Making the new deal for junior doctors happen

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How can the new deal for juniors be implemented in today's overstretched health service? How do you get clinicians and management to work together? On the Wirral falling house officer morale and recruitment stimulated a new approach, action learning, which proved to be highly successful. Action learning is not a new approach in management terms, but it is rarely used in the health service. Guided by an experienced facilitator, a group of people learn management skills by exploring and resolving practical problems relevant to them. A group of general practitioners and consultants used action learning to teach themselves more about management and at the same time to make changes which addressed many of the junior doctors' difficulties and solved the hospital recruiting problem.

The plight of junior doctors with regard to hours of work, educational opportunities, and morale has been recognised.^{1,5} Despite the efforts of the General Medical Council,⁶ postgraduate deans,⁷ the Department of Health,⁸ and individual consultants a recent survey showed that the training and working conditions provided for house officers were still unsatisfactory and inconsistent with the GMC's recommendations.⁹ Despite all these recommendations there are no established methods for stimulating change locally. It is difficult to produce lasting change by edict from above,¹⁰ and threats may enforce only reluctant compliance with the minimum requirements.¹¹

The Wirral Hospital NHS Trust is a large district general hospital, 15 miles from the University of Liverpool Medical School. It provides a comprehensive range of specialties and employs 30 preregistration house officers. Despite having met the recommendations of the junior doctors' new deal on hours,⁸ recruitment had become increasingly difficult over the previous two years and there were only 10 applicants for posts starting in August 1993. For August 1994, however, the trust is oversubscribed. We describe the action taken to produce this turnaround.

Action learning

In September 1992 general practitioners and consultants formed an action learning set.¹² Its primary aims were to teach clinicians about management and encourage personal development. In action learning participants learn by exploring a practical problem. As well as analysing the problem and making recommendations, a successful action learning set must also implement the necessary changes. We chose to work on the difficulties of house officers as this problem was relevant to our clinical practice. Our approach was "we have got a problem—how can we make our jobs more attractive?" rather than the traditional "how can we coerce junior doctors into doing what we think they should?" We aimed to turn the Wirral Hospital into a

place of excellence where house officers would be keen to come to learn.

Method

The group contained two general practitioners (ASM, RJA), a chemical pathologist (WDN), an anaesthetist (JKM), a psychiatrist (MAB), a paediatrician (DM), and a general surgeon (CAM). We were guided by an experienced facilitator (HJ) and learnt to apply classic management methods to assess problems and possible solutions and influence key decision makers. The only member to have a house officer was the surgeon. The group's diversity provided a balanced and objective view, the general practitioners in particular bringing new ideas on training and education. We met for one day a month away from the hospital to emphasise commitment and reduce interruptions. We were given full support and a free rein by management.

Junior doctors at all levels have problems, but we believed that improving matters for preregistration house officers would generate change for all junior doctors. We therefore decided to concentrate on preregistration house staff as this would ensure the project was sufficiently circumscribed to be practical.

The initial stages consisted of discussion, a search of published work, and consultation with all interested parties. Ideas were generated quickly by brainstorming—as many ideas as possible being put forward with no attempt to evaluate them until afterwards. At first this was alien to our analytical medical training but it proved to be very effective. At each stage we agreed a detailed plan of action with specific duties for each member and a timetable.

STAGE I: DEFINING THE PROBLEM

The national picture was assessed by reviewing published work. The problems identified were inadequate personal support and career guidance, haphazard education, poor living and working environments, and inappropriate working practices. There was an imbalance between service commitment and educational opportunity. Addressing this catalogue of problems would reflect the true spirit of the new deal better than a narrow emphasis on hours of work. We chose to measure Wirral hospital's performance against the benchmark of the GMC guidelines for the preregistration year.

