1 Richards P. Educational improvement of the preregistration period of general clinical training. *BMJ* 1992;304:625-7. (7 March.)
2 Firth-Cozens J. Emotional stress in junior house officers. *BMJ* 1987;295:533-5.
3 Juniors call for an overhaul of higher training. *Hospital Doctor* 1992 March 19:1.

SIR,—Peter Richards unnecessarily confuses the issue[1]; insufficient attention has been paid to improving "practical supervision and education" within the constraints of a single preregistration year.

The education committee of the General Medical Council has long held opinions concerning the educational and practical content of the preregistration year.[2] Specifically, it is increasingly argued that tasks of little educational value, such as routine phlebotomy, filing of results, bed finding, and portering, have no place in the preregistration year. I am not aware of any preregistration job, including my own, in which a significant part of the working week is not taken up with these and other tasks. If juniors were spared these duties, time would be created for the educational programmes that Peter Richards describes, without the unnecessary expedient of a second year of training. This is hardly a new suggestion, yet only lip service seems to have been paid to the idea of reducing workload in such a way. The plight of preregistration house officers is in the hands of the universities and the GMC, who have the power to implement these guidelines if they so wish.[3]

Unfortunately, a reduction in service workload and fewer hours on call is not all that is called for. The "pot filling" approach to medical education in this country has produced generations of medical graduates poorly equipped for the self directed study and performance review that characterises successful continuing medical education outside the formal environment of clinical school.[4] Not only are house officers demoralised and exploited but they lack the necessary skills and motivation to take advantage of educational opportunities. The answer to this, in a glib nutshell, is a radical revision of preclinical and clinical educational practice. It is this area that should be the focus of Peter Richards's article if he and the Council of Deans indeed wish to produce a happier, well motivated, confident, and competent group of preregistration doctors.

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1 Richards P. Educational improvement of the preregistration period of general clinical training. *BMJ* 1992;304:625-7. (7 March.)
2 General Medical Council. *Recommendations on basic medical education.* London: GMC, 1980.
3 Smith R. Medical education and the GMC: controlled or stifled? *BMJ* 1989;298:1372-5.
4 Sackett DL, Haynes RB, Tugwell P. *Clinical epidemiology: a basic science for clinical medicine.* Boston: Little, Brown, 1985.

SIR,—Peter Richards's plans for the preregistration years will demand changes in outlook by consultants as well as preregistration trainees.[1] Present clinical students observe the predominant service role of house officers and model their expectations and behaviour accordingly; and so it goes on through general professional and higher training until they themselves become consultants. The result is stasis with little will for change.

In this region we plan a pilot study to assess and analyse the in service educational profile of posts and establish a detailed job content. In this way clear objectives for the preregistration year can be agreed by consultants, house officers, and managers. The tasks of these groups can be defined together with those of other juniors and the nursing staff. The outcome can be enforced by strict accreditation of posts.

We could write about the need for adequate assessment, induction, communication, alleviation of stress, and much more. Suffice it to say that the proposals for a two year preregistration period based on medical education command attention as a basis for much needed reform. We believe that some of the best examples of forward thinking are to be found in smaller district hospitals. Much effort should be spent on strengthening this good will rather than disqualifying these hospitals from training house officers. And it will not serve the cause of senior house officers to suggest that they should take over house officers' duties in small hospitals.

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SIR,—Although there are some superficial attractions in Peter Richards's proposed changes for the preregistration period of general clinical training,[1] the root cause of the problem has not been addressed. The reasons for dissatisfaction with the preregistration year are mainly lack of supervision and training and excessive hours of work.

The proposal as it stands, having acknowledged these problems, leaves the responsibility for supervision and training in the hands of another junior doctor who would have a mere six months' more experience in the post. Clearly, the effectiveness of such training and the wisdom of such an arrangement are open to debate. In reality, even this unsatisfactory cover may not always be possible as the two doctors, by virtue of job sharing as proposed, would not always be working simultaneously. Therefore the more junior doctor would still be left without any ready access to help and advice. The more crucial requirement that any supervision must be provided by the consultant and senior grade staff has been made conditional on their availability and other service commitments, including work outside hospital.

In effect, there will be hardly any change from the present situation except the remote possibility of a small reduction in the number of hours worked each week. As this will be at the expense of shortening the undergraduate medical course (which will need a much more radical reappraisal than mere tinkering) and increasing the preregistration period (essentially to meet manpower requirements consequent on any reduction in the number of working hours) I believe that the proposal is superficial and irrelevant.

The essential requirements for any improvement in the preregistration period must include at least the following: protected time for teaching by senior staff; the continuous availability of senior staff for supervision and support at all times; a well designed rotational scheme of training during the preregistration period; effective formative assessment; enhancement of the teaching skills of consultants and senior grade staff; and regular appraisal of posts by the postgraduate dean or the dean's representatives, or both, and the doctors in training.

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Medical training in Germany

SIR,—I qualified in Germany and have worked as a house officer in Britain as well as an Assistenzarzt (senior house officer) in Germany. When comparing postgraduate medical training in Germany and the United Kingdom I believe that support and training of junior doctors in the United Kingdom are excellent. The real problem in Britain is too little sleep. House officers work on average 80-100 hours a week. Such long hours are hardly known in Germany and contribute to the bad reputation that the NHS has in other European countries.

The idea of extending the preregistration period is interesting.[1] Long working hours could be reduced, allowing a better quality of life and more time for training and studying. Young doctors would thus gain more experience, in both medicine and life, before becoming fully registered. The average age of a recently qualified doctor in Germany is about 27 and that of one in Britain 23 or 24. This means that those in Germany have more experience of life—much more, considering the broader school education in Germany. Taking this and European Community requirements into account, it would certainly not be wise to shorten the basic medical training as Peter Richards suggests.[1]

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SIR,—Stephen Brearley discusses medical education within the European Community.[1] We have conducted our own survey of medical training in Bonn (Germany) and Bristol (United Kingdom). This study highlighted some pronounced differences in training that are not immediately apparent when the curriculums of the two medical schools are compared.

In Germany medical training lasts six years and is followed by 18 months as *Artzt im Praktikum.* In the United Kingdom basic medical training lasts five years and is followed by one year as a preregistration house officer. In Bonn a student faces 180 hours of lectures and 720 hours of clinical exposure to general medicine; 85% of the clinical teaching takes place in the final year as a student. In Bristol 110 hours is devoted to lectures and tutorials in general medicine and total clinical exposure amounts to 1122 hours, equally divided between the third and fifth years of the course. General surgery is similar, with 108 hours of lectures in Bonn and 110 in Bristol. Clinical exposure to surgery is 720 hours in Bonn and 1122 in Bristol.

The European Community recognises such courses as comparable,[2] and superficially they are. The content of the clinical attachments, however, differs greatly. In Bristol medical students start on the wards much earlier in their training and tuition is aimed at helping them to master the basic skills of history taking, examination, and presenting cases. There is also ample opportunity to learn basic practical skills, such as placing an intravenous cannula or a urinary catheter. In Bonn, by comparison, students concentrate all their ward work into the final year. There is less formal clinical instruction and far less emphasis on acquiring practical skills.

Having both worked in the United Kingdom and Germany, we think it important that these differences in clinical training are recognised by employers and employees when hospital appointments are made. We heartily endorse "free migration" as an influence for good but emphasise the need for this to take place early in medical education. It is only through the expansion of exchange schemes such as the European Community's action scheme for the mobility of students (Erasmus), which allows exchanges of medical students, that differences in training can be recognised at an early stage in a doctor's career.