

recognised in any published material, and over the years we have progressively lowered our threshold for seeking consent. We don't yet insist on written consent from patients for all case reports, but we may eventually do so.

This week's case before the General Medical Council also shows that doctors must be very clear about what the patient has consented to: vague statements about the information being used in teaching and research will not be enough. Patients must be told that the material will be published, and ideally they should see a final draft of the paper to be published. Indeed, one of the expert witnesses in the case argued that doctors and patients might negotiate over what appears in the final version. Editors, who often want substantial changes in papers, must also be part of that process.

Those who dread (as I do) the arrival of more process and bureaucracy may think that we are going too far. Surely, the argument goes, publication of reports on patients is essential for medical education and the development of medical knowledge, and the small risk that patients may be identified

is outweighed by the overall benefit. But some patients are very distressed by discovering that material has been published about them without their consent; medical journals and textbooks are read by non-doctors; and most patients will give consent, which means that the advance of medical knowledge will not be impeded. We have to do better.

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Atopic eczema

We should look to the environment

Atopic eczema now affects at least one in 10 schoolchildren in Europe.¹ Affected children often have to endure intractable itching, chronic loss of sleep, and the stigma of a visible disease. Family life is also disrupted, and the costs of atopic eczema in Britain may be as high as £470 million each year, with up to half of the costs being met by patients.² Although much scientific energy has been directed towards understanding how atopic eczema behaves at a cellular level, the causes of the disease are still poorly understood. While few doubt the importance of genetic predisposition,³ recent observations from a range of sources suggest that environmental factors may also be crucial.

Several studies have suggested that the prevalence of eczema has increased twofold to threefold over the past 30 years.³ Some of this increase probably reflects changes in the way in which parents and doctors use the label of "eczema," but the magnitude and continuity of the trends, the consistency among different studies, and the reports of similar trends in symptoms of asthma and positive results of skin prick tests favour a genuine increase.¹ Reasons for the rise in atopic eczema and other atopic diseases are less clear, but it seems unlikely that genetic factors could account for such a rapid change. One possible explanation is that changes in the indoor climate as a result of central heating and better insulation have increased children's exposure to allergens such as house dust mite. It is also feasible that exposure to low grade primary irritants and atmospheric and indoor pollutants makes children more vulnerable to sensitisation. Studies examining the relation between urban pollution and atopic eczema in east and west Germany have so far been inconsistent.^{4,5}

Observations from the national child development study suggest that the prevalence of eczema in childhood (both reported and examined) is greater in smaller families and those of higher socioeconomic class and shows considerable geographical variation within Britain in a pattern similar to that of hay fever.⁶ These findings would be difficult to explain in terms of genetics alone. Studies of children from Tokelau who migrated to New Zealand and of Chinese immigrants in Hawaii have shown large increases in the prevalence of atopic

eczema in the migrant children compared with similar genetic groups in their country of origin.^{7,8} Children of black Caribbean origin who were born in London have been shown to be at higher risk of atopic eczema than their white counterparts,⁹ and studies examining similar groups in Jamaica are currently under way.

These migrant studies support the notion that environmental factors associated with development and urbanisation are important in the aetiology of atopic eczema. We do not yet know whether these factors are "allergic" in nature, such as exposure to new or higher concentrations of airborne or dietary antigens, or whether they are due to physical factors, such as differences in susceptibility to cutaneous irritation and dryness that are unmasked by cooler, less humid climates. Atopic eczema is usually a chronic and intermittent disease, so that studies of prevalent cases cannot easily separate factors that determine incidence from those that determine chronicity.

Since atopic eczema usually starts in the first year of life and heritability is linked most strongly to the maternal side,¹⁰ some environmental influences may act during fetal life or in early infancy. One study has suggested that month of birth may be a risk factor determining whether children with atopic eczema subsequently develop allergy to house dust mite,¹¹ and others have shown that defective production of interferon gamma in cord blood cells that have been triggered by allergens can predict the development of subsequent atopic eczema.¹² Preliminary work by Godfrey *et al* has shown an association between disproportionate growth of the fetal head in relation to the trunk and limbs, and raised total serum IgE concentrations in adulthood.¹³ An intervention study has shown that manipulating diet and levels of antigen from house dust mite during gestation and early infancy in children at high risk of developing atopic disease significantly reduces the number of new cases of atopic eczema.¹⁴ More randomised controlled studies are needed to estimate the contribution of such preventive measures in unselected populations and to determine the relative contributions of diet and house dust mite in atopic eczema.

