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# Modernising medical careers; the really hard work now begins

G Hughes

The recently released “transitional interim advice” from the College of Emergency Medicine<sup>1</sup> regarding implementation of the Modernising Medical Careers (MMC) post-Foundation programme indicates that we are entering a crucial phase in postgraduate medical education. The time for procrastination is over. Operational implementation is the next step.

MMC has had a controversial gestation. From conception to delivery there has been debate, discussion, angst and even hostility about its merits. It is probably a more complex and radical overhaul than the Calman reforms of the late 20th century. Supporters believe that the medical profession needs to get its act together to cope with healthcare delivery in the 21st century and streamline training in a consistent and coordinated way. Detractors argue that it will reduce the quality of the end product, is confusing and there is no guarantee that it will achieve its desired target. The Foundation Programme (the first phase of MMC and currently in only its second year) is too nascent to be judged objectively.

At first glance, a slightly jaundiced eye might see the seven pillars at the heart of the new programme (training will be trainee centred, competency assessed, service based and quality assured, flexible, coached, customised and structured) as something thought up at an away day for Madison Avenue advertising executives. It all sounds wonderful in theory. Let's hope it is not a load of education-speak gobble-dyook. It is not clear how much real negotiation has been involved in formulating the programme—has it been centrally driven, with little room for true discussion, or has it been a truly multifaceted process, with consultation from those at the coal face and using give and take? Whatever its merits and limitations, MMC is here to stay and needs implementation.

The transitional interim advice mentioned above has resulted from terrific endeavours by the college and its officials. The time and effort invested

to get to this stage should not be underestimated. This is a real achievement. Well done to one and all.

The document confidently states that 70 specialist registrar entry points per year will be needed in England at the ST1 level to meet the target for consultant expansion, but to meet the number for trained doctors 120 entry points will be needed. Predicting future workforce numbers is risky. In 1997, the Australian Medical Workforce Advisory Committee (AMWAC) published bold predictions of specialist emergency physician numbers needed nationwide; 1200 by 2007.<sup>2</sup> Trainee recruitment numbers were set and it was planned to reduce intake from 2003. These 1997 recommendations were eventually replaced as they were way off the mark. In 2003, an AMWAC review discovered that trainee intake had to be sustained at higher numbers than expected and so the planned reduction was scrapped. There will be a further update in 2007–8. Reasons for the inaccuracy of the 1997 predictions are detailed in the AMWAC reports.<sup>2</sup>

There is a lesson here for the UK and it is that, with the best will in the world, workforce predictions are nothing more than a best guess and only time will tell their accuracy. Review and re-calculation is needed. It must also be borne in mind that the Australian predictions were in the context of an essentially stable health system. The problem for UK planners is that the NHS is now an unstable health systems.

The way the NHS will actually function in 2013 (a key year in the transitional interim advice document) is by no means certain. Market forces (which are inconsistently applied and perhaps only when it suits the politicians), choice (whatever it means), foundation trusts and private finance initiative hospitals, long-term recruitment and retention and funding are the ingredients that make predictions both tentative and fragile. Add to the mixture a potential gate-keeping (triage as well as fund holding) function of primary care trusts (yet another bundle of care that can be sold off to the highest bidder), and who

knows what role emergency departments will have.

Another risk ahead is the practicality of training—from the trainer's point of view. The new programme (“run-through” sounds like an attack of diarrhoea and “run-through training” sounds like potty training for toddlers) will demand a tremendous amount of trainers' time, not just in training but in assessment too. Will trusts release their senior staff when there is work on the floor to be done? The conundrum of trying to balance service delivery and training is challenging and is an eternal quandary. Investment is needed but there is no guarantee this will happen.

The Deanery Schools in Emergency Medicine have a critical role. Implementation demands attention to detail, with careful collaborative planning. An important function will be the Deanery's relationship with local providers. These relationships will need nurturing, but there will also need to be contracts, formal reporting and monitoring. What if a foundation trust takes a view that service delivery overrides training? Will the Deanery be impotent? Can they penalise providers who fail to comply?

Medical graduates who qualified in the early years of this century (especially in 2003 and 2004) are potential casualties in this transition period. They are vulnerable and need to be catered for. It will be a tragedy if they are victims of these changes. Other potential victims are those who will successfully complete their training. There may not be enough consultant posts for them, and they may end up scrambling for non-consultant posts. If they are desperate for work, they may fill subconsultant posts at lower salaries. Is this what the government wants? Is it what is meant by the phrase “the doctors we need” (v “the consultants we need”)?

Attention to detail, cooperation and collaboration, clear accountability and reporting lines, an ability to review the numbers and a solution for the potential victims of these changes are essential. Good luck.

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