From the Editor

Clin Med 2009;9:100–1

The chapterhouse

Worcester Cathedral has one of the earliest circular chapterhouses dating from Norman times with later additions, including the decorated rib vaulting of the roof. The roof is supported by a huge central Norman pillar. Discussions and debate have taken place in this cathedral over many centuries and throughout time this pillar must have impeded the view of both speaker and listeners alike.

The Royal College of Physicians (RCP) is fortunate to have its own modern version of a chapterhouse, the Council Chamber, designed by Denys Lasdun and built in reinforced concrete. While some architects are of the view that the introduction of this construction material marked the end of architectural history, no one can dispute that this development has removed the need for a central pillar. Visibility for all council members at the RCP is greatly enhanced when compared with the cathedral's original chapterhouse. Members can listen to any speaker in the College Council and look them straight in the eye. The wide-ranging expertise around the table is always impressive.

Regular discussion in the Council Chamber has considered the proposals for the appointment of training grade doctors to take up their posts in August 2009. This is a sequel to Modernising Medical Careers (MMC) and when this editorial sees the light of day in April 2009, the process will be well advanced. It is perhaps of value to document the current plans to fully appreciate the expertise, time and effort that has been invested to ensure a successful outcome.

Academic clinical fellowships are offered in a wide variety of specialties and deaneries for those aspiring to, or considering, a career in academic medicine. Applications were conducted via the Academy of Medical Sciences website with interviews and job offers completed in January 2009. Those unsuccessful in this round can apply to the clinical training programme.

The MMC website includes an excellent (if lengthy) *Reference guide for postgraduate specialty training in the UK*, more commonly known as *The gold guide*. The site includes details of the application process, vacancies and competition, the recruitment process, interview and offer arrangements. Deaneries or colleges are responsible for specific training opportunities with easy access to all sites. The recruitment process is clearly outlined with the eligibility criteria and choice of specialty. Job advertisements will run from January to May 2009 with clear timelines. The application is CV based with a standard shortlisting and interview process and agreed scoring mechanisms. For many specialties applications for the core medical training (CMT) programme (CT1–CT3) after completing foundation years 1 and 2 are separate from the subsequent specialty training (ST3–ST6).

The RCP is responsible for running the appointment system for CMT.[1] The website provides access to register for CMT by downloading an application form which can be completed and submitted online. Applications can be made to a maximum of four deaneries with a system for linked applications for 'medical couples'.

Many individuals have had major input in the planning of the revised scheme. On behalf of the College, Bill Burr, working with Liz Berkin and Peter Belfield, has developed the standardised national recruitment system. The 2009 system will include a pilot online knowledge test for applicants which will be evaluated over the course of the year but will not contribute to the scoring system. The recruitment project team has drawn on the expertise of a wide range of individuals to ensure an improved system.

In a recent issue of the *Clinical Medicine* (2008;8:589–91) Mary Armitage, until recently

Clinical Vice President at the RCP and now Clinical Advisor to MMC at the Department of Health (DH), emphasised the importance of collaboration between the profession and the DH. In the same issue, Margaret Turner-Warwick (2008;8:573–5) also reminded us of the importance of the patient–doctor relationship and the links between the professions and government. The omens for August 2009 look promising but continuing constructive debate within and outside the chapterhouse will still be needed.

Reference

1 Core medical training recruitment. www.rcplondon.ac.uk/education/cmt/Pages/Overview.aspx

Spasticity in adults: management of botulinum toxin

Spasticity is a distressing symptom and any improvements in treatment are welcome. The RCP has recently published evidence-based national guidelines on the management of spasticity using botulinum toxin. The guideline development group, chaired by Lynne Turner-Stokes, is to be congratulated on a guide which is a model of clarity to describe the effective and appropriate use of botulinum toxin. The full document can be purchased at **www.rcplondon.ac.uk/pubs/brochure.aspx?e=272**

ROBERT ALLAN

European Union patient safety

John Scarpello

John Scarpello
MD FRCP, Deputy Medical Director, National Patient Safety Agency

Clin Med 2009;9:101–2

In this issue, Lee McGill describes recommendations on patient safety from the European Commission, including the prevention and control of healthcare-associated infections, which it is hoped will be adopted in 2009 (pp 136–9). What might these recommendations contribute to improving patient safety and what are the implications for physicians and clinical teams?

McGill refers to the earlier technical report entitled *Improving patient safety in the EU* which states that between 8% and 12% of patients admitted to hospitals suffer from adverse events while receiving healthcare.[1] These figures are similar to reports from Australia and the USA and while many of these adverse events are recognised and dealt with before patients suffer harm, the impact of such incidents on patients and their families can be substantial: they often add to the costs of care, may increase in-hospital stay, and some result in litigation. Healthcare staff involved in serious incidents may be traumatised and develop stress-related illness. There is now widespread acceptance that healthcare providers should strive to improve quality of care and patient safety by developing better processes and system delivery. Importantly they need to contribute to risk management systems designed to record information on adverse outcomes and safety incidents.

The National Patient Safety Agency (NPSA) was established in the UK in 2001 following the publication of *An organisation with a memory* by the Chief Medical Officer.[2] The NPSA is a special health authority with a core function to collect and analyse information on patient safety incidents in England and Wales. It has developed the NHS Reporting and Learning System (RLS) which is the most comprehensive national reporting system in the world with over three million incidents on the database and around 80,000 cases reported by NHS staff each month.

Voluntary reporting systems have well-recognised limitations.[3] The NPSA has developed a novel approach in analysing these incidents in order to better inform the NHS and others of specific high-risk practices and to suggest actions to improve safety in these instances. Such alerts are published as rapid response reports and are available on the NPSA website. Unfortunately, incident reporting is variable and detects only a minority of adverse events.[4] Reporting between trusts is varied and low reporting by senior medical staff is common. Various reasons have been advanced for this including the time involved, the perception that it will make little difference or that the incident has been dealt with and thus no further action would be helpful. Clinicians often describe their frustrations that, even when detailed incidents are reported, trust management often fail to support change due to competing priorities. Some may fear that disciplinary action may be taken. In this, the European Commission's recommendations are most helpful since they emphasise the importance of blame-free reporting as the basis of a successful