of the trainee's progress, whereas appraisal is the educational process which leads the trainee to the successful assessment.

The Royal College of Surgeons of England (1998) require formal assessments to be completed at the end of every SHO post as a prerequisite to sitting the MRCS examination. The principle is laudable, but it would seem that the practice is lacking. In the armed forces officers are taught how to appraise and assess people under their command; excepting 'training the trainers' type courses there appears to be little in the way of teaching for consultants who fill in assessment forms — although postgraduate deans do have funds for such (Orme, 1999). It has been suggested that no consultant should be responsible for a higher surgical trainee until they have been trained as a trainer, shouldn't similar advice be applied to the basic surgical trainee?

Learning by apprenticeship is a well established tenet of general surgery, but the young doctors emerging from medical schools now learn by vastly different methods. Rote learning has been replaced by integrated teaching and self-directed study. Current training methods for basic surgical trainees are improving, but the next generation of surgeons will be failed by a system which does not adapt. There will always be natural educators, people who inspire and communicate instinctively without effort. For the rest, training and educational method can be taught — although the continuing pressure on consultants' time and enthusiasm will make this a difficult lesson to learn.

The lost tribe will only stay lost if they fail to take control of their education, or at the very least make sufficient noise to be heard and guided. Sadly, although the Royal Colleges and the postgraduate deaneries may be listening, the NHS seems deaf.

Judith Stocker
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