We then reviewed the local problems from the viewpoint of house officers, senior medical staff, and management. We found that few medical students spent time at our hospital and that final year students perceived the posts as too busy. In addition, in 1991 and 1992 reorganisation of our services across the two sites led to major disruption for house officers and reduced their senior support. The river Mersey was a psychological barrier, distancing house officers from their friends in Liverpool. Accommodation for house

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Box 1—Recommendations

- Substitute philosophy for job description
 - Offload inappropriate tasks
 - Clarify job content
 - Personal mentor
- Education
 - Formal education programme
 - Protected teaching time
 - Log books
 - House officer steering group
 - Personal development
- Housekeeping (a return to "the old days")
 - All house officers resident in one block
 - Upgrade mess (showers, decor, laundry room, reading room, water filters and ice machine, games room, non-smoking television room, etc)
 - Appoint mess steward to lay out breakfast 7-10 am
 - Free breakfasts
 - Barrier protected parking adjacent to mess
 - Corporate membership leisure club
 - Out of hours catering

officers was spartan and widely scattered across both sites. The doctors' mess was poorly equipped, unattractive, and underused, and out of hours catering was inadequate.

Some of the senior clinicians and managers viewed house officers as a transitory and expendable resource. This was identified as a key problem. The house year was not managed and did not have defined service commitment, specified job demarcation in relation to other hospital groups, or structured education.

STAGE II: INTERESTED PARTIES ("STAKEHOLDERS")

Interested parties in the hospital were identified as the house officers and medical students, the consultants, management, registrars and senior house officers, nursing staff, and the postgraduate education bodies. We tried to anticipate their views, gauge how helpful they would be, and how important it was to gain their support.

STAGE III: RECOMMENDATIONS

We drew up an idealised house officer post, decided which aspects were attainable, and proposed the appropriate changes (box 1).

STAGE IV: ACTION PLAN

The next stage was to replace the traditional job description with a "philosophy" for preregistration house officers (box 2) and develop programmes for education and personal development, including regular assessment. We aimed to meet and influence key clinicians and managers, improve accommodation and housekeeping, and market the posts and the hospital.

Programme

Group members met with the hospital's junior doctors' task force and with management, which both supported our proposals. The management agreed to fund improvements to the mess, to appoint a mess steward, and to provide free breakfasts, leisure club facilities, and dedicated car parking. The hospital consultants' medical board agreed to the introduction of a house officer steering group to evolve and evaluate standards, oversee changes, and monitor adherence. They also agreed to the establishment of an educational programme, including a dedicated hour's teaching each week. These were endorsed by the hospital's council. This formal support has enabled the changes to be made despite a lack of commitment from some quarters.

The postgraduate dean supported us and agreed that preregistration house officers should be attached only to consultants who show a commitment to training and education. This support was particularly influential in view of the new arrangements for funding of training grades.

TIMETABLE

We presented our proposals in July 1993 and they generated such enthusiasm that management decided to implement them immediately to benefit the house officers joining in August 1993. Work began that week on the housekeeping and domestic improvements.

HOUSE OFFICER STEERING GROUP

We set up the house officer steering group, accountable to the chief executive and postgraduate dean. We believed that it was important that this was not simply the action learning set. The group is chaired by the postgraduate tutor (a rheumatologist with house staff) and has representatives from the consultant body (CAM, JKM), nursing staff, house staff, management, an external educationalist (ASM), and a psychiatrist (MAB).

The steering group meets quarterly. Its remit is to agree minimum criteria for house officer posts, run the education programme, monitor adherence through the use of compulsory log books and attendance records, and interview selected preregistration house officers and consultants. Regular reviews should continue to improve standards and, if necessary, the group will be able to apply sanctions. It will increasingly be active in assigning house officers to supervising consultants and in planning for future requirements of house officers. It will in due course take responsibility for organising the induction programme for house officers and the open evening for medical students. As a final protection for preregistration house officers, the group can provide an independent reference.

Box 2—The Wirral Hospital's philosophy for preregistration house officers

We hope that in providing good house officer posts, we will in turn attract good candidates who will contribute to improved health care of the people of Wirral.

Purpose

The purpose of the preregistration year is to consolidate undergraduate education with supervised clinical experience. The year should be enjoyable and stimulating, with opportunity for continuing education and personal development

Environment

High quality accommodation and living conditions are provided. Holiday, leisure, and study time are respected. A team spirit is fostered, with due recognition of the role of the house officer. There are clear lines of communication and appropriate support and supervision

Education

In addition to general clinical training, a broad portfolio of activities is offered, including exposure to non-clinical support services. Time for formal educational activities is protected and attendance at these expected. Emphasis is placed on personal development, including the acquisition of appropriate responsibility, career guidance, and introduction to issues of management and public relations

Conditions of employment

Specific details of individual house officer posts and a complete package of conditions of employment are available from the personnel department, Arrowe Park Hospital, Wirral L49 5PE (Tel 051 678 5111)

MENTORS

Members of the action learning set agreed to act as personal mentors for a group of house officers. Each member was allocated five house officers from outside their own discipline whom they meet individually every three months. In a semistructured interview they explore both work related and social-domestic problems and act as external support outside the structure of the firm. This has already proved valuable—the house officers were pleasantly surprised to find that someone took a personal interest in them. Several issues were raised that could be resolved by consultant action, individually or through the steering group. We thought that four house officers were clinically depressed, and the psychiatrist now provides an additional and more formal counselling service.

