that all over the world children go to school in yellow buses, and can understand no currency other than the dollar, has its own ways which are as strange to us as we are to them. Doctor Denton Cooley (acclaimed by his followers as America's greatest surgeon) told his residents, you had better call him Mister Treasure, with just possibly a reference to Sidney Poitier's 'In the Heat of the Night' character who insisted on being addressed as Mr Tibbs, not just Virgil. In the USA the Doctor status was lost a long time ago. All dentists, osteopaths, podiatrists and veterinary surgeons are called Doctor and many other therapists besides. The title Doctor is largely devalued. To identify a doctor the public need to look for MD, often on car registration plates. Americans use the word physician to embrace all those we call doctors whereas in Britain it has a much narrower meaning: we broadly divide hospital doctors into two camps, the physicians and the surgeons. In the USA the title Professor is completely devalued and not used other than with sarcastic intent. There are so many tiers of assistant and associate professors, that when you have to specify 'full' professor, there is no point. On the other hand in Britain professors in hospitals are rare. For the happy few who have the title, it is so nice to be called 'Prof', a pleasing form of address, respectful yet cosily avuncular.

So what is a consultant? It still has a special cachet in British medicine or why would nurses want to be consultants? But in common usage it is meaningless. The travel agent and electricity board's automatic switchboard tells us 'all our consultants are busy' and architects, accountants, engineers, heating engineers and so on, all do a little consultant work in retirement. What does it mean? Nothing.

What is a specialist? A generation ago it was a term of respect as used by a GP but in the hospital where the general surgeon and general physician controlled the beds and in turn the hospital, generalists trumped specialists.

Words change their meaning. Euphemisms have to be replaced by new euphemisms. Spastic and cretin were medical words but in the mouths of school boys became terms of abuse so were replaced by cerebral palsy and congenital hypothyroidism, more difficult to mouth and not suited to invective. Status words are adopted by those who seek status. The expansion of Surgeon's Assistant is one such. While Lynne Truss was not looking, the apostrophe was dropped⁴ and Surgeon Assistant emerged. Take Nurse Consultant and drop the redundant word to make it manageable (you choose which one) and you can be anything you want to be. No wonder the surgeons (male at least) are happy to be Mister without needing to be reminded that once it meant Master. Female surgeons would prefer to be called Doctor than fail to be recognized as medically qualified. It really does not matter. Being a

surgeon is doing what a surgeon does. How we are titled is of little consequence.

Tom Treasure

Carol Tan

Guy's Hospital, London SE1 9RT, UK

E-mail: Tom.Treasure@ukgateway.net

REFERENCES

- 1 Loudon I. Why are (male) surgeons still addressed as Mr? *BMJ* 2000; **321**:1589-91
- 2 Ibery N. Do surgeons wish to become doctors? *J R Soc Med* 2005;**99**:in press
- 3 Le Fanu J. *The Rise and Fall of Modern Medicine*. London: Little Brown, 1999
- 4 Truss L. *Eats, Shoots & Leaves*. London: Profile, 2003

Modernizing medical careers: a response from the Academy of Medical Royal Colleges

Jonathan Osborne, in his open letter to Royal College Presidents¹ makes many important points. However, he misses some of the fundamental reasons about the need for change in medical training. He denigrates the Royal Colleges for bowing to Government pressure and calls on us to halt the reforms.

It is important to recognize that medicine has changed and that methods of training which were appropriate 25 years ago are less so now. It is true that the consultant of the past was held responsible for a great deal more; but usually as a generalist with fewer highly specialist skills, than those in today's post Calman era. But they had to be. They were often appointed to either a single-handed or at best two-person practice and would be expected to not only be clinically competent to deal with a wide variety of conditions but also to undertake teaching, research and management. The practice of medicine has now changed from a situation where a single consultant was head of a large team of juniors to a much flatter structure with many more consultant members of a team. Between them this team is expected to provide the comprehensive range of abilities and skills previously provided by one or two people.

Tomorrow's Doctors,² the booklet produced by the GMC in the early 1990s was one of the starting points for the recognition that medicine has now become so vast that no

single person can be expected to know everything that an individual patient might need. They recommended that undergraduates should be taught the principles of medicine and to recognize when they are beyond the limits of their own knowledge. Today's medical students are different from the past. They have a common set of core knowledge but are much more inquisitive, knowing when and how to seek additional knowledge and help. They expect to work in mutually supportive teams, to be life-long learners and to undertake regular critical appraisal of their own performance and that of their colleagues. This 'new breed' of medical student is now feeding through into specialty training and will soon be forming the consultant workforce.

At a specialist level things, too, have changed. Acute medicine has become much more complex and, at the same time, much of our practice has become high volume and relatively routine. This clearly oversimplifies the situation but is the background to thinking around reforms of specialty training. In the past we may have over-trained doctors with skills they would never use, training them as totipotential specialists who, in reality, used only selected areas of their competence. Today, in our pressurized NHS, we need doctors who are 'fit for purpose' to undertake the tasks which patients need. It is, of course, important that we identify the broad areas of competence which are essential for safe practice in a more specialist area. The reform of surgical urology training is perhaps the clearest example of this. In the past, all urologists were trained to a high level of competency and could carry out the majority of urological operations. Yet the majority of today's urology practice is either 'medical' urology or operating on the prostate and bladder. More extensive operations on the bladder and kidney are rarely needed. So the training plans are now in two parts, with all trainees becoming competent at the first level and only a few going on to be competent in the more complex surgery. Similar thoughts are being applied across other specialties.

