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MTAS, MMC, PMETB – WHAT NEXT IN BRITISH POSTGRADUATE MEDICINE?

Sir,

I read, with interest and sadness, the Statement, published in the last issue of the *Journal*, by our Vice Presidents Peter Brunt and David Webb, on what they describe as the recent MTAS fiasco. It was not clear whether the opinions expressed were personal or whether they had the support of the President and Council. Nor indeed was it clear whether the Academy of Medical Royal Colleges shared some or all of these views.

The Statement led me to conclude that the Royal College of Physicians of Edinburgh acknowledged that, along with the other Royal Colleges, it had contributed significantly to this disaster, along with the BMA and the MMC. I take this to mean that there were sins of commission and/or omission. In due course it would be of interest to Fellows, and important to Collegiate Members, to better understand the nature of the Colleges' involvement in this sad saga.

Our Vice Presidents reminded us that, as a consequence of the serious outcomes of this fiasco, leading figures in the BMA and MMC had felt it appropriate to resign. They did not add, however, that the responsible Minister may have been sacked for her officials' contribution, nor did they explain why the Chairman of the Academy of Royal Medical Colleges (the collective College management vehicle for interactions with the Department of Health) had not resigned.

The Statement seemed to indicate that at the heart of the issue of this collegiate involvement was the weak position the Medical Royal Colleges now have with regard to influencing postgraduate medical training in the UK. This position was created in the 1990s by the then CMO, Sir Kenneth Calman who, with the support of the first two Chairmen of the Academy of Royal Medical Colleges and several influential postgraduate deans, developed a programme which sought to ensure the transfer of postgraduate training responsibility in the UK out of the reach of the Medical Colleges and Faculties and over to government, using the post graduate deaneries as its operational bases. With the establishment of the Specialist Training Authority, chaired by a former Chairman of the Academy of Medical Royal Colleges, the Colleges were lulled into believing that their pre-eminence in this field was to be retained. But it was clear to some that within a short period of time this Specialist Training Authority would be abandoned and replaced with other management systems, which ensured the effective exclusion of the Colleges. It is remarkable that over the last decade the Colleges, through the offices of the Academy, have continued to be deluded that they play a central role in postgraduate medical education in the UK.

The Vice Presidents have reminded us that the Health Editor of the *Times*, after reviewing the MTAS saga, publicly declared that the Colleges must raise their game, otherwise they stand to become marginalised. The authors of the Statement seem to agree with this view, but seem to have failed to appreciate that the Colleges have been firmly marginalised for more than a decade. The Government now holds all the cards and any return of influence to the Colleges is likely to be dependent on the outcome, among many other things, of the independent review, being undertaken by Sir John Tooke.

As the Colleges await the outcome of this independent review, they perhaps ought to reflect that, if given an opportunity to re-engage effectively in postgraduate education, their current fragile and short-term collegiate management systems may not be able to meet the challenge. Is the governance of the Academy of Medical Royal Colleges really fit for purpose? This is an institution which appears to have a wide (21 members), broadly based constituency, both geographically and by medical specialist representation. Yet, in the past, its governance was dominated by five Colleges, whose Presidents worked closely together to deliver outcomes suitable to them. It is still a mystery to many that the current Chairman of the Academy is not a serving President of a Medical Royal College/Faculty. How this came about and how the position currently has legitimacy has not been explained.

In principle, I would strongly support the proposition that the Colleges play a more proactive but advisory role with government, and thereby substantially enhance their independence and leadership role within the profession. But this approach will need to be considered with extreme care and indeed may prove not to be possible. History shows that this is likely to be vehemently opposed by the BMA, an institution which, because of its central trade union role, works/trades closely and regularly with government. This highly successful and wealthy trade union has made rich pickings over the decades when the leadership of the profession has been fragmented. Understandably, it will not readily abandon its perceived leadership role, which now extends far beyond representing doctors' financial and contractual interests. The speed and manner in which the long- serving BMA Chairman (James Johnson) was despatched by this union revealed a level of authority and ruthless efficiency that must have shocked the Academy of the Royal Medical Colleges. These comments will come as no surprise to Sandy Macara and Mac Armstrong, distinguished former leaders of the BMA. Both are aware that I have always had some difficulty in reconciling the legitimate and important trade union function of the BMA, which could see the transfer of precious new NHS financial resources into the bank accounts of doctors or diminished patients' access to doctors, with BMA committees on medical ethics and medical education etc.

College historians will also remind their Presidents that successive UK governments have not been comfortable with the Colleges exercising a measure of independent leadership within the profession. Indeed, it is possible that the last time this took place was when a former Prime Minister called the Presidents to Downing Street and advised them that if they made further statements questioning government policy their charitable status might be in jeopardy. This is an area which needs exploration. Recent developments with regard to the examination of the charitable status of independent schools suggests that the current charity regulators are now unhappy with charitable institutions that are deemed to be too close to Ministers.

Finally, in the context of this MTAS fiasco, I am sadly reminded of the last time I was aware of trainee doctors commenting on the role of the Medical Colleges with regard to professional leadership in the UK. It arose during the information-gathering stage associated with the Royal College of Physicians of London's Working Party on Doctors in Society: 'Medical professionalism in a changing world'. This working party was chaired by Baroness Cumberlidge and included in its membership was Dame Carol Black (currently Chairman of the Academy of Medical Royal Colleges) and Mr James Johnson (BMA Chairman of Council who recently resigned over the MTAS affair). Out of all the comments received from trainee doctors, Baroness Cumberlidge and her team selected the following to be included in the published report in 2005:

> 'I feel that our profession has been sold up the road by our superiors over the years for a few pieces of silver, for their own selfish interests. That has eventually placed us, both present and future doctors, in very difficult positions, undermined our morale, confidence and standing in society. We lack leadership and foresight in our present day peers and seniors.'

