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Certification of Higher Surgical Training

SIR,—It has been decided that graduates intending to become consultants should obtain a certificate of specialist training and education. To implement this the Royal College of Surgeons and the Association of Surgeons have set up a Joint Committee on Higher Surgical Training (J.C.H.S.T.) and a number of specialist advisory committees for each subspecialty. Over the past two years these committees have been reviewing the present state of surgical training. Throughout this discussion period those involved in the existing training programmes have stressed the need for flexibility and variety in schemes and training posts for obvious reasons. We want to train individuals to develop their maximum potential. No trainee is like another, just as no two jobs, teachers, or hospitals are similar. This is the strength of British surgery. The trainee does not spend all his apprenticeship in one hospital as the American resident does; he moves around, finds the job best suited to his requirements and personality, and so gets a broad appreciation of the specialty and its practitioners.

Having decided upon the curriculum, the Specialist Advisory Committee in General Surgery has set as its next task the inspection of posts. It has moved from debate to action. In the wake of inspection has come documentation with recognition of some posts and rejection of others. There is no doubt that the act of inspection has stimulated improvements in the quality of a number of posts, but the rejection of some posts or the limitation of their use to short periods of time is restricting the freedom of choice of the individual trainee and negating the assurances that maximum freedom of choice would be encouraged.

Different men have different needs—for example, a young man who has spent most of his pre-Fellowship time in a busy gen-

eral hospital may best be trained after Fellowship by spending all his time in a teaching hospital. Similarly five gastrectomies done under close consultant supervision may be of far more value to one man than 50 done with little supervision. It is essential to maintain a complete variety of posts, without restrictions, so that the trainee can put together the training he thinks will make him suitable for the type of post he will ultimately seek. The quality of our surgeons has been maintained over the years by this facility. When a man completes one job, which has given good experience in one sphere but was deficient in another, he seeks a post which will fill the gap in his experience, but it is becoming apparent that posts which have deficiencies will not be acceptable to the J.C.H.S.T.

If we accept that our trainees are adult, sensible, and intelligent men who know what they are doing and where they want to go, we should allow them to choose their own training. The certifying committee should abandon the idea of recognized posts and award their certificate when the trainee believes he is prepared, after receiving a detailed report from trainee and trainers. If there are any serious deficiencies in the trainees' submission this could be pointed out and arrangements made to rectify it. Such a system would need general guidelines concerning the type and length of training the committee think is ideal, but this need not be binding on any individual and each man would be considered separately. Some men might achieve certification earlier than others and the competitive spirit would be maintained.

Though such a system would not need formal recognition of posts, a description of each job should be prepared after a

careful inspection so that both trainer and trainee know what they have to offer. The abolition of formal recognition of posts would also avert a hitherto little discussed problem. Should the trainee relinquish his recognized post, once certified, to make way for new trainees? Few will want to move to other posts at this stage unless such a move produces a higher salary and rapid promotion to consultant status.

Before writing an accurate assessment of a job it must be studied carefully. This takes time and local knowledge and we believe that this should be done by the local postgraduate committees that already exist in the regions. These committees could also undertake the responsibility of reviewing a candidate's submission for higher certification—passing it to the central committee for formal approval if acceptable or guidance in difficult cases. There would have to be occasional spot checks by the central committee to maintain uniform standards throughout the country, but most of the work would be done at a regional level by the men who know the jobs and the trainees.

It is impractical for the J.C.H.S.T. to say that they will consider any individual's proposed career plan as a special case, because our present appointments system prevents the arrangement of long-term programmes, except within the tenure of a single appointment. Although the degree of competition for senior posts is too great, we have not met any registrars who believe that the present element of competition at each stage should be eliminated. It is this competition and particularly the efficacy of the selection committees at consultant level that has ensured that new consultants are properly trained and suitable for their particular appointment. This most effective system should not be altered in any way.

One final plea. The absence of a timetable for the introduction of higher specialist

certification is causing our registrars great concern. The J.C.H.S.T. should announce a date when certification will be required by consultant appointment committee. If inspection takes another year it would be reasonable to expect all men to obtain a certificate from 1977. Before this date appointment committees should take no account of the scheme. Men beginning their post-Fellowship training in 1974 will then know that their training will have to satisfy the J.C.H.S.T.—We are, etc.,

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Confidentiality

SIR,—The letter of Mr. R. R. L. Pryer (14 July, p. 104) raised some extremely important issues. There are really four inter-related questions that require examination. Are the data entered into the systems indicated by Mr Pryer of value even without full identification particulars of individual patients? Does the addition of identification particulars increase the value of the data? Can the costs of such systems be justified within the overall expenditure of the health service? If the answer is yes to the first three questions, can confidentiality be safeguarded?

