Letters

No time to train the surgeons

Royal College of Surgeons of England responds

Editor—The Royal College of Surgeons of England agrees with Chikwe et al that surgical training must be a priority.[1] The specialty is facing serious challenges both in delivering services and in training because of the reduction in junior doctors' hours of work. However, some of the enforced changes are to be welcomed: no one can truly regret that trainees are no longer expected to work a total of over 30 000 hours, or over 85 hours a week. Furthermore, the impetus for the reform of senior house officer training was the general recognition that training was poor and needed a radical overhaul, especially in surgery.

HENRIK SORENSEN/PHOTONICA

To compare hours worked in the past with the other figures in the editorial relating to hours of daytime service and training in a 48 hour week can be confusing when we are faced with a 56 hour week. We need to focus on not only the hours worked but also what is done in the time, ensuring that training opportunities are maximised. Delivery of training is not easy, but some examples are working well given commitment from trainers and trainees, good management support, and accurate profiling of hospital activity, particularly at night.

The colleges and specialist associations are devising new seamless training programmes in surgery in which assessments are based on competence rather than time. This college is working to provide more and better courses to support surgical training, when possible locally. We anticipate a greater use of skills laboratories and simulators, another call on resources. We are pressing for dedicated training lists and clinics, so far without much success. To deliver training and ensure patient safety more consultants are needed, so with current staff shortages existing trainers must be given dedicated time to teach and train, which will inevitably affect their service throughput.

Although creating a better training programme for surgeons with a reduction in working hours requires considerable resources, it is an opportunity to create a new and efficient training system for the surgeons of the future, who will in no way be inferior to the current cohort of young consultants.

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Competing interests: None declared.

1 Chikwe J, de Souza AC, Pepper JR. No time to train the surgeons. *BMJ* 2004;328:418-9. (21 February.)

Medical profession must re-establish its independence from government

Editor—Chikwe et al's description of surgical training in the United Kingdom is a damning indictment of the politicians and medical leaders whose decisions have resulted in the present shambles.[1] The content and duration of surgical training should have been solely the responsibility of the Royal Colleges of Surgeons. Instead politicians have sought to diminish the authority of these colleges, as well as undermining the independence of the medical profession in general. Furthermore, they have adopted European working time legislation with no regard for its impact on medical training and continuity of care.

Senior medical figures are also culpable. Despite the current crisis the chief medical officer is trying to introduce an even more abbreviated form of consultant training. If successful he will further devalue postgraduate medical training in the United Kingdom. Elsewhere postgraduate deans have failed to address the obvious problems, and their current tinkering with the junior and senior house officer grades is likely to make matters worse. And despite their proximity to Westminster successive presidents of the Royal College of Surgeons of England have failed to represent their specialty effectively.

If postgraduate medical training in the United Kingdom is to regain its former high reputation the medical profession must re-establish its independence from government and the Department of Health. It is not in the public's best interests if standards of medical training are dictated by those with a vested interest in getting consultants on the cheap.

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1 Chikwe J, de Souza AC, Pepper JR. No time to train the surgeons. *BMJ* 2004;328:418-9. (21 February.)

Only repeal of European Working Time Directive will help

Editor—The really depressing aspect of the pithy and well argued editorial by Chikwe et al is that the outcome has been obvious for years.[1] The European Working Time Directive is a disaster for medicine.

No amount of teaching in classrooms can compensate for practical experience. No reorganisation of hospital medicine, grades, or subdoctor "assistants" will help. Only a repeal of the directive will do that.

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1 Chikwe J, de Souza AC, Pepper JR. No time to train the surgeons. *BMJ* 2004;328:418-9. (21 February.)

Golden age of surgical training didn't exist

Editor—Four points strike me on reading the editorial by Chikwe et al and the responses on bmj.com.[1 2]

Firstly, there was no golden age of surgical training. We spent more time as "junior doctors." Some staggeringly bad surgeons were appointed under the old system, as well as highly experienced and motivated ones.