MARKETING

We organised an open evening for medical students in September 1993. We sent personal invitations to students from the universities of Liverpool and Manchester. The invitations emphasised that the hospital provides posts lasting 12 months that fulfil the new deal on hours, formal education in protected time, and cheap leisure club facilities. It included our house officer philosophy. The evening consisted of formal presentations, a tour round the hospital, and an informal meal at which the students met many of the hospital's consultants. The evening was attended by 80 students and was well supported by consultants and management.

The commitment of the consultants and the trust to its house staff was clear, and we are oversubscribed for August 1994.

Discussion

The process of analysis, discussion, and consultation took several months but ensured that our ultimate recommendations were based on local needs as well as national problems and that they would be supported by the majority. Our strategy of involving and influencing key people generated widespread support and, as a result, lasting improvements have been made. The action learning set will be active for another year and will gradually relinquish its role to the steering group.

Once our recommendations had been produced the speed of change surprised us all, with many improvements being made for the house officers joining in August 1993, a year ahead of our target date. Our senior house officers are already requesting similar support, and in time this initiative should improve all our junior posts.

The group thought that several factors were critical to the project's success. The group was perceived to be objective. It was highly committed to solving the problem and avoiding failure. We made the time to think the problem through in depth and research it thoroughly. We accepted the likely failure of a piecemeal approach and decided on a whole new philosophy. We took great care to keep our proposals practical because we would have to carry them out ourselves. We convinced the trust that the problem was important for the whole hospital. Finally, the trust's commitment to management development for its clinicians ensured a sympathetic hearing.

Our successes emphasise the value of teamwork. The action learning process was fundamental and taught us to use the abilities of each team member and to welcome differing views. We learnt how to select, define, and plan tasks; analyse problems; understand other people's perspectives; influence colleagues; and bring about change. Set members also benefited individually from the exercise, developing varied skills, learning from each other, and increasing their

personal effectiveness. It was particularly valuable to be able to take time out from the working week to reflect and develop insights into our individual needs.

To our knowledge, this is the first collaborative action learning programme to involve both consultants and general practitioners. The successful outcome has established action learning on the Wirral, and further project groups have been formed. Action learning could be applied to many other issues in the health service and would be valuable wherever doctors and managers wish to work more closely together to resolve organisational problems.

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ANY QUESTIONS

How quickly does the soft swelling overlying a skull fracture appear in children under 1 and is it possible for a fracture to occur without initial swelling? The timing could have implications in cases of non-accidental injury.

The skull vault of an infant is soft enough for a neurosurgeon to cut with stout scissors at operation but elastic enough to withstand mechanical forces which would fracture the skull of an adult or older child. This is the basis for the view that unusual violence is needed to fracture an infant's skull (excluding in rare cases of an intrinsic bone disease such as osteogenesis imperfecta). The finding of a skull fracture in an infant brought to hospital is therefore usually regarded as reflecting considerable violence to the underlying brain and also to have sinister overtones if the explanation offered for the child's injury seems vague or unconvincing.

Mechanical forces great enough to fracture a bone also damage the adjacent soft tissues and cause local bleeding and swelling. It would be most unusual for a skull fracture not to be accompanied from the start by bruising and swelling as the scalp is extremely vascular and is easily separated from the underlying pericranium and bone of a subgaleal haematoma. Over the following days or weeks the haematoma resolves and the swelling and bruising disappear. The timing of these changes is not an exact science, but a skull fracture without swelling or bruising is almost certainly more than a week old, and I would expect a fresh fracture in an infant's skull to be accompanied by local swelling or bruising in virtually every case.—DOUGLAS GENTLEMAN, consultant neurosurgeon, Dundee