Training in urology

SIR,—The letter from the president of the Association of Surgeons in Training (12 May, p 1281) raises a number of important issues. There is no doubt that there is at present a serious imbalance between the number of senior registrars in training in urology and expected consultant vacancies. This discrepancy is fully appreciated by both the senior registrars and the Committee for the Development of Urological Services of the British Association of Urological Surgeons. However, we cannot agree with the solutions which Mr Logie puts forward.

The president and council of BAUS are committed to encouraging an increase in the number of "pure" urological consultant appointments. The senior registrars are in full agreement with this, and a recent poll has shown that 95% of those in training at present are prepared only to apply for "pure" urological appointments and not for posts offering a mixture of general surgery and urology. We recognise that only by increasing the number of urologists in England and Wales to provide at least the same ratio of urologist: per head of population as already exists in Scotland can our patients be offered the best standard of treatment available. If the decision is taken to continue to advertise mixed appointments and if attempts are made to train surgeons for such posts the penalty would be increased mortality and morbidity. Those who advocate such a course must be honest enough to recognise this fact and to make sure that it is understood by both patients and medical politicians.

In the interest of patients there can be only one solution and that is the continued increase in the number of consultant urologists. All urology should be performed by properly trained urological surgeons. Only in this way will the lot of those with urological disease improve. The cost effectiveness of urological units is well established.

Urological senior registrars will not willingly tolerate any change that will prevent the fulfilment of the improved standard of care which could be made available by an expansion in "pure" urology.

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SIR,—My *BMJ* arrived today and I noted Minerva's remarks (12 May, p 1290) about quality of care in the NHS and also the letter from Mr J R C Logie (p 1281) on "Training in urology." It occurred to me that Britons have become accustomed to adversity to the extent they have become proud of it and even defend the NHS quite blindly. Before leaving Ontario, where I practised urology for 23 years, I was a member of the Province of Ontario urology manpower committee. There seems to be a comfortable but not overadequate number of urologists practising there for a population of 13 million. This number has stayed static more or less at about 153. It seems incredible to me that a country with the population of England and Wales should have only 127 consultants and 31 senior registrars. One could therefore

argue that there are grossly insufficient numbers of full-time urologists to provide the "best" care for all without the necessity for private care. This is not to deprecate the standard of care given by general-surgeon urologists, but surely they may be in the same position of trying to provide more good care than their numbers allow.

One sometimes gets the impression that some British doctors are becoming like gambling men—"We always lose but it's the finest sport in the world."

If a quarter to a third of urological work is done by general surgeons, where is the justification for not making more urology consultant posts even at the expense (regrettably) of general surgical posts? From this distance it would seem that there exists some form of insanity prevalent among British "planners" and "administrators." Could that dread disease be socialism, which they are trying so hard to export to this continent?

We do have our problems here, too: it sometimes rains in South Carolina.

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Dehydration and thromboembolism

SIR,—We were interested to read Minerva's comments on dehydration and pulmonary emboli (28 April, p 1153). Recently a fit, slim, active 29-year-old airline pilot who regularly plays squash at county level and who never flies for more than three hours at a time was admitted to hospital with pleuritic pain and haemoptyses. The chest radiograph showed a wedge-shaped opacity at the right base, lung scans showed both absent ventilation and perfusion in this area, and a venogram showed a thrombus in the right popliteal vein, although clinically there were no local signs. Full haematological studies have shown no blood abnormality.

Perhaps the combination of repeated muscular trauma and the dehydration associated with strenuous physical exercise may have been important factors in this case.

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Co-operation over surgical training

SIR,—In 1972 the Conference of Surgical Colleges met in Cape Town and later in Ottawa and Chicago. These meetings were remarkable. For the first time the American College of Surgeons, represented by its president, joined the Colleges of England, Edinburgh, Glasgow, Ireland, Australasia, Canada, and South Africa and played a full part in the discussions and decisions, the main topic being training for a career in surgery. Not only was there a very great measure of agreement on all important matters but the future appeared bright, with the representatives from all colleges speaking of the value of unity and looking forward to an increasing measure of intercollegiate co-operation. For several years afterwards the pattern had been set and the wish of the colleges to work together governed educational debates and the

designing of training programmes and examinations.

