From the Editor

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Modernising Medical Careers

Over time there have been major changes in nearly all aspects of the National Health Service (NHS), for example in clinical practice, management, organisation and delivery. In this context, it is all the more surprising that the nomenclature for doctors in training – house officer, senior house officer (SHO) and registrar – have changed little since the inception of the NHS. It must, however, be conceded that the terms 'registrar' and 'senior registrar' have now been abolished and merged into a single grade of specialist registrar. This was not just a change in terminology, but reflected the introduction of a formal training programme, the annual assessment of competencies and the completion of comprehensive logbooks.

We are now in the midst of the major Modernising Medical Careers (MMC) programme. The proposed changes will ensure that the training programmes in all specialties are relevant for current and future needs and that there is clear evidence of increasing competence over time using a variety of formal assessments.

The term 'house officer' is now consigned to history and has been replaced by Foundation Year 1 training to which a second year has now been added (Foundation Year 2). Each year consists of three posts, each of four months duration, providing broad-based experience in medicine, surgery and a variety of other specialties including general practice for most trainees. In the past, house officers were often informally appointed by consultants and the medical students attached to their firm. This concept, like that of the archetypal consultant as portrayed by James Robertson Justice in *Doctors in the House*, still lingers in the medical and national conscience. For many years, house officers were appointed by formal advertisement, application by curriculum vitae (CV), followed by shortlisting and interview. A new multi deanery computer-based system was introduced for the appointment of Foundation Year 1 doctors in August 2005 and, for the most part, has worked well. Candidates submitted a list of preferences for their rotations – the higher the number of points scored, the more likely they were to be appointed to their first choice. Half of the points were awarded from automatic CV scoring which identified honours points, prizes or intercalated degrees. This was complemented by eight paragraphs of 75 words each demonstrating that they understood the General Medical Council (GMC) guidelines of good medical practice. The applications and marking were all completed electronically, a remarkable system which did not include a formal interview.

There was a particular problem with applications from some overseas undergraduates studying at GMC-approved medical schools. Some had little experience in history taking and clinical examination compared to UK undergraduates. There were real problems with clinical competence and thus patient care in a minority. The system was also criticised by some UK medical schools that did not include an intercalated degree in their undergraduate curriculum since their students were unfairly penalised and tended to score lower on the automatic assessment of their CV.

The application system for August 2006 was duly revised. The CV was no longer scanned, but there was an opportunity in the first two paragraphs of the application form to include academic achievement. With hindsight it was clear that even the most outstanding student could only accumulate a small proportion of the total points for academic excellence under the revised system.

Following this year's first round of appointments, many medical schools identified that students with excellent undergraduate careers had not been appointed to Foundation Year 1 rotations and would either be entered into a second round appointments system or assessed for competency. The revised system commonly failed to select

students with an excellent academic track record at variance with recognised practice. These concerns were further compounded by undergraduates being able to bypass security codes and access the system, thus potentially altering allocated marks. The clinical competence of applicants from overseas has once again been brought into question.

These problems have created enormous unhappiness and threaten to undermine the new, and essentially sound, system. The GMC has already withdrawn recognition from some overseas medical schools pending further assessment, and a system for assessing clinical competence before individuals take up their post will be introduced. It should also be possible to introduce a formal CV assessment to ensure that academic excellence in an undergraduate's career is fully recognised. The application system will clearly need to be more secure.

Once these changes are in place it should be possible to ensure a fair and effective system in subsequent years for appointments to Foundation Years 1 and 2 posts.

The problems encountered in these first steps in the long march to comprehensive changes proposed by MMC should alert us to further potential problems. Major changes are planned for specialist training beyond Foundation Year 2. After career guidance each doctor will decide which training programme to pursue either in general practice or in the hospital-based specialties. Each specialty will have a specialist training programme relevant to current needs. For the hospital-based specialties this will usually be two years in a general training programme followed by five to six years in a specialist training programme. The principles underpinning these programmes are well developed, but there is still a huge gulf between the proposals and practical implementation.

We have some 10,000 newly qualified young doctors in Foundation Years 1 and 2 and 20,000 doctors in the UK at SHO level. All these changes are due for implementation in August 2007, but there is little current practical guidance as to what they should do and few clear details about the number of individuals who can enter these programmes. There is little time left to finalise details of each individual programme and arrange advertisement, applications, shortlisting, interviewing and appointments.

These changes need a much longer transitional phase for effective implementation – they are far too complex to introduce in one phase from August 2007. The MMC implementation team need to rapidly agree a gradual introduction of the programme and communicate it clearly and effectively to the new generation of young doctors whom we need to foster, encourage and support if they are to be the competent, positive, happy workforce that we need for the future to ensure high standards of patient care.

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