Secondly, having observed and trained registrars for 20 years, I have not seen any deterioration in quality. Training in emergency surgery may even improve with designation of an on-call consultant "surgeon of the week" to take trainees through emergency cases during the day. Under the new contract at least one list a week must be a teaching list for senior house officers. Despite the shift system, enough training lists should be possible to teach all senior house officers in rotation.

Thirdly, we must not be confused by the terms specialist and generalist. It has always been quicker to train a specialist than a true general surgeon. Perhaps we need a new term for the undifferentiated "basic" surgeon, produced by a shortened, competency based training programme.

Fourthly, politics and medicine are developing so rapidly that the staffing and training needs of only a few years from now are difficult to predict. I take comfort from the fact that the NHS has been in existence for over 50 years and has never got close to sorting out appropriate staffing levels or training. There is no chance of it getting it right any time soon.

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1 Chikwe J, de Souza AC, Pepper JR. No time to train the surgeons. *BMJ* 2004;328:418-9. (21 February.)
2 Electronic responses. No time to train the surgeons. bmj.com 2004. http://bmj.bmjjournals.com/cgi/eletters/328/7437/418 (accessed 28 Apr 2004).

The rot is deep

Editor—Chikwe et al highlight the crisis in surgical training in the United Kingdom.[1] Many of the advantages of the "apprentice" model have been destroyed without a comfortable and successful new structure being in place. Some elements can be rectified with ease—comprehensive academic courses, wet labs, a refashioned senior registrar phase, for example. The previous hours of exposure can clearly not be amassed without an absurdly long training period.

One of our goals should be to have the shortest overall training period that is capable of producing the best doctors fit to do their jobs. To what extent can we take the best from other systems and adapt to our situation? Why does it take four to five years to qualify in medicine in the United Kingdom when in other countries this can be achieved in four years? More importantly, why in the current era can newly qualified doctors do so little?

The current situation comes on the back of several years of deskilling of medical students due in part to the loss of students' integration into clinical firms. This loss is one of the costs of a modular course, fine in concept but unrealistic unless the previous experiential training is fully replaced. And these comments are not new.[2]

The need for proficiency in appropriate core skills at all stages should be recognised. Beyond a minimum period, progress should be competency based. Medical students, who will be paying for their education, should be vigorous in demanding it.

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1 Chikwe J, de Souza AC, Pepper JR. No time to train the surgeons. *BMJ* 2004;328:418-9. (21 February.)
2 McManus IC. Richards P. Winder BC. Sproston KA. Vincent CA. The changing clinical experience of British medical students. *Lancet* 1993;341:941-4.

Learning from the New Zealand experience

Editor—In New Zealand in 1985 junior doctors' working hours fell from an average of well over 80 hours a week to less than 58 hours a week within a year.[1] This helped satisfy concerns that quality of care was adversely affected by fatigue caused by excessive hours. Several problems quickly became apparent, most of them similar to those outlined in the editorial by Chikwe et al.[2]

For basic surgical trainees the impact of such reforms on training is demoralising. Many of the British hospitals I have worked at are planning to change their registrars and senior house officers to full shift, resident on-call rotas in August 2004 to comply with the European Working Time Directive and New Deal. Instead of spending most operating lists with their consultants and participating as part of a team in regular ward rounds and clinics, junior doctors will be moved to rotas.

In New Zealand the average training time for residents has lengthened to up to eight years,[3] largely in response to the impact on training of reduced working hours and shift systems. That the chief medical officer is contemplating reducing the overall length of training in the United Kingdom at the same time as hospital trusts are reducing working hours of surgical training by over 80% is surprising.

Overseas surgical trainees need to review their future in the United Kingdom as quality of life has been obtained at the expense of quality of training.

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1 Canterbury District Health Board RMO Advisory Committee, Child S. Viewpoint: Time to revisit Ashburton? Junior hospital doctor employment in New Zealand 1985-2002. *N Z Med J* 2002;115:253.
2 Chikwe J, de Souza AC, Pepper JR. No time to train the surgeons. *BMJ* 2004;328:418-9. (21 February.)
3 Jarvis J. Response from an RMO. *N Z Med J* 2002;115:253.

