



THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

Terry Hanafin
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Modernising Medical Careers
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Dear Mr Hanafin,

GAT response to the MMC consultation document

The Group of Anaesthetists in Training (GAT) is the sole professional representative body for trainee anaesthetists in the UK. GAT is an important constituent part of the Association of Anaesthetists of Great Britain & Ireland. With more than 3000 members, GAT represents >90% of trainee anaesthetists in the UK. Trainee anaesthetists form the single biggest group of hospital specialty trainees within the NHS.

GAT is on record as having been opposed to the rapid introduction of MTAS, and was far from surprised by the turmoil that ensued in the summer of this year. However, now is not the time to apportion blame; it is time to learn from the mistakes made by the administrators of MMC and MTAS, and to move forward. The careers of the consultants who form the future of the NHS are still very much at stake. It is time to repair some of the damage and to put an effective interim solution in place until the results of the Tooke Inquiry are published and accepted.

GAT's response is presented in a similar fashion to the original document, arranged in two sections.

PART ONE

Short listing: we support the proposed local short listing process for 2008.

National or local application: we support the local application process for 2008 - it is tried and tested, and is known to work. After piloting, a central application process may be suitable in the future.

Number of applicants: we support Option 4 for 2008, as this would appear to be a good interim compromise and will place as many doctors as possible in their chosen region or specialty within the NHS.

Computer system: we are not alone in having no confidence whatsoever in a national computer-based system. This should not be used as an interim measure for 2008. Local processes should be allowed to function as in the past until a robust and reliable system is devised for the future.

Units of application: we support the BMA view that "UOA" should be meaningful to junior doctors in an attempt to limit the disruption to both working and social life that is associated with lengthy travel times.

National timetable: we support an integrated national timetable so as to minimise confusion about application, short listing, notification and interview dates.

Other issues: we support the BMA's view that entry criteria into ST1 should include a limit of 12 months' experience, and that the limit should be removed for application to other ST years.

PART TWO

Timing of the application process: having asked for this originally, we support staggered start dates for trainees in anaesthesia. As a specialty we are ready to move forward with such proposals, both for the 2008 selection processes and into the future beyond the Tooke Inquiry.

Transferable skills: anaesthetic trainees have skills, attitudes and knowledge that would be of benefit to other specialties. However, the degree of skill transferability is not universal between all specialties. Safe anaesthesia depends upon a combination of detailed factual knowledge and complex practical skills. As a result, it is not standard practice to allow a trainee anaesthetist to give an anaesthetic without immediate supervision until a year of training has been successfully completed and competencies have been assessed. This is not true for most other specialties. Thus, it is relatively easy for anaesthetic skills to be effective when "transferred out", but there is no specialty whose acquired skills comprise the majority of those necessary for the safe practice of anaesthesia.

FTSTA positions: these may be useful as a way to gain additional experience or to act as a pathway to non-consultant grades if a CCT and consultancy are not a trainee's aims. For the near future, they will also act as a "holding position" that will allow many trainee doctors to stay in work while the problems associated with MMC and MTAS are resolved. This grade should eventually be a small one.

Uncoupling: we believe that a rigid training structure for all doctors in all specialties is both unrealistic and unworkable. Each specialty should be allowed to devise a training structure suited to itself and its trainees after appropriate consultation. Trainee groups such as GAT must be included in the planning and implementation processes. Competitive entry has always been a core part of medical training in the NHS; we see no reason to change this. Offer Model 2 is probably the preferable structure for the future. However, the competitive application process for core training in anaesthesia in 2008 should persist, with the possibility of further competitive entry into the ST3 grade upon completion of the initial two years. Additional ST2 and ST3 posts may be necessary to accommodate trainees who are already in the system.

Conclusions

The failures of the combination of MMC and MTAS were not those of vision or commitment. These failures resulted from haste compounded by a lack of consultation and piloting. The MMC consultation document sets out cogent options for an interim solution for the NHS. However, GAT strongly believes that an effective and fair selection process for the future can only be based upon open consultation with all involved groups – notably trainees and their representative bodies – and the careful piloting of potential solutions before extension and national implementation. GAT also thinks that training arrangements should be constructed so as to allow the easy transfer of trainees between the different countries of the UK.

We remain keen to be involved in the development of these processes.

Yours sincerely,

Dr Paul Johnston
Vice Chair, GAT