Modernising Medical Careers and the career framework

Sir,

Having lived through a number of changes in medical education over the last few decades, it is possible to cast a wearied eye over the changes introduced by Modernising Medical Careers (MMC), as outlined in Professor Heard's editorial (vol 67(8), 2006, p. 396), and say 'Oh no – not another change!' However, this particular change strikes the very backbone of the entire postgraduate training of a doctor. It has also split the profession in their views.

Originally briefed to look at just the senior house officer grades, MMC has taken a much broader view, I think correctly, to look at the entirety of postgraduate education.

There are several plus points. No-one can argue with the vision of MMC – it is about training doctors for the 21st century to support patients and their families in health. It will achieve this by ensuring a competency-based assessment of the skills of a doctor and by maintaining standards.

However, all changes come with problems. First, there is the process of initiating the change from one system to another. We saw this in the fiasco of the appointments of the foundation year 1 grades when hundreds of bright young medical students were left jobless. Perhaps just a teething problem but one wonders whether this could have been foreseen. There is now the threat of many foundation year 2 doctors being left jobless. Whether this will be a threat or a reality we will need to wait and see. However, one feels that there must be the same number of posts in the 'system' to allow all to get jobs, unless, of course, there is a huge influx of doctors from abroad.

So, will MMC make a good doctor? The vision is clear, but much of the training and competency assessment will be left to those on the ground. One does get the feeling that one is pushing the trainees along a factory belt, assessing them on their competency rather than on whether they are a 'good' doctor in terms of their knowledge, skills and behaviour. Also despite, being described as 'flexible', there is little flexibility compared to the system that we currently have. There also appears to be little time for gaining experience as, with both the working time directive and the reduction in the length of training, there appears to be much less time spent with patients and on the wards.

I am also rather concerned about how the fixed-term specialist training will work out, as most trainees will want to join the run-through specialist training in order to ensure a number as soon as possible. This means that there will be little time for doctors to try other specialities before going into the chosen one. The career post again appears to be a dead end post, currently equivalent to the non-consultant career grade post. However, the opportunity is there for competing for entry into the run-through training programme, although I suspect this will be hard.

I welcome this tremendous change and vision of future postgraduate training, but still feel somewhat concerned that we may be losing the flexibility and the experience that our doctors currently gain. However, whether we will get a 'better' doctor remains to be seen. Can we have some evidence – please?

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Effective use of preassessment appointments

Sir,

It is now widely accepted that preassessment of surgical patients is advantageous. The gold standard would be to review all elective patients who are to undergo a general anaesthetic in a preassessment clinic and to flag up any issues that can be optimized in order to reduce the perioperative complications and morbidity. However, as this practice becomes more accepted as the ideal, the spectre of resources and funding raises its familiar head.

As both surgeons and anaesthetists, the authors often find themselves assessing and investigating patients who are elderly and unfit either the night before or even the morning of surgery. To investigate the use of the preassessment clinic appointments as a resource at the hospital a month of elective admissions were audited gathering data on patient age and American Society of Anesthesiologists grading and attendance at a preassessment clinic. The results corroborated the authors' suspicions that the preassessment clinic appointments were not being allocated effectively.

Of 223 patient episodes (from a small tertiary referral unit) only 45% obtained and attended an appointment at the preassessment clinic. Of these there was a modal distribution of attendance of 50:50 in the age ranges 11 to 70 years, tailing off sharply at the extremities of life. The American Society of Anesthesiologists gradings showed similar figures with grades 1 and 2 well represented while 3 and 4 were rarely assessed.

While the authors' trust serves a very large geographical catchment area they suspect that this is a fair representation of preassessment clinics around the country. It highlights the need for clinicians to be more involved in the selection of patients to be preassessed.

The authors have introduced a form for use in outpatient clinics to encourage consultants to earmark patients they feel would benefit from preassessment. The audit loop will be closed once these changes have taken effect.

The authors wish to share this experience and encourage other hospitals treating surgical patients to assess the way that the preassessment clinic appointments are utilized. It is vital that the effectiveness of this valuable resource is maximized in the current climate where there are less appointments available than preoperative surgical patients.

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