Choosing trainees carefully may be the solution

Editor—Chikwe et al mainly blame the Calman reforms and the European Working Time Directive for the crisis in surgical training.[1] Maybe a share of the blame lies with the medical establishment, especially the royal colleges and postgraduate deans, who have an influential role in selecting trainees.

Some trainees have two right hands and are a pleasure to teach; some have two left hands and teaching is torture. Most trainees are in between. Even with reduced hours, it is possible to train; the trick is to identify the right trainee.

One way of ensuring that the outcome of current training programmes is not "dumbed down" consultants is to select experienced trainees. A considerable wealth of talent and skills exists among doctors known as "time expired" senior house officers (who have not obtained a numbered post three years after obtaining the MRCS) and non-consultant career grade surgeons.

Young doctors who have just finished basic surgical training will not have acquired sufficient surgical skills to allow them to complete specialist training to very high standards in the truncated time available in the higher surgical training programmes. They can further their surgical skills in so called non-training posts (trust fellowships or staff grade posts).

A good trainee will seek out good training. Only when they are sufficiently skilled and experienced should they enter the higher surgical training programme. Selection procedures for these programmes must not prefer academic achievements to surgical competencies.

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1 Chikwe J, de Souza AC, Pepper JR. No time to train the surgeons. *BMJ* 2004;328:418-9. (21 February.)

Summary of rapid responses

Editor—The 35 responses to the editorial by Chikwe et al overwhelmingly agree that surgeons' training in the United Kingdom has suffered under Calmanisation and will suffer more when the European Working Time Directive comes into force.[1] Not all respondents find that the time invested in training is at issue (some reckon that the hours presented in the editorial do not quite add up), being more concerned about the quality of the training. Lost opportunities for training are highlighted, with programmes in other countries cited as effective.

Two anaesthetists emphasise that disciplines with clinical procedures at their core require a different form of training than less procedure oriented clinical specialties and that the directive makes shift systems the only option. A cardiothoracic surgeon finds the current system not bad but the system for training cardiothoracic surgeons in the United States better. A consultant physician in haematology and oncology agrees but a trainee ophthalmologist does not.

Disagreeing with Chikwe et al, a spinal surgeon from Australia argues that the root of the problem is the concentration of resources on structured training for specialist surgical registrars, which has led to the comparative paucity of training opportunities for the more junior grades. Underfunding and a lack of trainers in the workplace are to blame rather than Calmanisation, adds a locum consultant general surgeon.

Many correspondents outline possible solutions. These include dedicated training lists, initially for the senior house officer grade and later for training registrars; contracting out training to deaneries and trusts and recruiting retiring surgeons as dedicated surgical trainers. Let's also

maximise training opportunities: every case in an operating theatre is a training opportunity and should be perceived as such. Let's have better opportunities for training and development for all grades, including consultants.

The responsibility for taking action now lies with all future patients—that is, taxpayers and trainers—argues one respondent. And responsibility for career progression to consultant lies with trainees too, says another. Most respondents are not gloomily pessimistic in seeking a way forward but the fundamental problem of funding and staffing remains.

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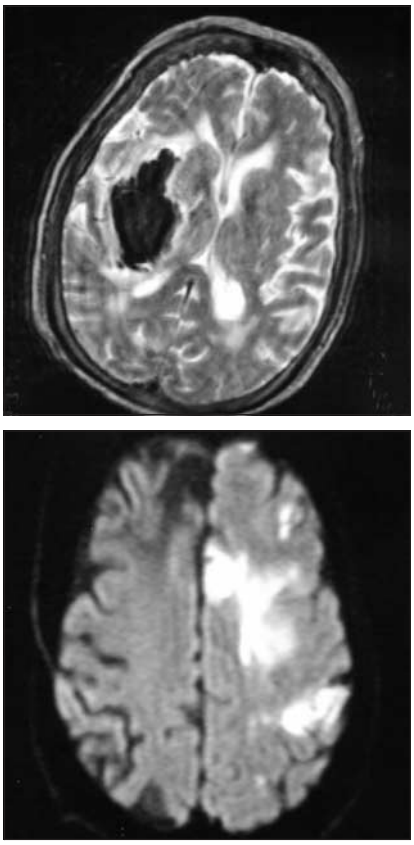
Competing interests: None declared.