The increasing integration of other professional groups into the team caring for patients is also of relevance in thinking about the future

We must, of course, also recognize that the public, our patients, are changing too. Their illnesses may be largely the same but their knowledge and expectations are much different. Far from being passive bystanders and recipients of what we deliver to them, they are an integral part of most decision-making processes in medicine. All Colleges now have patients and carers representation and the paediatricians are even developing processes to consult with children. Medicine today is truly a patient/professional partnership.

Far from being led by Government the Royal Colleges are taking a leading role in these inevitable reforms to defend educational principles that we believe to be

paramount to the future of medicine. We do not necessarily agree with all of the pressures put upon us, but we have tried to work constructively. The Postgraduate Medical Education and Training Board was set up by Act of Parliament to better regulate and quality assure training.³ It is an independent body approved by, but not under the control of, the Secretary of State and answerable to Parliament. The Academy of Medical Royal Colleges fought hard to have a medical majority on this Board and to ensure that the Royal Colleges had the right to nominate six members. Although the Postgraduate Medical Education and Training Board has had teething problems it is the Royal Colleges who have been able to provide the professional input which is beginning to better ensure the quality assurance of postgraduate medical education.

The Colleges have played a major role in writing the curriculum for the Foundation programmes; even Osborne agrees that this part of reform will be an important vehicle to turn our new-style medical students into competent doctors ready for specialist training. Having started on these training reforms we cannot stop. It might be comfortable to wait a few years whilst the Foundation programme embeds, but the fundamental reasons for reform mean that we must proceed as quickly and as safely as possible. Our trainees rightly expect it. The Foundation programme started in August 2005⁴ and the new specialty programmes have to start for these Foundation graduates by August 2007. There is little time left, and the Colleges and the Postgraduate Deans are working closely with the Modernizing Medical Careers team to ensure that the Foundation trainees are not disappointed. However we do recognize the need to manage the transition well.

One of the major concerns, which drove the recent reforms, was the 'lost tribe' of senior house officers. This has been compounded by trust doctors and other unofficial grades appointed to cope with the European Working Time Directive. There may be up to 25 000 young doctors currently in this grade, and we have a responsibility to develop training programmes which recognize their achievements and that those capable of progressing are given every opportunity to do so.

Osborne is right—entry into training will become even more competitive. Not only do we have a major increase in output from UK medical schools but we also have free movement across all of the 25 EU states. Doctors from all of these countries have the right to apply for specialty training programmes. International medical graduates also have the right to apply in open competition along with everyone else, although there are suggestions that permit-free training may be coming to an end and visa controls may be brought in.

The Postgraduate Medical Education and Training Board legislation allowed for doctors to have experience as well as

training and qualifications taken into account when evaluating suitability for entry on to the specialist register. The Colleges have been working with the Postgraduate Medical Education and Training Board to produce explicit criteria for Article 14. The standard to be achieved is that of the current certificate of completion of training (CCT) or a consultant in the NHS. Adequate knowledge will have to be demonstrated and, whilst examinations are the clearest way to show this, it is open to applicants to find other ways to show they have it.

Osborne rightly points out that the number of hours of 'training' has plummeted from about 30 000 hours to much less, perhaps even 50%. Operative time for trainees has been dramatically reduced. We must, therefore, make better use of training time and every patient contact and trainee/trainer contact must be an educational opportunity. This means that trainer time must be explicit and valued. Some Colleges have made an hour of educational supervision with their consultants each week an absolute condition for approval of training placement; and it is expected that such explicit standards will be reinforced by the Postgraduate Medical Education and Training Board. The current commissioning reforms in the NHS threaten to destabilize training. The Colleges have been pressing the Secretary of State and the Department of Health to take training seriously. This message has been received and we expect announcements soon about how the implicit costs of training in the new NHS, including Foundation Trusts in England, can be secured. We have stressed the need for 'Training today for Excellence Tomorrow'.

It might seem from this reply that the Medical Royal Colleges are being complicit in a Government policy to deliberately remove their centuries old responsibilities for setting and maintaining standards of both training and specialist practice. Nothing could be further from the truth. Change is inevitable but we firmly believe that the Colleges

should remain the guardians of educational standards and that we must adapt our training to a modern world and a virtual monopoly provider of care.

The Calman reforms were phased in by specialty over a number of years. Modernizing Medical Careers must all start at the same time. It is going to take a huge and committed effort by all to ensure that by 2011 we begin to see our new breed of 'fit for purpose' specialists emerging from our training programmes. The exit standard is not being dumbed down—it is that of the existing certificate of completion of specialist training/CCT. The new specialist will be less experienced than in the past but will be able to cope with the majority of patients who present to them and will know when and how to ask for help—usually from their own team. There are, of course, special issues around remote and rural practice and these are being addressed.

The Royal Colleges were established in the 16th century with a remit to improve standards of care in order to protect the public. Their prime role on behalf of the public has not changed, but their methods of working must adapt to changes in medicine and the expectations of society. We cannot go back to the 'good old days'.

Alan Craft

Chairman, Academy of Medical Royal Colleges; President, Royal College of Paediatrics & Child Health
E-mail: A.W.Craft@newcastle.ac.uk

REFERENCES

- 1 Osbourne J. Modernizing medical careers: an open letter to Royal College presidents. *J R Soc Med* 2006;**99**:56–7
- 2 General Medical Council. *Tomorrow's Doctors*. London: GMC, 1993
- 3 Postgraduate Medical Education and Training Board [<http://www.pmetb.org.uk/>] Accessed 6 March 2006
- 4 General Medical Council. *Foundation Training*. London: GMC, 2005 [<http://www.gmc-uk.org/education/foundation/index.asp>] Accessed 6 March 2006