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LEADING ARTICLES

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MEDICAL PRACTICE

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Incompetence in medical practice

SIR,—Professor Philip Rhodes's leading article on medical incompetence (17 May, p 1293) documents clearly and sensitively a problem close to many of our hearts, but when I looked in the article for practical solutions I did not find them.

I am a registrar; one of my senior house officers is keen, polite, and friendly but inexcusably incompetent. He came to Britain from a developing country and qualified here two years ago. The reference which got him this job was woolly and noncommittal, and when asked to expand on it his previous boss had hedged, "Well, he's not outstanding but no, he's certainly not a liability."

Everyone covers up for him, especially me. The nurses know not to administer a drug he has prescribed until it has been countersigned by the ward sister or myself. Patients justifiably angry when a practical procedure has been ineptly or inappropriately performed are told white lies, and sometimes damn lies, to excuse him. I occasionally remove several days' worth of clinical notes and replace them with more respectable entries before the boss's ward round.

I do all this because he is a nice chap and he does his best. I do it because I have defined my responsibility as being towards my own patients in the here and now. I do not have the time, the inclination, or the moral courage to start laundering his dirty linen in public. And, perhaps spurred by the bourgeois guilt of my ancestors' imperialism in his country of origin, I do not want to be the one who turns his already sad life into a disaster by steering his medical career on to the rocks. My boss is neither ignorant nor stupid, but I suspect that after much soul searching he will also opt for the line of least resistance through a mixture of professional denial and moral apathy.

As Professor Rhodes says in his first sentence, "Competence in medicine is recognisable and incompetence even more so." Doctors such as our senior house officer stick out like sore thumbs and the proposed set of watchdog committees to seek them out would be a superfluous piece of bureaucracy. The starting point for reform should be a realistic and detailed plan for a re-education system which is both humane, discreet, and practical. I would like to propose the following.

Junior doctors who are failing on the job have, by definition, slipped through a number of nets. Formal lectures, small group seminars, bedside teaching, and on the job experience have all failed as methods of education. The examination system in its various forms, and the consultant's certificate of satisfactory service, have failed as methods of assessment. Any back up system which relies again on these methods is unlikely to succeed, and I suggest that a new system should be based on an entirely new approach: the "apprenticeship" of bad junior doctors to good ones.

Most of the attitudes and techniques which have translated my own theoretical knowledge into practical competence have been gleaned from colleagues only a little older (and perhaps not much wiser) than myself. There is no shortage of junior doctors who, given time and financial incentive, would be able and willing to teach by example. They need not be encyclopaedic in knowledge or a model of competence in every practical procedure—in fact, it would be better if they were not. What they would be able to offer is a knowledge of their own limitations, a sense of priority, and the basic imperatives of professionalism and safety—the very areas in which the prospective apprentices are most dangerously lacking.

The skills of good junior doctors are a rich resource which should not be wasted. Our better house officers, senior house officers, and junior registrars could well be used in a system of "shadowing" in which the teaching commitment was just formal enough to define trainer and trainee but not so rigid as to destroy peer group camaraderie. To encourage them, and to avoid insulting them, they should be rewarded with hard cash and with a realistic reduction in their regular workload.

If a committee were to be set up, let it address itself to the following questions: will such a shadowing system work? How big does it need to be? Who will orchestrate it and who will pay for it? How will we identify juniors suitable to act as trainers? What system will be necessary to support and evaluate their efforts? And how, at the end of the day, will the progress of the apprentice be assessed?

If I were my boss, and I knew that our present senior house officer could be taken aside by a third party and sent to spend six months on the heels of a sensible role model with the likelihood of emerging a better and humbler doctor, and that his case would be treated sympathetically and confidentially, I would speak up tomorrow. At the moment, when the alternative to doing nothing is consigning someone I like and care about to the professional scrapheap, I would prefer to do the former.

ANONYMOUS

Haemoglobin concentration and linear cardiac output, peripheral resistance, and oxygen transport

SIR,—Mr M K Daniel and his colleagues concluded from their results that "the optimum packed cell volume for oxygen transport is the highest that can be achieved," stating that this is supported by athletes who train at high altitudes or