1 Electronic responses. No time to train the surgeons. bmj.com 2004. http://bmj.bmjjournals.com/cgi/eletters/328/7437/418 (accessed 26 Apr 2004).

Scan immediately for stroke using MRI when possible

Editor—We agree with Wardlaw and Farrall that a strategy to scan all patients immediately for stroke is optimal.[1] They say that magnetic resonance imaging (MRI) has some perceived disadvantages in imaging acute stroke, despite its advantages.



Top: MRI T2 gradient image showing intracerebral haemorrhage as low signal due to deoxyhaemoglobin susceptibility. Bottom: Diffusion MRI image (B1000) showing acute infarction as high signal (acquisition time 1 minute)

In our experience, the advantages of an early imaging strategy with magnetic resonance imaging outweigh its disadvantages. By combining diffusion weighted imaging with a T2 weighted gradient sequence the sensitivity for both infarction and haemorrhage is high (figure). The room times for this technique are similar to computed tomography, and most patients can be scanned by magnetic resonance imaging.[2] The interpretation of the scans is more straightforward and their reproducibility high.[3]

In a British district general hospital where there may not be ready access to a specialist neuroradiologist or stroke specialist, we believe that magnetic resonance imaging with diffusion weighted imaging carries advantages in ease of interpretation, with a higher sensitivity and specificity than computed tomography, particularly in patients in whom the diagnosis is less obvious.

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Competing interests: None declared.

1 Wardlaw JM, Farrall AJ. Diagnosis of stroke on neuroimaging. *BMJ* 2004;328:655-6. (20 March.)
2 Buckley BT, Wainwright A, Meagher T, Briley D. Audit of a policy of magnetic resonance imaging with diffusion-weighted imaging as first-line neuroimaging for in-patients with clinically suspected acute stroke. *Clin Radiol* 2003;58:234-7.
3 Schulz UGR, Briley D, Meagher T, Molyneux A, Rothwell PM. Sensitivity of diffusion weighted MR-Imaging performed several weeks after a minor stroke or TIA. *J Neurol Neurosurg Psychiatry* 2003;74:734-8.

Turning a blind eye

Testing the success of blinding and the CONSORT statement

Editor—Reports of randomised trials should state clearly whether blinding was attempted, and if so who was blinded and how this was done.[1] Fergusson et al note that blinding may be ineffective in some trials, making them less sound methodologically than they seem to be.[2]

But trial participants asked to guess the treatment they received might well be influenced by outcome. We might expect to see an apparent breaking of the blind more often in trials when the effect of treatment was a marked, for either an intended outcome or adverse effect. Indeed, end of trial tests of blindness might be tests of hunches for adverse effects or efficacy.[3 4] Assessments of blinding success would be much more reliable in trials when they can be carried out before the clinical outcome has been determined.

Furthermore, those who successfully decipher assignments may disguise their unblinding actions.[3 4] That difficulty, along with the aforementioned interpretational difficulties, lead us to question the usefulness of blinding tests in some circumstances.

The CONSORT statement recommends reporting the findings of an assessment of blinding if it was done.[5] Fergusson et al say that the CONSORT statement should be amended, to suggest that assessment of blinding should be done routinely. We are not convinced that all trialists should carry out such an exercise. Furthermore, CONSORT is a set of reporting recommendations—it does not make statements on how trials should be done, but asks that what was done should be fully and accurately reported.

