Applying for flexible training

Application process is too slow

EDITOR,—One of the drawbacks of the present flexible training scheme is that the system for applying is not rapid enough.¹ For those whose partners are on short term contracts, such as junior doctors, the delays inherent in the scheme belie its flexibility.

I applied in August 1993 for a place on the scheme as a part time senior registrar in gastroenterology. I was interviewed and had been granted manpower approval by April 1994, but no places were available for flexible senior registrars in gastroenterology then. In November, still awaiting manpower approval, I applied to the Royal College of Physicians' adviser for flexible training, and in January 1995 manpower approval was granted. By this time my family and I had moved to a different region, and I then had to wait for another interview with a senior registrar appointments committee in the new region. In March I was finally appointed a flexible senior registrar in Mersey region, one week before my husband's contract in that region finished.

The present application scheme still incorporates too many delays. The quotas for manpower approval for flexible training in each specialty should be updated more frequently, preferably every six months. The college advisers should be able to provide applicants with information about the numbers of vacancies or the length of the waiting list for each specialty. Once an applicant has been interviewed the outcome of the interview should apply nationally rather than regionally, so that if an applicant moves to another region before being able to take up his or her post there is no need for a further delay while another senior registrar appointments committee is convened. This is particularly important for those specialties that are oversubscribed with applicants for flexible training, when there may be some delay before a successful applicant is granted manpower approval.

Despite these drawbacks I encourage candidates to use the flexible training scheme as it offers greater scope for balancing work and family commitments than a full time appointment.

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1 Morrell J, Roberts A. How to make an application for flexible (part time) training. *BMJ* 1995;311:242-4. (22 July.)

Process has since been simplified

EDITOR,—Jacqueline Morrell and Angela Roberts's article on how to apply for flexible training publicises the scheme well but comes at an inopportune time, given the considerable changes taking place at the moment.¹ The article should not be seen as a definitive guide on "how to do it."

The authors clearly experienced considerable difficulties in obtaining their flexible training posts and are right to point out many of the pitfalls. During the past two years the flexible training working group of the Committee of Postgraduate Medical Deans has been created and has helped simplify application. The group comprises all associate deans involved in flexible training along with representatives of the royal colleges (most of which now have a special adviser for flexible training), representatives from the NHS Executive's medical education training and staffing department, and representatives from the junior doctors committee of the BMA. This group has provided a forum for discussion of the problems experienced in organising flexible training and has, we hope, smoothed many of these out.

An individual trainee applying direct to a postgraduate dean's department will find that the

associate dean or equivalent responsible for flexible training will be able to give information on dealing with the appropriate royal college along with the name of the adviser on flexible training. All deans have a "fact pack" about dealing with the royal colleges. Furthermore, funding for flexible training now rests, in most cases, directly with the postgraduate dean's department, which funds all of the salaries of doctors doing flexible training as opposed to half of the salaries of full timers.

Other changes are expected in the near future, but the flexible training working group is in a unique position to advise on all aspects of flexible training. Despite many uncertainties regarding implementation of the specialist registrar grade, all doctors currently doing flexible training at registrar or senior registrar level will be guaranteed a national training number and be able to continue their training flexibly in the specialist registrar grade, provided they fulfil the basic entry requirement. Guidance for new applicants for flexible training under this system will be available later in the year.

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Differences in mortality after fracture of hip

EDITOR,—C R Packham¹ suggests that case mix may have been responsible for the variation among hospitals in 90 day mortality after admission for fractured hip that we reported.² The possibility that patients' characteristics may explain differences in outcome is the reason why a multivariate analysis was necessary. Clearly, such an analysis has to be limited to those factors for which information is available, and our prospective audit, like any other study, could not record every conceivable potentially explanatory factor. This was one of the main points that we addressed in our response to previous letters about our study.³

Nevertheless, we conducted fairly extensive interviews with patients in addition to extracting records from case notes and thus were able to enter a reasonably large number of variables into the logistic regression model. Specifically, these were age; sex; the prior activities of daily living score; the type of residence from which patients were admitted; the number of pre-existing illnesses; the type of fracture; the length of, delay to, type of, and timing of operation; the anaesthetic given; the use of prophylactic anticoagulants and antibiotics; and (as dummy variables) individual pre-existing illnesses and hospital. Our analysis used forwards entry of variables in 441 cases for which data were complete and was subsequently repeated on the smaller subset of indicated factors in 547 cases (14 missing). As reported, only the first three variables listed above and (from the last two variables listed) cardiovascular disease and hospital 6 emerged as significant predictors of death. All of these findings, including the significance of male sex—although not the apparent protective effect of one hospital—are consistent with the literature.⁴

Packham questions the adequacy of the model and the proportion of variability explained. In logistic regression, however, there is no measure analogous to the R² of multiple linear regression (used for continuous response variables) to indicate such a proportion. At best a 2x2 table can be

generated, matching the observed "yes/no" outcome with expected outcome according to whether the predicted probability exceeds an arbitrary cut off value such as 0.5, though this is rarely informative. Our interest is focused on identifying which characteristics of patients or hospitals are associated with the observed differences in mortality.

Finally, we agree that adequate adjustment for case mix is difficult and hence reiterate our previous comments that our results are hypothesis generating rather than definitive. We hope that they give rise to further research.

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- 1 Packham CJ. Differences in mortality after fracture of hip. *BMJ* 1995;311:571-2. (26 August.)
- 2 Todd CJ, Freeman CJ, Camilleri-Ferrante C, Palmer CR, Hyder A, Laxton CE, et al. Differences in mortality after fracture of hip: the East Anglian audit. *BMJ* 1995;310:904-8. (8 April.)
- 3 Todd CJ, Palmer CR, Camilleri-Ferrante C, Freeman CJ, Laxton CE, et al. Differences in mortality after fracture of hip. *BMJ* 1995;311:572-3. (26 August.)
- 4 Sainsbury R. Hip fracture. *Reviews in Clinical Gerontology* 1991;1:67-80.

Sanctions against apartheid were effective

EDITOR,—Ralph Crawshaw has taken advantage of a book review to offer a diatribe about the sanctions applied to South Africa in the days of apartheid.¹ In general, sanctions are regarded as an acceptable and at times effective instrument to bring about change, hence their application against Iraq, against Shell in the fiasco over the Brent Spar oil rig, and currently by many countries against France for continued nuclear testing. It is almost universally agreed that sanctions played a major part in achieving change in South Africa, which might not otherwise have occurred without serious violence, if not civil war.

Although Crawshaw seems to agree that economic sanctions were most effective, his condemnation is aimed at the application of academic sanctions. Over the years the same objections were voiced about art, theatre, music, literature, and, especially, sport. The inclusion of all elements was critical in inducing a change in thinking. South Africans got tired of being the pariahs of the world and eagerly grasped de Klerk and Mandela's initiative when it was offered.

While Crawshaw expresses sympathy with South African scholars who "experienced 20 years of frustration, anger, fear, and damaged self esteem," could he for a moment put himself in the position of the country's 80% black population,