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From the editor

Last dispatches

A long established tradition in the Foreign Office has recently come to light that, despite surviving numerous changes of government, upheaval and wars, was brought to an abrupt end in 2006. An outgoing ambassador, whose reports were usually a model of circumspection, had complete freedom to write whatever they wished in their final message home – about the post that they were leaving, the governments that they had served or the diplomatic service itself. The reports were particularly candid when written by a retiring ambassador. Many of these dispatches have recently been obtained under the Freedom of Information Act and broadcast by the BBC. They have subsequently been published as a series of essays.[1]

What an opportunity arises to follow the example set by the ambassadors and throw caution to the wind in my penultimate editorial (my final editorial, introducing the new editor, will feature in the August issue). Contributors to the journal have, of course, always been free to express their own opinion and a disclaimer is carried in each issue clarifying that the opinions expressed in each article are those of the author and not necessarily those of the Royal College of Physicians (RCP). Most contributors, however, are still influenced by the weight and authority of the RCP which seems to exert control over their pen, or at least their laptops, and adds prudence to their freedom of expression.

This editorial answers some of the commonly posed questions about the RCP from the perspective of an observer of the scene for some five years – a long time in some senses but a transient moment when set against the 500-year history of the RCP.

'Isn't the RCP remote from the real world in which we work?'

Although the RCP has an idyllic setting in Regent's Park, the delightful, airy, modern Grade I-listed building where no acutely ill patients flood through the doors day and night, where there are no worried and anxious relatives and the staff are all well dressed and well behaved, those from the 'real world' do bring their accounts to council of what clinical life is really like in the acute medical and other specialties. The regional advisers, the training committee, the new consultants' committee, personal emails from fellows and the regular regional RCP visits all bring information flooding in, which is analysed and debated and from which constructive and helpful plans emerge – but perhaps at slower pace than some would like.

'Why does the RCP collaborate with the government of the day and not stand up and be counted?'

The most challenging recent example arose from the planned introduction of the disastrous Medical Training Application Service (MTAS) for newly qualified doctors in August 2007 which brought the RCP close to drawing a line in the sand and an end to any further cooperation with government. Cooler and perhaps wiser heads just, but only just, prevailed. Determined but ultimately unsuccessful attempts were made to modify the scheme and the blame for the ensuing debacle then fell unfairly on several bodies, including the RCP. What has happened since? The RCP has assumed responsibility for the appointment in the early years of general and specialist medical training, introducing a hugely successful system for applicants and employers alike. This positive outcome could not have been foreseen at the time and was only achieved through continued collaboration.

'Why has the RCP allowed the loss of teamwork and continuity of patient care?'

This question exemplifies how a central organisation can usually only respond to unexpected events rather than prevent them from occurring. Senior physicians will recall the time not so long ago when the 'acute take' consisted of 10 to 12 admissions in 24 hours. The patients were admitted and subsequently cared for by the same clinical team. Patients were gradually discharged as they improved creating vacant beds on the home ward in time for the next acute take the following week. Contrast this with today's pattern of 60, 70 or more acute medical admissions per 24 hours which would have overwhelmed the previous pattern of working. Several features have combined to fuel the change – a much greater range of available treatment options, acutely ill patients no longer cared for either at home or in residential or

nursing homes, the increased demands associated with an ageing population and rising expectations among both patients and their families. How has the RCP responded? It has encouraged and supported the introduction of acute medical assessment units and the development of the new specialty of acute medicine at both consultant level and for doctors in training. This is a medium-term, rather than immediate, solution but a most positive approach nevertheless.

It does not answer the challenges of loss of teamwork or continuity which are related to the increasing work volume and the welcome reduction in working hours for doctors in training. An acute care fellow will be appointed shortly to lead a programme that will coordinate current work streams and develop new initiatives to produce coherent and practical solutions to these problems.

'Why can't the RCP ensure full employment for doctors in training?'

The writing of a response to this question coincided with the arrival in the mail of the *BMJ* which included an editorial by Andrew Goddard, the director of the RCP Medical Workforce Unit, summarising the situation clearly and succinctly.[2] Unlike the private sector, the NHS has always had a large number of doctors in training relative to the number of consultants in the service. However, until 2003, nearly half the trainees were international medical graduates, many of whom returned home after training and thus helped to restore the imbalance. In the last decade the number of places at medical school has increased so that the UK could become self-sufficient in respect of its medical workforce. An expansion of the consultant workforce of around 4–5% annually for the last 15 years has helped to provide employment for these 'home-grown' doctors. To absorb all those in training, consultant expansion would need to continue at an annual rate of 6%. The current financial climate makes this extremely unlikely. Will this open the door to a sub-consultant grade? Many doctors in training have said that this is a much better option than no job at all and indeed such posts are already present in some hospitals.

Conclusions

On reflection, despite the freedom of expression released in a penultimate editorial, the responses seem to more than justify the importance of the RCP in promoting and maintaining high standards of patient care. Constructive responses in a large organisation do simply take longer than today's high expectation for instant solutions.

References

1 Parris A, Bryson A. *Parting shots: the undiplomatic final words of our departing ambassadors*. London: Penguin/Viking, 2010.
2 Goddard AF. Planning a consultant delivered NHS. *BMJ* 2010;342:119–20.

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