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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Changing the FRCS exam

SIR,—Conversations with trainees in surgery and with fellow consultants show that Professor Roy Calne is not alone in his "Personal View" on the proposals (8 October, p 952) to change the FRCS examination. Moves to place the primary FRCS towards the end of basic training and to make the final a wide-ranging examination of the candidate's specialist training may at first glance appear reasonable, even desirable; but the objectives should be clearly defined.

(1) These changes can do nothing to help the surgeon in training who hopes to work in Britain. Everyone understands that the present FRCS means only that the holder has acquired a reasonable knowledge of anatomy, physiology, and pathology; read fairly widely in surgery; and made sense of a collection of patients with surgical physical signs. To secure

a senior registrarship in general surgery he still has to show that he can operate well, undertake investigative work, and, preferably, be preparing an MS thesis. None of these abilities is in fact going to be tested by a later sitting of a more searching FRCS. Indeed, the approach of this examination is likely to be something of a distraction from the work of a senior registrar; it will be extremely difficult to fail candidates who are so far advanced in their training; and it will carry no greater weight with selection committees for consultancy than good references, a reasonable body of published work, and the present certificate of Higher Surgical Training.

(2) The advantages to be derived from the new arrangement must therefore be intended to benefit those who intend to work outside the UK. This is not said to condemn the pro-

posal but it is important to recognise this fact. In the foreword to the new FRCS examination proposals of the Royal College of Surgeons of Edinburgh it is stated that "the international status of the British FRCS diplomas has declined in relation to the Higher Surgical Diplomas of certain other countries, notably the FRCS Canada, the FRACS and the Certificate of the American Board of Surgery. The principal reason for this is that the British FRCS Diploma is no longer the hallmark of a trained surgeon." Most surgeons would, I think, say that it has never been thought of as the hallmark of a trained surgeon, certainly in the UK; and the question is whether we want the FRCS to become one, so that it can compete abroad with other diplomas.

(3) One consequence of the new proposals would, presumably, be to reduce very strikingly the number of those qualified to sit the final FRCS. If the proposal is that the primary FRCS should be taken at the end of basic training, this must be after at least two years in postregistration surgical posts—that is, during most trainees' registrar period. If the

final FRCS is then intended to be taken some 2-3 years later this must mean that it is only taken after some two years in a senior registrar post. Quite properly these jobs are restricted in number so that they roughly equate with the number of UK consultant vacancies. If the new regulations come in we will be faced with the difficult choice between continuing the present numbers of senior registrars, or extending the number of these posts so that more foreign graduates can acquire the experience necessary to sit the final FRCS before returning to their own countries to practise.

(4) A good deal of pressure for the proposed change may be coming from specialists. The Edinburgh FRCS proposals state that, while the present FRCS exam covers the field of general surgery, "there is at present in the British system no means of assessing standards of higher training in the surgical specialties." This, of course, is true and standards in this country are maintained by assessors from the National Panel of Specialists sitting on all appointed committees, for senior registrar posts as well as those for consultant vacancies. Once again, we have to decide whether the future standing of those who will practise the surgical specialties outwith the UK should dictate the proposed changes.

There is a good deal to be said on both sides of this debate. What is certain is that these proposals, if adopted, would make quite an appreciable difference to the pattern of surgical training; so it is important that the issues should be looked at clearly, and that surgeons in training should, in particular, say what they think of them.

PETER F JONES

Royal Aberdeen Children's Hospital

How many medical students?

SIR,—The reason for the conspicuous failure of so many attempts to estimate correctly the number of medical students needed to supply the needs of our health services is (although she does not say it in so many words) spelt out in Mrs Rosemary Hutt's intriguing letter (15 October, p 1029). By inference she makes it clear that this failure is caused by equating "students" with "doctors" and "doctors" with "the needs of our health services"; and it is not enough to assume that any given number of doctors will fill a similar number of vacancies occurring in a dozen contrasting disciplines. Our medical schools today must train not just "doctors" but a variety of young men and women, wisely educated to become surgeons, physicians, psychiatrists, anaesthetists, and so forth, in numbers that bear some comparison to our health service needs.

In 1966¹ I wrote that "four years might lead to a first degree in medical science." Thereafter the "teaching programme might diversify according to the needs and intentions of the individual students"; but that "the facts of life require that . . . there should be a limited number of places only, in each of the diverging streams, leading ultimately to a reasonably balanced division of talents . . . according to the needs of the community. . . . Different streams of students and even individual students, would call for specially devised programmes of study," and "this would constitute a challenge to Deanship and offer exciting opportunities both to teachers and to those taught." Especially, one might now add, to those teaching in, and those destined for, the currently less favoured specialties.

It almost looks as though Rosemary Hutt may be on the way to converting a dream (a dream which many earlier writers have dreamed) into a reality. But when? In yet another eleven years?

CHARLES WELLS

University of Liverpool

¹ Wells, C A, *Annals of the Royal College of Surgeons of England*, 1966, **39**, 267.

