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## Training Surgeons

The Joint Committee on Higher Surgical Training has recently produced its second report,<sup>1</sup> which brings up to date the details of the scheme published in 1968<sup>2</sup> to "assist those who wish to obtain specialist surgical experience and training in the most expeditious and effective manner."

Though there has been more progress in some specialties than in others, it has been substantial in all, and indeed in orthopaedic surgery, paediatric surgery, and urology training programmes have already been inspected and approved at several centres in Britain. The visits of the specialist advisory committees to various centres have not only succeeded in clarifying doubts and dispelling anxieties but have often improved the organization of the actual training programmes themselves. A further important development is the spirit of collaboration that has arisen between the four Royal Surgical Colleges in the British Isles, the Association of Professors of Surgery, and the nine specialist surgical associations. The joint committee rightly regards this aspect of its work as being of great value for the future, eventually culminating in each branch of the surgical profession being able to speak with one voice on postgraduate educational policies, a hope that most consultant surgeons will endorse. For the sooner we have a unified system of training throughout the British Isles the better.

The joint committee has rightly emphasized several important points over which there had been considerable anxiety. In particular it stresses that the training programmes must remain adaptable to the individual trainees' needs. Many surgeons will also welcome the assurance that the committee appreciates the importance of relating the number of training posts and programmes to the career structure, both present and future. Nevertheless, while the intention of the various specialist advisory committees to maintain an individual relationship with the trainee and supervise his progress is laudable, and may be possible for the smaller specialties, it is difficult to see how a centrally based committee could adequately supervise the individual careers of the 138 general senior surgical registrars now in training. Indeed, since most areas of Britain have excellent senior registrar committees specifically for this purpose, it might be asked why the joint committee should attempt this function.

While the Fellowship requirements of the four royal colleges vary in some particulars they all demand four years' experience after qualification, much of which must be

spent in surgical training posts specifically approved by the colleges for this purpose. After obtaining the Fellowship the trainee must spend a further three to four years in training, and for these training posts the committee has defined three clear aims. The first is to designate those posts which provide the proper degree of experience and opportunity for study and research required by a potential consultant. The second is to establish a continuing relationship with each individual trainee specialist throughout his higher specialist training. And the third is to grant a certificate of specialist training without further examination to every trainee specialist who has satisfactorily completed a programme previously approved by the joint committee. In itself this certificate of higher specialist training cannot be a clear guarantee of immediate consultant grading. Nevertheless it will represent a clear recognition of the candidate's eligibility for consultant appointment.

Evidently considerable effort, thought, and organization have been required to achieve the substantial progress made in the past two years, and most surgeons will approve the steps that have been taken. It is particularly important that an attempt has been made to consider the requirements of surgeons throughout the country as a whole rather than those of a few confined to the larger centres.

Though the report will be generally welcomed many of the difficulties raised previously<sup>3</sup> still remain. Thus some detailed proposals about the career prospects would have been welcome, for the present situation is still most unsatisfactory. In September 1965<sup>4</sup> only two of the 865 consultants in general surgery were below the age of 35 and only 55 (or about 6%) below the age of 40. By September 1969 the number of consultants had increased to 886.<sup>5</sup> Seven of these were under 35 and 78 (or almost 9%) under 40. By September 1970 the number had risen to 897.<sup>6</sup> Thus, though some improvement had occurred, it was certainly meagre. Moreover, the report of the Godber working party<sup>7</sup> showed clearly that the average age at first appointment to consultant posts in England and Wales in the years 1963-7 had remained virtually static at 38.5. Though the figures for the 447 new consultants appointed between 1966 and 1967 showed that 65% were below 40, this figure gives an erroneous impression because it includes specialties such as otolaryngology, anaesthesia, and radiology, in which consultants are traditionally appointed much younger than in general medicine and surgery. The oppor-

tunities for surgical consultants have therefore changed little in the past quinquennium.

Similarly, with regard to the senior registrar grade in general surgery, again there has been only small improvement. The average age of the senior registrar group has decreased considerably, and parity has almost been established between the number of senior registrars completing training and the number of consultant vacancies available each year. This is certainly a step in the right direction, but there has been no appreciable increase in the number of senior registrars completing training each year or in the number of new consultant posts available. On the other hand no attempt whatsoever has been made to deal with the registrar problem, to which we drew attention three years ago.<sup>3</sup> In 1965 there were 626 general surgical registrars competing for 153 senior registrar posts and in 1970 there were 644 surgical registrars competing for 138 senior registrar posts. Thus probably at present there are five middle-grade registrars in post for every senior surgical registrar—clearly a situation which cannot be allowed to continue. Further progress cannot be made unless the number of registrar training posts is substantially reduced and related to the 46 or so vacancies occurring each year in the senior registrar establishment. These proposals are inextricably linked with those of coping with the work load and the service commitment to patients, especially in the district hospitals. The present proposals for an appreciable increase in the number of surgical consultants will, in part, help to rectify this, but it is also vital that a realistic career structure should be devised if the present anxieties of the hospital junior staff are to be allayed.

