J R Coll Physicians Edinb 2008; **38**:92–4

SELECTING THE DOCTORS OF THE FUTURE

Sir,

'Excellence delivered' (Boon N, Palmer K. Excellence delivered. *J R Coll Physicians Edinb* 2007; **37**:289–90) may be a fair description of the Tooke report, but it is an extremely over-optimistic description of what that report might achieve even if all of its recommendations are implemented.

It is too simplistic to write off the MMC/MTAS fiasco as harmful tinkering that broke a perfectly acceptable mechanism of training doctors. It was a well-intentioned but misguided and dreadfully executed attempt to address major problems, which have not and will not go away.

The first problem is that for many years (and especially in England) the shortage of home-grown doctors has given them phenomenal job security. The broad base of the hospital doctor hierarchy was conveniently filled with foreign graduates who were jettisoned when no longer needed. The Medical Training Application Service, by attempting to be fair and obscuring the origin of applicants, in effect nullified the one objective distinguishing feature between UK and other graduates. Anyone previously involved in shortlisting at junior doctor level, with 10 or 20 or more applicants per post, must have been aware of this.

The second problem is deciding who are the best future doctors, especially in the first few years of training. The vast majority have very similar objective achievements (a medical degree). It is arguable to what extent BScs and publications are good discriminators of clinical excellence. The best test is seeing someone going about their day-to-day work, and most of us would consider reliable recommendation from a trusted work colleague to be at least as good as anything else in selecting junior doctors. This system is, of course, wide open to abuse, hence the attempts to move away from it.

The third problem is deciding what we want from our doctors of the future. Boon and Palmer are unimpressed by competence and aspire, like Tooke, to excellence, but these are meaningless words. As I go about my daily rounds I would often settle for simple competence in most of the doctors I deal with. Arguably what many doctors lack is not flair but the ability to repeatedly do simple things well. But in any case, whether or not good enough is good enough just depends on how you define good. We need all different types of doctor in career grade posts, and the trick will be matching the right doctors to the right posts. Even in the highly competitive future, not all the survivors will be excellent, but it would be good to ensure they were all competent.

So we have tough choices ahead – do we embrace an open and highly competitive system because we believe it selects the best doctors and is fair to everyone, irrespective of origin, which means no medical future for significant numbers of expensively trained UK graduates? Do we give significant weight to personal recommendation in choosing doctors, because there is no more reliable way of assessing their merits, which means opening the door to nepotism, racism and other unacceptable favouritisms? And can we face up to the reality that a lot of medical work demands the competent delivery of repetitive, relatively undemanding tasks, perhaps ill-suited to some of our most 'excellent' colleagues?

J Main
Consultant Nephrologist, James Cook University Hospital, Middlesbrough

Authors' response

Dr Main writes cogently and frankly. We agree with many of the points he makes and hope the following comments will clarify our views.

We do not suggest that the MMC/MTAS fiasco has been 'harmless tinkering'. Indeed, we agree with Tooke that MMC needs fundamental revision. The Medical Training Application Service has effectively been shelved. We attempted in our leader to develop the theme that proper selection should be based upon identification of achievement and 'excellence', and that we need, for the health of the nation, to find and grow the best doctors.

Dr Main identifies workforce as a crucial issue. Modernising Medical Careers largely developed as a response to the problem of 'the lost tribe' of senior house officers who delivered much 'service', received inadequate training and had limited prospects of career progression. Some of these unfortunates were 'the foreign graduates destined to be jettisoned when no longer needed'. Such attitudes are clearly not acceptable, either as a way of treating doctors or of providing a good service to patients. Equally, the implication within Dr Main's letter, that shortlisting for higher posts was based upon nationality and race rather than upon achievement, is unacceptable. Modernising Medical Careers and MTAS sought to rectify these issues; Tooke aspires to develop this further and we support him.

Identification of the best doctors is indeed difficult, particularly since we are a diverse profession. We need the empathetic psychiatrist, the dextrous surgeon and the assiduous pathologist (to identify but a few), and the attributes required for these different specialties vary. To base career progression upon 'seeing someone going about their day-to-day work' is perhaps not the best way of selecting junior doctors. It is certainly open to prejudice and runs the risk of selecting clones of people you like, while failing to identify the requisite diverse group of individuals who can meet all the NHS needs. The Royal Colleges have actively sought ways of improving selection processes: knowledge through formal examinations; skills

by directly observed procedural skills (DOPS) and mini clinical evaluation exercises (mini-CEX); attitudes through multi-source feedback (MSF). These, coupled with objective evidence of achievement (including, in our opinion, undergraduate prizes, the honours degree, an intercalated BSc, research and audit endeavour), regular appraisal and assessment and (to a much lesser degree) the written reference, are surely the future.