Thus environmental factors seem to be at least as important

as genetic factors in determining the expression of atopic eczema. It is conceivable that such genetic and environmental factors work in concert rather than in competition. The challenge now is to quantify the contributions of specific risk factors that are amenable to public health intervention, such as reducing levels of house dust mite by changes to the design of buildings. Such interventions could reduce the rapidly growing burden of disease in developed countries and prevent similar patterns evolving in other countries that are undergoing rapid demographic change. The fact that the skin is so accessible presents a unique opportunity to visualise its interaction with external factors directly; and now that we have clearer definitions of disease¹⁵ the opportunity to find out more about the causes of atopic eczema has never been better.

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New arrangements for specialist training in Britain

Guidance notes for implementing the specialist registrar grade

In 1993 the Calman report set out to revise specialist medical training.¹ It recommended a curriculum for each specialty, structured training programmes, progression through training based on formal annual assessments of competence, and much shorter training in most specialties. Medical royal colleges and postgraduate medical deans would share in the planning and delivery of a new system to start by the end of 1995. On time, and after extended effort by the colleges, deans, and members of the NHS Executive, the new specialist training is to start for general surgery and clinical radiology in December and for all other specialties between April 1996 and April 1997.

Guidance notes for implementing higher training in the new system were released last week. The notes focus on arrangements for transferring present trainees to the new specialist registrar grade during a transition period, which should last less than a year for most specialties. Career registrars and senior registrars will be eligible for transfer, as will many in research training. Overseas doctors, defined as those who are not nationals of countries in the European Economic Area, will be able to transfer, depending on their rights of residency or available permitted time for postgraduate training in Britain. After the transition period overseas doctors without rights of residency will be able to enter the specialist registrar grade, the only limits being the availability of approved training programmes and funding. There will be an early need for colleges to define what they will accept in terms of overseas experience and qualifications for entry to the grade.

The notes describe a major innovation—fixed term training appointments—that will appeal to many overseas doctors. Appointments of six to 24 months' duration will be available for those without permanent resident rights in Britain and are aimed at providing planned programmes of specific training at a level equivalent to that of the specialist registrar grade. Fixed term training appointments will fill gaps in specialist registrar programmes and are aimed at replacing the often unplanned and unstructured "locum" appointments. Univer-

sity departments, subspecialty units, and others keen to offer training are expected to seek participants through international competition. Fixed term training appointments of shorter duration will be open to trainees with rights of residency in Britain and may be credited to subsequent specialist registrar training.

The notes describe procedures for entry to the specialist registrar grade when the transition period for a specialty is complete. There are new requirements for providing information to applicants; a new application process; and new standards for shortlisting applicants, obtaining references, and convening appointment panels. These will improve objectivity and fairness in appointments and will also test the resources and staff of postgraduate deans, who will be responsible for recruiting people to the new grade.

A feature of the new training is the emphasis on rigorous assessment of progress against defined criteria. Colleges will provide detailed descriptions of methods and standards, and these will be made available to both assessors and trainees. The outcome of reviews of progress will be monitored by colleges, and a summary report will be held by the postgraduate dean. Evidence that effective training has taken place will lead to recognition of a trainee's competence and skill and a recommendation to the appropriate authority that a certificate of completion of specialist training should be awarded.

An aspect that will be new to many is the introduction of training agreements between the trainee, postgraduate dean, and the hospital trust or trusts where training is to take place. The notes give principles rather than final detail but speak of key elements, including the structure and aims of the training programme and the standards of achievement expected of the trainee; an explanation of the methods and frequency of assessment; a commitment by consultants to regular in service tuition; and protected time for trainees to study and be trained. There will also be a commitment from the trainee to take an active part in the training.

A new system of national training numbers, to be main-