Training of registrars

SIR,—Many who are actively engaged in the training of registrars and senior registrars have from time to time felt that there should be an examination at the end of the training period. Professor Roy Calne's Personal View (8 October, p 952) gives cogent reasons against this being introduced in the United Kingdom, but I think that the most important reason against this being done is that the NHS is a monopoly employer. If a man has been accepted as a trainee in a branch of hospital medicine and spends perhaps six years at registrar and senior registrar level learning this particular skill only to fail an examination at the end he would then find it almost impossible to get any other post in medicine. He would be too old to train in any other branch and would not have the outlet of entering private practice, an outlet available in those countries where "boards" or similar tests are held. If in these circumstances an examination for specialist grades were held the examination would either have to be of such a nature that failure was unusual or the unsuccessful candidate would have to be allowed unlimited opportunities to resit it, thereby blocking training posts.

I agree that it is important to ensure that those in training posts receive adequate broad based instruction. At present in many branches general guide lines are suggested. But if these were more definite and it was ensured that the trainee received instruction in all the essential departments of the specialty by producing evidence of his competence in these many of the problems now experienced would be met.

I know that there is now an accreditation scheme but this does not take into account training in supraspecialist branches of a subject which can only be given at a few centres. Such instruction would have to be arranged with adequate provision for staffing and finance.

H R VICKERS

Little Milton,
Oxford

Care of the elderly sick

SIR,—Mr V H Cross deserves to be congratulated and not castigated, as he has been by some geriatricians (8 October, p 953), for exposing their illogicality in insisting on a separate specialty. His solution to the problem is close to one I and others have advocated. Geriatricians should explain why to date few other countries have been tempted to follow our example in separating geriatrics from medicine. Once again Dr Fine trots out that "gross distortion of the truth" that it was the "failure of general physicians to provide an adequate service" in 1947 and 1950 which necessitated the development of a separate specialty. Mindless repetition of this has misled a generation of physicians too young

to know the truth actually to believe it. The following dates and information may help to straighten the record:

1930: Responsibility for administration of poor law institutions and workhouses passed from boards of guardians to county and county borough councils. Before that medical care of inmates and patients was in the hands of general practitioners, and subsequently of the MOHs and their appointees.

1930-9: There was considerable advance in care of the chronic sick in the wealthier and more advanced local authorities, such as Middlesex and London County Councils, while extension of the excellent district nursing service did much to ease the lot of the chronic patient at home. But it was also the time of slump and unemployment and the poorer authorities could do very little.

1939-45: The time of the second world war and the Emergency Medical Service was bad for long-stay and elderly patients either at home or in hospital. The aged and chronic sick in those years were unable to claim priority in the face of the prime need for national survival.

1945-7: The NHS Act passed through the House of Commons; it was a time of uncertainty and stagnation.

1948: The NHS took over all hospitals, with a few exceptions, such as the Royal Masonic and the trade union hospital at Manor House.

c 1948-52: During this settling-in period very little money was available, and none for capital development. The state of most long-stay wards all over the country was Dickensian; not surprisingly, little had been done to them since 1939.

From 1948 onwards responsibility for care of long-stay beds passed to the RHB (but not teaching hospital) general physicians, who were also in charge of acute beds. When I was appointed in 1949 my senior colleague had been doing his best to supervise four chronic hospitals as well as two acute hospitals and a fever hospital serving a population of about 280 000. None of the chronic hospitals had any medical staff. My appointment meant that we now shared the work! Within a short time we pressed the RHB to appoint general practitioner clinical assistants at the long-stay units. After the usual passage of time this was achieved, although at the outset with pitifully few sessions.

By 1951 the beginnings of the current geriatric problem began to develop, with fewer elderly dying of pneumonia owing to the advent of antibiotics. Waiting lists began to lengthen, and I pleaded with the senior administrative medical officer to allow me to make domiciliary visits with the almoner to patients' homes to assess facilities and needs on the spot. The request was refused. I then said I would be prepared to do the visits for nothing if I could claim mileage. This request was also refused. A year or two later a geriatrician was appointed and allowed to make such visits!

The point that I make is that deficiency in care of the elderly certainly until the mid-1950s was due less to negligence by general physicians than to the realities of the time, the short period since 1948, when they had been made responsible, and shortage of staff and money.

Lastly, Dr Cooper (8 October, p 953) should let us into the secret of the special skill in "drug therapy" he claims geriatricians have and which the general physician lacks, and Dr Fine and others should be more specific about the oft-voiced claim that geriatricians have a special skill in diagnosing multiple pathology, which it is alleged general physicians do not have. Nearly all my patients are in the same age group as the geriatricians' and have multiple pathology, which my colleagues and I are not noticeably deficient in diagnosing and treating. Whether they come to the department of general medicine or to the geriatric department is very much a matter of chance, and many of them are ex-patients of that department. I gladly acknowledge the contribution of rehabilitation