But now—what has gone wrong? What has happened to all these good intentions? Everywhere one looks the spectacle of this surgical college or that taking a decision in isolation, even at times in defiance, of the views of other colleges catches the eye. "Do it our way" is the cry on all sides, or, "Let us abandon unity as an objective."

Another meeting of the Conference of Surgical Colleges is planned for October of this year. We would urge those who represent their colleges to attend it determined to find again that earlier spirit of unity which, if not lost, has at least been temporarily mislaid. The combined wisdom and experience of the colleges represented can lead the surgical world, provided the influence of the conference is exercised as a single unit and that the colleges of which it is composed are seen to be in co-operation rather than competition.

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JANNIE LOUW
Past-President,
College of Medicine,
South Africa

BROCK
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STANLEY MCCOLLUM
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College of Medicine,
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Medical manpower, staffing, and training requirements

SIR,—In the recent report of a working party on medical manpower (19 May, p 1365), a proposal has been made regarding an attempt to solve the "registrar bulge." At the moment in the popular specialties there are too many registrars competing for the available senior registrar posts, including those hidden by the universities, to guarantee a young trainee a consultant post in a reasonable time. The concept of the policy described is that there will be two types of registrar, those on the register and those outside. The selected trainee would be scrutinised over a period of a year and after that there would be room for him to achieve a consultant post within a reasonable time.

A gross omission is that there appears to be no mention of exercising control over the numbers of occult senior registrar posts in the undergraduate hospitals described as "assistant

lecturers," "lecturers," "research assistants," etc, so unfortunately the likely lad may run up the early posts easily enough, but may find himself competing for a long time in the penultimate consultant grade.

The great problem at the moment is that able and experienced young men with their fellowships in the district general hospitals are unable to re-enter the undergraduate hospitals. Quite a number of these doctors are trained and able to take consultant posts but they must be processed through the senior registrar grade, which, on reflection, is of the self-same nature as a registrar post in the periphery. To impose further restrictions, to reduce competition, to elaborate these bureaucratic corridors, is against professional freedom.

An alternative plan would be to abolish the senior registrar grade and replace it with six or eight years of seniority as registrar in the major specialties. When maturity is attained these registrars could apply for consultant posts either from within the hallowed corridors of the teaching hospitals or without. Young trainees would be quite prepared to wait as registrars with overtime payments if they considered that they would have a sporting chance of achieving a consultant post.

Let us avoid this rigmarole of bureaucracy, these petty and thwarting distinctions, and simply rely on the number of years a particular candidate has spent being trained in the specialty of his choice and his ability.

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SIR,—I have read the report of the BMA Council working party on medical manpower, staffing, and training requirements (19 May, p 1365) with some disquiet. There are undoubtedly problems to be overcome in the near future over the provision of an adequate level of staff in NHS hospitals and at the same time the right sort of training towards a rewarding career for its doctors. However, the proposals outlined in this report cannot be the answer to them.

The report proposes very early selection of doctors for specialty training: is it really possible to pick from SHOs with sufficient accuracy those who will become consultants? There would undoubtedly be a large number of frustrated junior doctors waiting for probationary training posts. Further, the earlier a doctor commits himself to a career the less easy is it for him to change course should he or his superiors realise that it is the wrong one.

The report suggests that the number of registrars (in post for two years) should match the number of senior registrars (in post for four years) and the number of consultant vacancies. There are approximately 700 consultant vacancies per year: this implies a total of 2800 senior registrars and 1400 registrars. If there were 14 000 consultants, only about one in three would have either a senior registrar or a registrar, and, assuming that many of these specialist trainees would be concentrated in postgraduate hospitals, it does

not take a mathematical genius to realise that the average consultant in a district general hospital would be without any assistance of the sort he now enjoys (and needs).

The report implies that the service work load in these hospitals would be borne by overseas graduates carrying out "training" appointments of limited tenure. Are we to assume that in future our only hope of assistance is from overseas graduates whose source may be cut off at short notice? Any change in the migration pattern cannot be compensated for by adjusting medical school intake in under 10 years. I fear that a registrar may turn out to be a luxury denied many consultants in provincial hospitals not fortunate enough to be part of a specialist training scheme. Do such consultants take kindly to the idea of being resident on duty?