Dr Main's final comments relate to 'what we want from our doctors of the future'. The shape, in addition to the volume, of the medical workforce is changing rapidly: new roles for nurses; innovative minimally invasive, hybrid interventions; and expanding community services are all examples. Tomorrow's doctors will inevitably have to adapt to changing healthcare requirements; they will obviously need to be competent (and 'able to do simple things well'), but we surely must expect something more. We have to identify individuals who have leadership ability, not only to lead our research and our professional groups at national and regional levels, but at the coalface, too.

Current and future doctors, be they general practitioners, consultants or staff grades, have to supervise, teach and inspire those other health workers who will deliver aspects of care that do not require a medical degree. More effective ways of identifying the attributes necessary to become a doctor are being developed (DOPS, MSF, mini-CEX and knowledge-based assessment as we discuss above). These will identify 'excellence', and their acquisition will equip the next generation for new roles. If the standard of practice in all branches of UK medicine is to be sustained and improved, and if we are to recruit the best undergraduates into medicine, we surely do not want to develop a group of plodders who can 'do simple repetitive tasks well'.

[1]N Boom, [2]K Palmer
[1]*President of the British Cardiovascular Society*
[2]*President-elect of the British Society of Gastroenterologists*

WRONG MESSAGE TO ASPIRING DOCTORS

Sir,

The perception that doctors who do not find consultant posts become disillusioned as a result of undertaking limited, repetitive and unstimulating tasks (Boon N, Palmer K. Excellence delivered. *J R Coll Physicians Edinb* 2007; **37:**289–90) conveys the wrong message to those who aspire to follow a medical career. Surely the unwritten contract that an applicant to medical school makes with the public, at whose expense he will receive his medical education, is that he or she will give something back, regardless of whether or not he achieves consultant status. And there is a lot to give back, given the huge state expenditure on medical education which can only be partially met by tuition fees, and the huge financial rewards that come after achieving a medical qualification. In return, the least that the public expects is that even those who have failed to achieve consultant status should deal with them with compassion and professionalism.

Accordingly, even in the sub-consultant context, my belief is that the doctor–patient relationship does not deserve to be labelled as 'limited, repetitive and unstimulating' because, by so doing, we not only devalue it but, even worse, we rob it of its entire content of compassion and professionalism.

I would be the first to admit that not all can obtain 'glittering prizes' and that consultant status in a prestigious specialty is not necessarily the only prize on offer. In fact, judging by how idealistic I was when I entered medical school, aspiring only to achieve that warm glow that emanates from the unique interaction that constitutes the doctor–patient relationship, I find it difficult to believe that almost everything that has happened in my subsequent medical career has amounted to an attempt to subvert that ideal in favour of the principle that the only kind of excellence that matters is to achieve as high a position as possible in the career pecking order.

OMP Jolobe
Retired geriatrician, Manchester

Authors' response

We do not wish to give the impression that fulfilment in a medical career can only be achieved as a consultant and that general practitioners or doctors in non-consultant hospital roles are destined to be disillusioned as a result of them 'undertaking limited, repetitive and unstimulating tasks'. As we have stated in our reply to Dr Main, we need to train a full range of senior doctors – in mainstream hospital medicine, laboratory services and general practice, to name a few. These specialists will derive professional and intellectual satisfaction in different ways: a holistic long-term patient–doctor relationship in general practice, an MRC grant award for an academic and an accurate, illuminating report from a pathologist are obvious examples. By definition most young doctors do not obtain 'glittering prizes', but we argue that we need to court excellence in all trainees. We owe this to patients who deserve the best possible healthcare, to the medical teams with whom we interact and frequently lead and to ourselves, since striving for excellence improves personal satisfaction.

In our view excellence should not be equated with 'top of the class'. It is not a competition that pits trainee against trainee, but is defined in terms of achievement of specific goals; goals that are more stretching than those required to become competent. All trainees must demonstrate all-round competence, but each should strive for excellence in aspects of their performance. This could be excellent technical skills for a surgeon, communication skills and

empathy for a psychiatrist or laboratory skills for an academic. The challenges are defining excellence within each specialty (including general practice) and then objectively showing that excellence has been achieved. The Royal Colleges, together with specialist societies, are moving towards this by refining both curricula and tools for appraisal and assessment. The 'e-portfolio' will include these objective aspects as well as other evidence of accomplishment, including success in postgraduate examinations, BSc, PhD, publications, etc. The portfolio for the budding general practitioner will clearly be very different to that of the aspiring hospital-based paediatrician and the criteria for excellence will be tailored to the needs of each specialty.

