The new undergraduate curriculum: are PRHOs equipped to do the job?

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Background to the debate

Tomorrow's doctors[1], published by the General Medical Council (GMC) in 1993, led to the first major change in the undergraduate curriculum in medicine for many years. The main recommendations were to reduce the burden of factual information imposed on students, to encourage learning through curiosity, to change attitudes of mind and behaviour to be more in keeping with a doctor, and the acquisition of essential skills required for the pre-registration house officer (PRHO) year. Undergraduate teaching in a number of UK medical schools has now changed from the traditional pre-clinical/clinical curriculum to one integrated across disciplines from the start[2,3]. There is increased use of problem-based learning, education in the community by general practitioners (GPs), special study modules, and objective structured clinical examination to assess clinical skills.

The GMC identified two purposes for the PRHO year in *The new doctor*[4]:

1 To put into practice the key skills learned and the knowledge gained during the undergraduate years.
2 To demonstrate that PRHOs are ready to accept the duties and responsibilities of a fully registered doctor.

This debate was an opportunity to assess whether the curriculum changes have affected the ability of the PRHOs to practise as doctors. The motion was: 'This house believes the present PRHOs are inadequately trained to do their job'.

The debate

In proposing the motion, Professor Sir Michael Rawlins recognised the difficult job that medical schools have in turning 18-year-old school leavers into experts in a number of subjects and skills over a period of five years. However, a number of deficiencies or omissions in the curriculum and standards require more scrutiny, in particular prescribing errors in the PRHO year. Current house officers are not achieving the recommendations of the Nairobi declaration on prescribing (to ensure that the right drug is prescribed to the right patient at the right dose at an affordable cost). For example, 55% of prescribing errors are in dosing, many PRHOs being unaware of the need to adjust drug doses in renal failure or how to assess renal function. The 100 deaths per year from prescribing errors (75% avoidable) suggest that not enough time is given to training in therapeutics, pharmacology and clinical pharmacology at undergraduate level. UK doctors are also the slowest to use new therapies and tend to hang on to older treatments. The GMC has failed to secure instructions to medical schools to improve the teaching of prescribing, particularly with respect to evidence-based medicine and randomised controlled trials – although, ironically, complementary medicine is covered.

Professor Sir Graeme Catto, in opposing the motion, felt that current PRHOs are adequately trained. He compared favourably the 2% of PRHOs each year whose ability to practise during training was questioned with the 5% rate for registered doctors. His answer to the hypothetical question of 'what is the job?' was that it is to fulfil the requirements of the 'new doctor', which are not the same as in 1965. Current PRHOs have to contend with a number of different issues:

- the New Deal
- intensity of work
- lack of a team
- lack of a mentor (ie no feedback given to the PRHO)
- expectations of seniors beyond what PRHOs can achieve.

He also referred to the GMC visits to hospitals around the country. Seven referred specifically to the quality of PRHOs, and all were complimentary. An example is Newcastle where PRHOs were felt to be well prepared, clinically more competent, with more appropriate attitudes, a better understanding of their role and better interpersonal and communication skills than PRHOs trained during earlier years.

The motion was seconded by Dr Fiona Moss, who pointed out that the PRHO year was set up as a safety net following the death of a patient at a time when doctors could practise anywhere once qualified. She highlighted the changes over time in the NHS, such as length of hospital stay from an average of 11.9 days

in the 1960s to the current average of 3.2. Dr Moss felt that the GMC was not changing fast enough to keep up. Two-thirds of PRHOs who completed a questionnaire three months into their post did not feel equipped to do it and half had felt compelled to gain consent for a procedure they did not understand. The practice of ward cover by PRHOs rather than accident and emergency work when on call for the first time was also questioned. She felt that this policy poses a danger to patients and PRHOs alike. They are often asked to review patients with routine but occasionally serious complications for which they are not prepared and for which they have limited supervision – a problem because of the unwritten rule which prevents doctors from complaining or seeking redress. Some of these issues could be improved with a longer induction for new PRHOs, such as the two-week period in some London hospitals.

In seconding Professor Catto, Professor Roger Green stressed the need to make the PRHO post supernumerary. It should be the final year of basic medical training, enabling PRHOs to apply their acquired skills without them being critical for service provision. He considered the role of the clinical tutors/educational supervisors in ensuring that the PRHOs have adequately fulfilled the year and are fit to practise as registered doctors. Only 1% a year are not 'signed up', suggesting either that PRHOs are not doing a bad job or that the tutors/supervisors are failing in theirs. The results of the Quality Assurance Agency Review of Medicine (QAARM) were used as further evidence of the quality of PRHOs trained with the new curriculum: 18 employers were satisfied. There were complimentary comments by the QAARM on the skills and knowledge base of the graduates and the appropriate attitudes, equipping them to become 'humane, rational doctors'. A study of supervisors' ratings of two cohorts of PRHOs trained in the old and new curricula in Manchester[2] favourably demonstrated the abilities of the latter in specific competencies and skills (eg 92% were rated competent or better than competent at writing prescriptions).

Discussion

A number of interesting points were raised from the floor in discussion, including those listed below.

In support of the motion:

- Manchester found that 10% of PRHOs were deemed less than competent in their prescribing skills. Imperial College Medical School still requires a pass in clinical pharmacology and therapeutics to pass finals.
- More educational foundation for prescribing skills is necessary during medical school.
- A longer shadow period is required in the final year to improve skills and preparation for PRHOs, with mentors/supervisors taking on their role more rigorously.
- Nearly half of PRHOs encounter a problem for which they are unprepared. This could be improved by providing guidelines and better information technology (IT) facilities on the wards.
- More people than the current one or two should assess PRHO fitness to practise.

Against the motion:

- The job of PRHO has significantly changed and cannot be compared with previous experiences of the job. The problems are due more to changes in PRHO's duties than to their abilities.
- New PRHOs need a chance to use their skills. This could be improved with better handover and a longer crossover period between incoming and outgoing PRHOs.
- PRHOs should be supervised and not practise independently. Use of IT in the new curriculum should help reduce errors with the introduction of electronic prescribing.
- The New Deal has had the positive effect of providing high quality education for PRHOs within their reduced hours.
- The learning curves of PRHOs depend on their future career choice (eg GP, medicine, surgery).

Summary

In summing up, Professor Catto referred to the impossibility of achieving the correct balance in a constantly changing position. Only minor alterations to the curriculum are required, such as improving the ability to prescribe and proper shadow periods. The way PRHO posts are constructed needs changing more than the curriculum.

Professor Rawlins summation was brief and to the point: the problem lies in the gap between what the GMC and everybody else would like the job to be and what it actually is: in other words, a reality check is needed.

There was no clear winner in this debate. At the start of the debate 18 were against the motion, seven for, with the majority undecided. At the end, 23 were against and 17 for the motion, with only a small proportion still undecided.

References

1 General Medical Council. *Tomorrow's doctors: recommendations on undergraduate medical education.* London: GMC, 1993.

2 Jones A, McArdle PJ, O'Neill PA. Perceptions of how well graduates are prepared for the role of pre-registration house officer: a comparison of outcomes from a traditional and an integrated PBL curriculum. *Med Educ* 2002;**36**:16–25.

3 Jones R, Higgs R, de Angelis C, Prideaux D. Changing face of medical curricula. *Lancet* 2001;**357**:699–703.

4 General Medical Council. *The new doctor – recommendations on general clinical training.* London: GMC, 1997.