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1 Moher D, Schulz KF, Altman DG for the CONSORT Group. The CONSORT statement: revised recommendations for improving the quality of reports of parallel-group randomised trials. *Lancet* 2001;357:1191-4.
2 Fergusson D, Cranley Glass K, Waring D, Shapiro S. Turning a blind eye: the success of blinding reported in a random sample of randomised, placebo controlled trials. *BMJ* 2004;328:432. (21 February.)
3 Schulz KF, Chalmers I, Altman DG. The landscape and lexicon of blinding in randomized trials. *Ann Intern Med* 2002;136:254-9.
4 Schulz KF, Grimes DA. Blinding in randomised trials: hiding who got what. *Lancet* 2002;359:696-700.
5 Altman DG, Schulz KF, Moher D, Egger M, Davidoff F, Elbourne D, et al. The revised CONSORT statement for reporting randomized trials: explanation and elaboration. *Ann Intern Med* 2001;134:663-94.

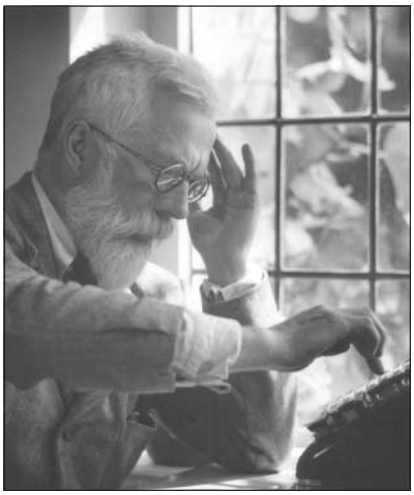
Authors have blinkered view of blinding

Editor—Fergusson et al consider a trial to be double blind when the patient, investigators, and outcome assessors are unaware of the patient's assigned treatment throughout the conduct of the trial.[1] They are quite wrong to do so.

The whole point of a successful double blind trial is that there should be unblinding through efficacy. That is to say that there should be no incidental reasons, apart from efficacy, as to why the treatments are distinguishable but that the treatments should reveal themselves through efficacy. If the treatments are not distinguishable at all, then the treatments have not been proved different.

The classic description of a blind experiment is Fisher's account of a woman tasting tea to distinguish which cups have had milk in first and which cups have had tea in first in support of her claim that the taste will be different.[2] Here the efficacy of the treatment, order of milk or tea, is "taste" and the lady's task is to distinguish efficacy. Fisher describes the steps, in particular randomisation, that must be taken to make sure that the woman is blind to the treatment.[3] But if he were to adopt the point of view of Fergusson et al, there would be no point in running the trial, since if the woman distinguishes the cups, the trial will be declared inadequate, as she has clearly not been blind throughout the trial.

Of course, in a parallel group trial, the patients only have one treatment. But not



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R A Fisher (1890-1962)

unreasonably in such a trial every patient who has had a good outcome might guess, with no other grounds to go on than outcome, that she was on active treatment and every patient with an unsatisfactory outcome might guess that she was on placebo. If the treatment is effective the guesses will distribute unequally between the arms of the trial and the trial will then be declared "not blind." Fergusson et al seem to have a blinkered view of blinding. Their proposals are illogical and need rethinking.

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1 Fergusson D, Cranley Glass K, Waring D, Shapiro S. Turning a blind eye: the success of blinding reported in a random sample of randomised, placebo controlled trials. *BMJ* 2004;328:432. (21 February.)
2 Fisher RA. The design of experiments. In: Bennet JH, ed. *Statistical methods, experimental design and scientific inference.* Oxford: Oxford University Press, 1935.
3 Senn SJ. *Dicing with death.* Cambridge: Cambridge University Press, 2003.

Authors' reply

Editor—Altman et al and Senn correctly note that a strong relation is likely between patients' improvement, real or perceived, and a subsequent guess by patients, investigators, or outcome assessors that active treatment had been assigned. Admittedly, assessing blinding by simply examining the proportion of correct "guesses" is not a particularly good choice. However, to argue that we should not attempt to assess whether blinding had been maintained is an even poorer choice.

