Clinical training – back to the future

‘Experience is the name every one gives to their mistakes’
Oscar Wilde, Lady Windermere’s Fan

More than a decade has passed since our welfare state displayed a health service second to none. This distinguished era in Danish medicine came to an abrupt end in 1981, when a new agreement was forced upon junior doctors by the government against the advice of all Danish doctors, their professional associations, and their scientific societies. The authorities required that working hours, including night service and time for training, were reduced to 40 hours a week. Having reached the goal the government was forced to a further reduction in working hours to 37 hours a week as a result of a new compromise with the unions.

This offshoot of the general community policy in Denmark originated in the politicians’ ambition to improve environment and working conditions for all wage earners in the country. As predicted by junior as well as senior doctors a disastrous discontinuity in clinical work and clinical training was soon revealed. In an attempt at compensating for the reduction in working hours a structural change of postgraduate education and training has now been introduced with the purpose of speeding up the production of specialist doctors. Unfortunately, no economic resources for training programmes were allocated and no time for senior doctors to accomplish bedside education, performance feedback, and on the job surveillance was granted. Frustrations bloom, especially among junior doctors, who admit that nothing in their student careers prepared them for clinical work. The particular Danish experiment, which was carried into effect under nearly absurd conditions, may have satisfied politicians’ and hospital administrators’ wish to see specialist doctors perform patient care. By doing this at a discount price clinical training threatens to mirror H C Andersen’s fairy-tale The emperor’s new clothes. To add insult to injury the implementation of the junior doctors’ agreement has turned out to be used as a concept for calculation of wages by foregoing 150% or more to compensate for night work. One question that now remains to be answered is what challenges policy makers will face when the National Health Service reacts by squeezing still more junior doctors through the education system in still shorter periods of time? Another question to be answered is how drastic will qualifications of future consultants, in particular surgeons, decrease when the opportunity of acquiring practical skills is lost?

There is little information on the way in which politicians and hospital administrators cope with their mistakes. What we see is that they still display the principle of the greatest happiness of the greatest number of patients – other things being equal at the expense of the patients. The short working hours combined with a severe pressure from the junior doctors union explain why there has never been so many doctors employed in Danish hospitals. It is also true when politicians argue that there has never been so many permanent positions in the Danish health system. A 37 hour week, however, permits less than 50% of junior doctors to be present at all times and a future surgeon will typically have only 70–80 days during a 9 month training period to perform his practical skills during work on the day shift. This provides the important obstacle for maintaining continuity in patients’ care and junior doctors’ education. The ‘inappropriate’ use of doctors is a problem that has defied solution in Denmark, partly because the problem has itself originally been defined by doctors, produced in excess during the late 1970s, and not by patients.

A multi-level of permanent posts for senior doctors was recently introduced to obviate the lack of qualified doctors in the hospitals. The new reform of genius, converting educational posts into permanent posts threatens to eliminate the first and ultimately the problem itself when educational posts no longer exist. The French would say ‘apres nous le délie’, but in Denmark we are more steady – awaiting how and when qualified candidates for the new permanent posts will appear.

A third important question, which remains to be answered, is whether research makes better doctors.¹ The short answer given by many junior doctors may be no, but...
a moment’s reflection will show the misleading simplicity of the question. Although some doctors may benefit from research training more than others, Danish gastroenterology needs, in addition to innovative research, clinical researchers who can catch up with the newest developments and integrate new information. Although McCormick’s dictum, ‘medicine is not science, and it is certainly not art’, may also be valid for gastroenterology, progress of the discipline is a scientific activity, rooted in both basic and clinical research. Every gastroenterologist should, therefore, have sufficient scientific background to understand and recognise sound scientific arguments for changing a clinical practice. Clinical training, which might be shortened if combined with clinical research, would also benefit by this approach. Training programmes that meet the postgraduate doctors’ needs for education to become an expert in gastroenterology remains, however, a promise unfulfilled in Denmark, if experience is not learned from mistakes.

JØRGEN RASK-MADSEN

Department of Medical Gastroenterology 261, Hvidovre Hospital, University of Copenhagen, DK 2650 Hvidovre, Denmark