The British Hospital Doctors Federation presented its proposal to the Royal Commission on the NHS last year. It permits both proper training for junior hospital doctors and adequate opportunities for women and general practitioners to participate in hospital medicine at any level of skill, part-time or full-time. Its basis is the preservation of the role of the consultant as we know it today.

The BHDF is in favour of rationalising the hospital staffing structure so that those who enter it at the bottom emerge after a reasonable length of time in training with a permanent post appropriate to their training skills and abilities. The SHO posts and registrar posts should permit appropriate entry into general practice and other posts outside hospitals, and those that enter senior registrar jobs should nearly always attain consultant rank. Nevertheless, the BHDF has formed the opinion that another style of post must be created to support the consultant, and whether it is entitled specialist, integrated medical practitioner, or hospital practitioner is immaterial provided it is open to those with a high degree of skill in the specialty, with sufficient competence to work with a considerable degree of autonomy but always under the aegis of a consultant. This style of post should be open to everyone who does not wish to undertake the full commitment and responsibilities of the consultant. On the basis that the salary is above that of a senior registrar yet not quite that of a consultant it will prove attractive to many doctors.

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Fibromuscular dysplasia

SIR,—I was interested to read Dr Aurell's report of two cases of renal artery stenosis due to fibromuscular dysplasia arising in previously normal vessels (5 May, p 1180). He implies that this is the first such report providing evidence against the presence of these vascular abnormalities from birth. I would like to point out to him our report¹ of a patient in whom the condition developed in a renal artery which had been normal at the time of angiography three years earlier; this had demonstrated contralateral fibromuscular dysplasia.

Incidentally I wonder why the second patient, who progressed "until renal function

was almost completely lost," was not offered surgery, which we² and several other groups have found to be effective in improving function. Perhaps surgery was not technically possible because of the extent of involvement of the vessel, which is difficult to assess from fig 3.

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¹ Jones, E O P, Wilkinson, R, and Taylor, R M R, *British Medical Journal*, 1978, **1**, 825.

² Worth, R C, et al, *British Journal of Surgery*, 1977, **64**, 545.

* * * We sent a copy of this letter to the author, whose reply is printed below.—ED, *BMJ*.

SIR,—I am grateful to Dr Wilkinson for bringing to my attention his recently published case, where contralateral progression of fibromuscular dysplasia was observed after an ipsilateral attempt to correct the disease surgically. Thus, his case is similar but not identical to my two cases, where bilateral normal renal angiograms were present before any signs of the disease had appeared. Dr Wilkinson asks if my second patient was considered for surgery. She was, and different approaches were discussed. Tragically, the patient died of an acute myocardial infarction while these discussions were going on. At necropsy the renal arteries were not examined.

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Coronary care

SIR,—The Personal View by consultant physician I W B Grant (Edinburgh) (14 April, p 1012) shows the gulf which exists between general practitioners and some hospital consultants, but thankfully not all. He writes, revealingly, about his personal experience of recent circulatory illness, and, while we must sympathise with him, we must not allow what he writes to influence too much the younger generation of doctors who read the columns of the *BMJ*.

Dr Grant writes: "Since I realised that my general practitioner could not help me if I had a coronary thrombosis, admission to a coronary care unit seemed to be the only solution to my problem." What an insult to general practice. Is Dr Grant saying that all patients who think that they have coronary thrombosis should be self-admitted? Self-admission to coronary care units may be theoretically desirable, but in practice is likely to have dramatic results, and it will be interesting to see who will be admitted when the system becomes choked. What will happen to those who are refused admission? Will hospitals put up extra beds, and will the unions allow it?

The final sentence of the article is worth quoting: "What we can do at least is to diminish anxiety by using appropriate drugs, which should always include night sedation when necessary because, as I have now discovered for myself, the difficulty in getting to sleep in a patient who has or believes he may have coronary artery disease is a harrowing experience." In the past 30 years we have seen many kinds of night sedation used, and general