We applaud the aim of CONSORT and understand the reticence to be prescriptive with regard to trial conduct. However, the CONSORT statement does ask trialists to report not only the method used to generate a random sequence but also the details of its implementation and concealment. Similarly, we believe that there is room and need for better attention and guidance with regard to the reporting of blinding.

Our paper examines how trialists report on blinding, not only with regard to outcome, but also with regard to process. To be charitable, one might categorise the results as "not very well." While pre-trial measures can be taken to help ensure successful blinding, these measures alone do not ensure that blinding will be preserved during the trial. Since the claim of assay sensitivity for trials with a placebo arm rests on the assumption of appropriate blinding, we do not have the luxury of continuing to avoid the challenging measurement issues involved.

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Why we don't test for blindness at the end of our trials

Editor—I write with reference to the paper by Fergusson et al.[1] Asking patients or their clinicians at the end of a trial which drug they think they were taking confounds failures in blinding with successes in pre-trial hunches about efficacy.

Thirty years ago, at the end of the first ever trial of aspirin and sulfinpyrazone for threatened stroke, we asked our trial clinicians to predict which drug each of their patients had been assigned.[2] With four regimens in this "double dummy" trial, we'd expect correct predictions for 25% of patients; our clinicians' predictions were correct for only 18% of them ($2P < 0.05$).

This apparently nonsensical result made sense when we compared it with our incorrect pre-trial hunches that sulfinpyrazone probably was effective and aspirin probably was not. When our patients had done well, their clinicians tended to predict that they had received sulfinpyrazone; when patients had suffered strokes, these same clinicians tended to predict that they had received aspirin or the double placebo.

But what if their pre-trial hunches about efficacy had been correct? If patients who had done well were predicted to have received aspirin, and those who had done poorly were predicted to have received sulfinpyrazone or the double placebo, our end of study test for blindness would have led to the incorrect conclusion that blinding was unsuccessful.

Once a trial is under way, I'm not smart enough to separate the effectiveness of blinding from the effects of pre-trial hunches about efficacy, and I've never met anyone who is. Accordingly, we vigorously test for blindness before our trials, but not during them and never at their conclusion.

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Competing interests are available on bmj.com

1 Fergusson D, Cranley Glass K, Waring D, Shapiro S. Turning a blind eye: the success of blinding reported in a random sample of randomised, placebo controlled trials. *BMJ* 2004;328:432. (21 February.)
2 The Canadian Cooperative Study Group: A randomized trial of aspirin and sulfinpyrazone in threatened stroke. *N Engl J Med* 1978;299:53-9.

We are not "amueslied"

Editor—Professor Jane Wardle, as reported by Burke in her news extra item, is right to raise the issue of the worrying nutritional content of some breakfast cereals, but her suggestion that general practitioners should target patients for "Golden Nuggets" of nutritional advice takes the "Weetabixit" and will undoubtedly be greeted with a "Frostie" reception in primary care.[1]

There is not a "Shreddie" of evidence to show that this presents an effective approach to the problem. If Wardle has difficulty interpreting the nutritional content on cereal packets, how does she expect general practitioners to do so? Perhaps they could be provided with a "British Cereal Formulary" (BCF) as a reference guide.

Rather than "Alpen" general practitioners to become expert interpreters of cereal packets, we need to adopt a population approach to the problem by swimming up stream to find the goose that is laying the "Golden Grahams." A traffic light labelling system on all foods represents a feasible and practical solution. This will avoid confused patients from swarming round their general practitioners like "Hunny Bs" to a Pop Tart.

In the meantime, some general practitioners may consider offering advice to cereal offenders as an enhanced service agreement, but we doubt that primary care trusts would be "Ready (Brek)" to agree to finance this initiative. Primary medical performers indeed. If only life was "Oatso Simple."

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Competing interests: None declared.

1 Burke K. GPs should help patients avoid unhealthy breakfast cereals, expert says. *BMJ* 10 April 2004; http://bmj.bmjjournals.com/cgi/content/full/328:7444/854-g (News Extra) April).