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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Manpower and training

SIR,—I am training in surgery and therefore have a vested interest in the way the subject is taught. The needs of training demand increased numbers of consultants and restriction of junior "training" posts. If the career structure of hospital doctors is to be rationalised (12 July, p 147) then the opportunity should be taken to improve training for doctors in general and surgeons in particular.

In the UK specialisation starts after an initial period of general medicine, providing time to acquire a grasp of basic topics. Once surgical training is started general surgical examinations are taken early in training, allowing further specialisation later on. The UK examinations are acknowledged world wide to be of a high standard. However, they do not assess technical skill, and this is not measured by any other form of trainee evaluation. Each surgeon, both before and after fellowship, helps to manage many hundreds of patients, so that breadth of experience is guaranteed and the basis for sound clinical judgment acquired. When a surgeon finally becomes a consultant he or she is more than ready to take on the responsibilities.

Recently I have observed my counterparts in North America and discussed training with surgeons from the USA, Canada, and Australia. Their training schemes could suggest improvements useful in this country.

In Britain it is fashionable to consider American training too brief to be thorough and lacking in opportunities for taking personal initiative, resulting in a surgeon with limited technical skills and poorly developed clinical judgment. Although there may be some truth in the latter, so justifying the degree of supervision given to a new consultant by the departmental chief, the lack of technical skill can scarcely be true in a country where the risk of litigation is never far from a practising doctor's mind and where clinical audit and continuing peer review are more accepted than here. How, in five short years, are practical surgical skills acquired, when in Britain a general surgeon is lucky to be appointed to a consultant post within 12 years of qualifying in medicine?

Once accepted on to a programme in the US, and through an initial probationary period, a trainee can expect to complete his apprenticeship. He can therefore concentrate. He will work with a few surgeons at one or a few neighbouring hospitals. Thus the technical variation he sees will be restricted, though this is not necessarily a problem if training institutions are carefully monitored and accredited. He will live in one area and not waste energy seeking his next post and moving house. The surgical teams he works with will be largely predetermined, but then the theoretically advantageous flexibility of UK training posts is often enjoyed only by a minority because of intense competition for the better jobs.

The US trainee's hours of work will be long, and, in addition to doing the clinical work, he will be expected to spend time in the library so that he can support his views on diagnosis and management with a thorough background from the current literature. He will be under constant supervision in the operating room: the surgeon responsible may well scrub for every case, and must at least be present in the hospital at the time of surgery, albeit an appendicectomy at 4 am. This last is the difference that has provoked most criticism, the trainee being described as merely "cutting on the dotted line." Perhaps it is better to be shown the dotted line than to find it by a prolonged process of trial and error. Close supervision from the very beginning of a training programme has real advantages. From the outset instruments are held properly, sutures placed accurately, knots tied correctly, and dissection performed accurately and economically. With such attention to detail technical skills are learnt in an orderly and efficient manner, so that by the end of a given year of the programme a certain breadth of skill should have been achieved.

The haphazard system we use compares most unfavourably and is partly a result of an excessive clinical workload necessitating relegation of training to a lower priority than elsewhere. Work tends to be unsupervised and bad technical habits adopted early prove difficult or impossible to eradicate later. Because he is expected to "get on with it," a junior surgeon may feel it to be a sign of inadequacy to ask for help or advice in a difficult situation; similarly, he is not encouraged to discuss minor points of detail. Some surgeons will take their juniors through an unfamiliar procedure, some willingly, some with discouraging irritation. Others rarely teach surgical skills directly and see their junior's work only when there is a serious problem. Since even the simplest operations are capable of considerable variation, it is perhaps time to lay aside the "see one, do one, teach one" philosophy.

When a junior surgeon moves from hospital to hospital his new consultant will often have only the vaguest idea of his capabilities. He then has a period either of frustration at being unable to use his skills or of stress through being left with situations he does not have the experience to handle properly. Neither is conducive to efficient learning.

And what of the patient? Surgeons at every level in Britain strive to provide a good service for their patients. But more supervision during training would undoubtedly result in better surgery, both during training and afterwards.

Finally, what of the role of research? A period of research is now a mandatory part of surgical training in the UK, even for those destined for a busy service post in a district general hospital. In North America and Australia it is not seen to be so necessary, although a good grasp of published reports is expected, and the ability to interpret other people's research papers is certainly enhanced by time devoted to academic work. The UK requirement for research derives partly from the intense competition from large numbers of juniors for a shrinking pool of senior posts. Academic work looks good on a curriculum vitae and a productive period in a surgical unit laboratory is obviously better than the same time spent in a series of short lived locum posts. Publications also provide the only currently available method of objective comparison of trainees in this country. Nevertheless, the true value of research for most surgeons is limited, and increasing emphasis on academic achievements may well take attention yet further away from the important business of acquiring clinical, including technical, skills.

My suggestions for improving surgical training require that much of the surgery done should be performed either by a consultant (or other fully