What has been achieved for the senior registrar grade now needs to be attempted for the registrar grade, and the Joint Committee for Higher Surgical Training and other interested bodies should consider this urgently. The gentle breeze we noted in 1968 continues to blow in the field of postgraduate surgical education. But it is not yet a wind of change, and furthermore not all the nodes it has produced are those of acquiescence.

<sup>1</sup> Joint Committee for Higher Surgical Training, *Second Report*. London, Royal College of Surgeons of England, 1971.

<sup>2</sup> Joint Committee for Higher Surgical Training, *Report*. London, Royal College of Surgeons of England, 1968.

<sup>3</sup> *British Medical Journal*, 1968, 4, 401.

<sup>4</sup> *Lancet*, 1966, 2, 1456.

<sup>5</sup> *Lancet*, 1970, 1, 944.

<sup>6</sup> *Health Trends*, London, H.M.S.O., 1971

<sup>7</sup> Department of Health and Social Security and Department of Health for Scotland, *The Responsibilities of the Consultant Grade*. London, H.M.S.O., 1969.

## Non-rheumatic Myopericarditis

Acute rheumatic carditis may be in danger of passing unrecognized as the classical form of rheumatic fever becomes rarer. In elderly patients, especially, bacterial endocarditis may likewise remain undiagnosed until irreversible cardiac damage ensues. The report of the Rheumatic Fever Working Party<sup>1</sup> clearly showed that the long-term effects of rheumatic carditis are closely related to the degree of cardiac damage at the time of initial diagnosis and treatment. That early recognition affects the long-term prognosis in other forms of myocarditis is probably also true. Though diphtheritic and Fiedler's<sup>2</sup> (idiopathic or isolated) myocarditis were recognized

in the past, "myocarditis" on its own was long considered a questionable diagnosis reached as a last resort.

It is only rather recently that the large number of potential causes of myocarditis have been appreciated. They include toxic substances—such as emetine and alcohol—bacteria, spirochaetes, rickettsiae, fungi, parasites, and viruses, and autoimmune reactions. However, in most of these conditions the generalized systemic reaction or disease dominates the clinical picture and the cardiac symptoms are of minor importance.

Such causes of myocarditis were initially identified from necropsy studies.<sup>3</sup> Overt clinical disease is usually rare in the acute stage, but advances in laboratory techniques have allowed viruses in particular to be more frequently recognized. Laboratory diagnosis is based on culture from faeces and sputum and from changing antibody titres to a specific virus. Poliomyelitis virus has been cultured from heart muscle. Though many viral illnesses have been associated with the occasional case of myocarditis (including psittacosis, measles, mumps, variola, vaccinia, and infectious mononucleosis), the most commonly involved are the Coxsackie viruses. These are divided into groups A and B (with a number of subgroups) according to the pattern of disease they induce in suckling mice.

Coxsackie B can induce pericarditis, myocarditis, and meningitis in man. As well as causing Bornholm disease (or epidemic pleurodynia) it is responsible for some cases of "acute benign pericarditis." A report from Colindale in 1967<sup>4</sup> on 1,160 Coxsackie B5 infections noted that 31% had meningeal symptoms, 23% myalgia or Bornholm disease, 15% respiratory disease, and 5% cardiac involvement (with two deaths). W. G. Smith<sup>5</sup> reported 10 adult cases of Coxsackie B myocarditis, with seven complete recoveries. Most previous reports of this condition from newborn babies and infants had shown a far gloomier prognosis.<sup>6</sup> T. W. Mattingley<sup>7</sup> also noted this difference between the high infant and low adult mortality from this disease.

In many epidemics, largely affecting adults, electrocardiographic changes have indicated myopericarditis.<sup>8</sup> Between 5 and 12% of patients have been affected.<sup>9</sup> G. S. Sainani<sup>10</sup> suggested that some of the patients might end up with chronic cardiac lesions, but the frequency with which acute attacks progress to chronic heart disease remains unknown. J. F. Goodwin<sup>11</sup> reported a follow-up of 74 patients with "primary congestive cardiomyopathy," of whom 55% had died. In some of these cases alcohol, and in others infection, may have caused the heart condition. E. N. Silber<sup>12</sup> reported cases associated with respiratory infections, some of influenzal origin, and recorded their subsequent course as acutely fatal, acute with recovery, subacute with recovery, or chronic with late death.

The clinical presentation of such patients has often been delayed and so recognized only at an advanced phase of cardiac dysfunction, usually when the patient has frank pulmonary oedema or congestive failure. When recognition was so late the prognosis was poor. J. P. Segal and colleagues<sup>13</sup> reviewed 159 cases of "idiopathic" myocarditis and noted certain earlier signs—conduction disturbance and dysrhythmias, particularly ectopic beats and atrial fibrillation. On radiography the size of heart was usually but not always shown to be increased. Auscultation might disclose a pericardial rub, an atrial triple rhythm, or summation gallop. Most authors agree that E.C.G. changes are nonspecific, with changes in S-T and T waves predominating. Most forms of myocarditis, like the cardiomyopathies, are apt to give rise to mural thromboses, leading to the risks of systemic or pulmonary emboli, and these may even be the presenting complaint.