To optimise outcome, major trauma needs senior-led care to direct decision making, surgical action and also facilitate teaching of trainees.^{1,2} Similarly, surgical exposure and experience is demonstrated to improve outcome, decrease complication rate and length of stay.³⁻⁵

These data imply an over-confident cohort of trainees, perceiving themselves proficient at managing trauma they may have not previously witnessed.

It would have been useful to see the data stratified into trainee years to assess confidence as training progresses. More importantly, it would be valuable to assess corroboration between perceived confidence and actual surgical proficiency.

We question the relevance of measuring confidence when actual ability to manage such cases is far more important and relevant.

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AUTHORS' RESPONSE

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We appreciate Avis and Mutimer's interest in our survey of 232 orthopaedic trainees' perceived confidence in the management of and exposure to significant trauma.

Apparent from the title, this study of a quarter of UK orthopaedic trainees reflects how often they perceive to be involved in index cases. It represents how trainees perceive their confidence and adequacy of training in the management of significant injury and details their perceived operative role.

Concern of misplaced sentiment regarding adequacy of training is more representative perhaps of a misplaced interpretation of the results. In addition, to illustrate their points, they cite surgical experience and economic outcomes from elective shoulder arthroplasty and thyroidectomy, evidence that is somewhat distant from trauma care. Their other reading matter is over 20 years old.

Analysis of training in operative orthopaedics has been made possible recently through peer-reviewed publication of data from the national operative logbook. A significant resource and source of valuable benchmarking data, the logbook is, however, limited to operative interventions. Trainee confidence and exposure to the overall management of significant trauma is not currently an aspect of the logbook and our study is the first to attempt to gauge these important aspects of training.

As such, this is the first demonstration of how trainees perceive their exposure to significant trauma, their confidence in its management and the adequacy of their training – issues that cannot be assessed through graded participation in an operative procedure alone.

If trainees demonstrate a perceived adequacy of training and a level of confidence greater than that expected of their seniority, then this must be factored in to the overall assessment of training as a whole and not dismissed out of hand. We do not vouch for the competency of surgeons completing the survey, merely report their responses.

In terms of demonstrating responses across training years, as stated in the paper, this was submitted although entirely appropriate editorial constraints prevented its inclusion within the published article. Should Avis and Mutimer wish, this information can be made available to them.

Training is in a state of flux. Whilst objective measures of participation in operations are of value, we ignore subjective assessments of trainee confidence, exposure and ability to manage cases at our peril. As stated, their inclusion alongside existing logbook data will enhance the assessment of training.