I cannot begin to imagine why Baroness Cumberlidge felt that, of all the comments she had received, this one should be embodied in this report. I am, however, aware that during the period I was President of the College I became deeply concerned at the power and increasing influence of government patronage on the affairs of the Colleges. This concern was publicly shared with Fellows and Collegiate Members in my valedictory message to them.

Our Vice Presidents are to be warmly commended for proposing radical reform in the relationship between the Colleges and Government. This is now desperately needed. But delivering will be difficult and maybe impossible. Those historians who have witnessed the power of patronage are likely to be somewhat pessimistic that reform is now possible without a move to an all-elected second chamber and with it much more critical and vigorous search for government patronage by the Honours Committee. Without this assurance, I fear that history tells us that the practice of governments rewarding senior College Office Bearers (whether it be elevation to the House of Lords, knighthoods and other honours or chairing a government committee or enterprise after retirement) may prove too attractive for genuine reform. The fact that in the past certain Colleges have been repeatedly targeted by government for these 'gifts' adds a further dimension to the difficulties that will be faced by the Academy of Royal Medical Colleges.

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MODERNISING MEDICAL CAREERS: NATIONAL FORUM FOR SMALL-SCALE LOCAL AUDIT

Sir,

The PMETB has outlined the need for local quality control of all postgraduate posts and programmes. In response to this, we have initiated a rolling audit of education at King's Mill Hospital, Nottinghamshire which records trainee opinions regarding educational provision, inpatient/outpatient duties and on-call responsibilities.

Our 2006 audit demonstrated sub-optimal attendance at programmed teaching, with only 10% of doctors able to attend all sessions timetabled. More worryingly, 55% of doctors recorded that they maintained responsibility for patients whilst at teaching and 73% felt that clinical care had been compromised at some time by their attendance. Only 40% of SHOs had outpatient commitments whilst 80% wished to have some outpatient role. Forty per cent of SHOs had no involvement in structured teaching of undergraduates despite a stated desire to participate.

In response to these findings, we have made changes to junior doctor cover during timetabled teaching and have formalised a bleep-free system. We are working to make more outpatient slots available to trainee doctors and to formalise SHO involvement in undergraduate teaching.

We believe that similar small projects around the UK are at the heart of quality improvement, particularly given the emphasis on formal teaching under Modernising Medical Careers. Pockets of enthusiastic teachers exist in geographically discreet units but no formal mechanism exists at present for the exchange of ideas. Peer-reviewed publications do not routinely publish small-scale local audit, nor is it appropriate that they should. We believe the time has come therefore, for a national forum, driven by the NHS and PMETB,

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where individual units can share their experience and expertise to the benefit of all.

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Editor: A national forum for sharing educational practice could with advantage also be driven by the Royal Colleges.

NON-INVASIVE VENTILATION IN ACUTE EXACERBATIONS OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Sir,

Telfer *et al.* have comprehensively summarised in your recent issue of *the Journal* the substantial evidence for, and practical issues involved in, using non-invasive ventilation (NIV) for acute exacerbations of chronic obstructive pulmonary disease (COPD) with respiratory acidaemia.[1] There is no doubt that NIV can make a significant difference to survival from acute ventilatory failure with acidaemia in COPD. However, there are some other pertinent issues, not covered in detail in their paper, worth highlighting for general physicians.

Firstly, while there is now a significant evidence base for the benefits of NIV in acute hypercapnic respiratory failure secondary to COPD,[2] there is sometimes an observed tendency to neglect the other aspects of optimal 'standard' medical treatment, i.e. frequent nebulised bronchodilators, systemic steroid, controlled oxygen therapy via a Venturi system, with antibiotics, systemic aminophylline, diuretics, deep venous thrombosis prophylaxis, and antiarrhythmics as necessary. Specific failures in optimal medical treatment (before even considering NIV) have been well described.[3] In addition, the pivotal trials using NIV contained optimal medical treatment in the control arm.[2]

Secondly, there is not enough attention to methods of oxygen delivery. There is a tendency to administer oxygen therapy via nasal cannulae for prolonged periods off NIV. Nasal cannulae deliver low flow rates and uncontrolled oxygen therapy (due to changes in minute ventilation) leading to the dangers of acidaemia.[4] A high flow delivery system such as a Venturi mask minimises these risks by providing the total ventilatory requirement. In addition, over oxygenation prior to arrival in hospital is known to correlate well with the degree of acidaemia and, in over 20% of cases, the acidaemia can be completely corrected by altering the oxygenation even before NIV is considered. This applies uniformly to pHs from 7·25–7·35.[5]

Thirdly, NIV is often applied to patients with pneumonia and hypercapnic respiratory failure, but its effects here can be entirely unpredictable (potentially worsening VQ mismatch by removing hypoxic pulmonary vasoconstriction in consolidated areas of lung for example) and this should only be done in a high dependency or intensive care unit, and not in a respiratory ward.[6,7]

Finally, there will still be a significant minority of COPD patients in whom NIV is unsuccessful or contraindicated where invasive mechanical ventilation is not appropriate. In such patients, there is still a role for a trial of doxapram in the context of acute ventilatory failure, being vigilant for signs of adverse effects related to the drug. A short but timely intervention with doxapram (earlier rather than later) can be effective in getting over the acidaemia in the right setting. A Cochrane systematic review does confirm doxapram may have at least some short-term benefits on acid base status.[8]

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