We do not believe that doctors should be doing 'limited, repetitive and unstimulating tasks'. The shape of the workforce is changing as many routine tasks are (rightly) undertaken by nurses and other professionals allied to medicine. The modern doctor has assumed an extended role, personally delivering medical care and increasingly supervising other health workers to produce a health service that is appropriate for the twenty-first century. Surely success in this will achieve another 'warm glow' that comes from aspiring to excellence.

[1]N Boom, [2]K Palmer
[1]*President of the British Cardiovascular Society*
[2]*President-elect of the British Society of Gastroenterologists*

BENJAMIN FRANKLIN IN BRITAIN

Sir,

Readers who, like me, were interested in Huth's paper, 'Benjamin Franklin's place in the history of medicine' (*J R Coll Physicians Edinb* 2007; **37**:373–8), might care to visit Franklin House in London (36 Craven Street), where he stayed for close on 16 years as a paying guest of Mrs Margaret Stevenson and her daughter Mary ('Polly').[1]

It was there that he met Dr William Hewson (1739–74), often spoken of as 'the father of haematology', courted Polly and later built an anatomy lecture theatre at the rear of the house.[2] It was there that he learnt from Hewson and Dr William Hunter of the acrimonious correspondence between them and Professor Alexander Monro secundus, who so vigorously attacked them as a means of defending his research and reputation. Franklin's skilled mediation was successful and much appreciated by Hunter and Hewson.[3–5]

Though Franklin was not always respected by his juniors and colleagues,[6] he was a much-loved friend of Hewson, who died prematurely of septicaemia contracted at a post mortem, and of his widow and children whom he invited to stay with him in Paris and later in the fledgling US. Hewson's son, Thomas, born only months before his father's death, was much influenced by Franklin when his family lived in Philadelphia. He went on to study medicine there and subsequently in Edinburgh before having a distinguished career as a teacher of anatomy and medicine in a medical school of his own founding.[2]

D Doyle
Retired consultant in palliative medicine, Edinburgh

References

1 Benjamin Franklin House, http://www.thersa.org/franklin
2 Doyle D. William Hewson (1739–74): The father of haematology. *Br J Haematol,* 2006; **133**:375–81.
3 Monro A secundus. Observations, anatomical and physiological. Wherein Dr Hunter's claim to some discoveries examined. In: Gulliver G, editor. *The works of William Hunter FRS*. London: Sydenham Society; 1846; p.120.
4 Monro A secundus. A state of facts concerning the first proposal of performing the paracentesis of the thorax and the discovery of the lymphatic valvular absorbent system of oviparous animals: in answer to Mr Hewson. In: Gulliver G, editor. *The works of William Hunter FRS*. London: Sydenham Society; 1846; pp.92,291.
5 Hunter W. *Medical commentaries part 1, containing a plain and direct answer to Professor Monro jnr. interspersed with remarks on the structure, function and diseases of several parts of the body.* London: A Hamilton; 1762.
6 Withey, L. *Dearest Friend: A Life of Abigail Adams*. New York: Simon and Schuster; 2001.

KARDEX IS A BRAND NAME

Sir,

Although I support most of the views in Maxwell and Wilkinson's paper (*J R Coll Physicians Edinb* 2007, **37**:348–51), I have to take issue with the condemnation of brand names. Kardex (www.kardex.com) is the brand name of an office product manufacturer based on Ohio, US. The authors have included Kardex in the title of their paper and it appears a further seven times in the text without acknowledgement. Surely it would have been better to use 'drug chart' or 'prescription chart', particularly as none of the examples illustrated appear to be in Kardex format.

AJ France
Consultant Physician, Infection and Immunodeficiency Service, NHS Tayside

Author's response

My views are that the term Kardex is well and truly generic and is peppered all over the medical literature with regard to the document used in hospitals for prescribing. The Kardex company make filing systems, but I don't think I have ever seen one of their prescribing tools. In retrospect, this criticism could have been avoided by using the term 'drug chart', although that is not always synonymous with what we were describing as the 'kardex'.

S Maxwell
Senior lecturer in clinical pharmacology, University of Edinburgh