Scenes from Postgraduate Life

Towards a Good Hospital Guide

With 5500 medical posts at senior house officer (SHO) and registrar level, the Royal College of Physicians (RCP) has to review and/or inspect some thousand jobs each year for general professional training. Posts are normally approved for five years, but an increasing number are approved for less than this because of continuing changes in acute hospital practice and staffing, especially in metropolitan areas. In addition, the College carries out five-yearly (or shorter) inspections of senior registrar posts through its Specialist Advisory Committees (SACs) at the rate of 1–200 a year.

Each visit involves three to five people, including consultants, general practitioners and trainees, most of them from outside the district or region involved. Visits usually take a day, but could be three or four days if there is an extensive rotation of, say, senior registrars. Organization by the host hospital(s) can be a major undertaking and disruption of work considerable, since the appropriate consultants and junior staff have to be interviewed, the latter individually and in confidence. Expenses of the visitors are borne by the health district and may be large if members travel from a long way away or require several days' accommodation – in London, for example. Charles Newman wrote in his guide to the RCP, 'Ensuring that training posts are adequate is a costly business and it is provided for the community without financial help'. Not strictly true, since some money does come from hard pressed district budgets, but probably cheap at the price of ensuring standards.

Physicians are only one group who carry out training visits of this sort – inspecting hospitals, posts and people. Surgeons, obstetricians, psychiatrists, anaesthetists, radiologists, indeed all specialists, undertake broadly the same type of general professional and higher professional visits. Pathologists approve laboratories in their different disciplines, and psychiatrists tend to approve hospital training facilities rather than each individual post, except, of course, for senior registrars. Nearly 4000 preregistration posts also have to be visited every five years (or more often if necessary) by postgraduate deans on behalf of medical schools and each incumbent interviewed confidentially. Many universities provide guidelines which conform with the General Medical Council (GMC) recommendations on medical education. General practitioners have schemes for visiting trainers and trainees, as well as taking part in general professional hospital visits.

Such activity over the past fifteen or so years has done an enormous amount to improve job content as well as standards, especially in preregistration posts and in psychiatry, to take two different examples. But now that the initial exercise has been accomplished it may be appropriate to count the cost, both in money and in time, and to see if it is possible to devise less cumbersome machinery. Let me give a few examples. In the case of senior registrars an initial enquiry to the regional postgraduate dean about individual posts might elicit information that no change had taken place since the last inspection. The SAC could then decide whether it wished a visit to take place or not. Colleges might consider inspecting hospitals rather than individual posts, especially where general professional training is concerned, and drawing up checklists of what they expect of a good hospital, not just in terms of training and education, but in relation to staffing, bed numbers, rotas, facilities etc. Lastly, if all stages of education were to be truly integrated under the umbrella of the GMC, then universities might join with colleges to oversee the educational activities of hospitals and general practice.

Is it possible then to define a good hospital? Many of us who visit widely think we can tell when we walk in the front door. (How few hospitals have proper front entrances.) In general it is not the buildings but the people that matter. A sense of orderly bustle allied to alert and welcoming looks on the faces of the staff give a feeling of reassurance. This is reinforced by receptionists who do not treat you as a nuisance (or, worse still, ignore you) – come back the friendly head porter or beadle. Directions that direct and clocks that work are two other criteria of mine, recognizing how confused and fearful of missing appointments the average visitor is. I could go on, but what we need if we are to take professional quality assurance seriously, are lists of objective features which each professional group and, of course, patients think are important, practical and measurable: these could then be used with different emphases by each group in promoting quality – a sort of hospital *Which?* This is nothing new, only more complex. The latest annual report of the King Edward's Hospital Fund for London comments on the Fund's early help for London teaching hospitals: '... a tough line was being taken on eligibility for grants, with a bias against any hospital where viability, management or standards of clinical practice were in doubt'. In those days the Visitors consisted of one medical and one lay member. Now, in 1986, the Fund

has a new Quality Assurance Project, which hopes to focus once again on the acute hospitals.

The present *ad hoc* approach to hospital inspections is time consuming, costly and disruptive. I know of one district hospital that had four visits within two weeks to inspect preregistration posts, SHOs and Registrars in two different specialties, and one arm of a senior registrar rotation. What about a more radical solution? After years of discussion and no doubt partisan wrangling, the Canadian Royal College of Physicians and Surgeons came up with an answer which might be tried in Britain. They agreed that visiting teams should consist of only six people from

disciplines covering the 42 specialties involved, and that there should be no emphasis on any particular specialty within the group. With 16 medical schools plus rotations to associated peripheral hospitals and the customary five-year recognition, this means that only about three visits a year are needed, each taking a week to carry out. If our own career structure could be sorted out, and agreement reached on numbers and on the first two or three years of general professional training, there would be a lot of common ground among colleges. Could we get the colleges to agree to a pilot experiment with the Canadian scheme in one health region here?

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