Information systems can be of use in patient care, in management of the health service including planning, and in research. It is difficult to see how a system without patient identification can be of any value for patient care; the addition of identification particulars can, however, assist in such procedures as scheduling patients through repeat contact (for example, using systems initiated by the input of birth notification to control immunization programmes or the follow-up of individual patients where long-term surveillance is required). Increasing use is being made of information in the general field of administration of the health services; this information is used both as part of the general management process, and also to assist with the long-term planning. A number of authors¹⁻³ have indicated the value of using such data where cumulative patient files are available. These enable true indices of lengths of stay and readmission rate to be obtained. Only when such indices are available from cumulative files is it possible to obtain a true picture of the functioning of the health service; this is preferable to the biased view that can be obtained from event-type data, which is all that is available in the absence of identification particulars. In this situation the provision of identification particulars enables the cumulative data to be assembled on the computer file, but also provides a check on the accuracy which is greatly needed. For example, with cancer registration, where input of data may occur from a number of hospitals providing treatment for a patient, the availability of full identification particulars enables duplicate entries to be identified and adjustment of the statistics to be made. Acheson⁴ has shown after a relatively few years' experience with the Oxford Record Linkage Study how the assembly of cumulative files (using the linked data) can be of consider-

able value for clinical, epidemiological, and genetic research. He clearly indicated that such studies could not be achieved without the provision of identification particulars sufficient to bring together on the cumulative file the repeat events occurring to an individual.

There has been a gradually increasing demand for the use of information in the fields indicated above; however, it is important to bear in mind the costs of these information systems. The conversion of the basic event-type data to cumulative files linked by identification particulars adds only a small proportion to the cost of the system, but adds greatly to the uses to which the material may be put. It is thus suggested that the cumulative data can more readily be justified than a continued collection of event-type data without identification particulars of individuals.

It appears therefore that the essential question that requires resolution concerns the ability to safeguard the confidentiality of information in such systems. One must consider the protection of these data during collection, processing, and distribution of the analyses from the system. It is relatively easy to arrange for strict security of the data on collection and processing, though there is always the need to review the arrangements made. As far as the distribution of the analyses are concerned, this can be considered in relation to the classes of information to be released, and the categories of users. A lot of the output from such systems is tabular in nature and poses no threat whatsoever to confidentiality. Some investigators will, however, request release of unit numbers in order to provide access to patient records. Each specific study must be considered by appropriate representatives of the medical profession, depending on the level at which the study is to take place. This may involve contacting consultants whose patients are involved; it may be appropriate to draw the study to the attention and obtain approval of a division of a Cogwheel system, a medical executive committee, the research subcommittee or medical advisory committee to a regional board, or at national level the Ethical Committee of the B.M.A. In addition to obtaining approval for the study in principle the individual consultants whose patient records are to be studied should each be approached. Some research workers will desire to contact individual patients, in addition to the foregoing procedure the permission of the family doctor concerned and of the individual patient should be obtained before the research worker contacts the patient. As was emphasized by the recent statement from the Medical Research Council,⁵ no undue pressure should be brought to bear upon an individual patient to participate in such a study.

The questions mentioned in the beginning of this letter are easy to pose but difficult to answer, either in a short letter or a lengthy article. The above points just indicate the general approach that should be made to safeguard confidentiality on this important issue. It is essential, as Mr. Pryer suggests, that the system and the safeguards should be spelled out, and representatives of the profession should agree that these are satisfactory. Review

of the precautions should be periodically undertaken, and the system and its operation should be open to inspection. It is suggested that only where an individual patient is to be contacted by a research worker should the patient's written permission for this be obtained. For a number of the systems it might even jeopardize patient wellbeing to obtain written permission for entry of these data into the information system; for instance, where information is required for entry into the national cancer registration scheme it would pose major problems if written permission for this to occur had to be obtained from the patient.—I am, etc.,

M. R. ALDERSON

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Winchester

- 1 Alderson, M. R., *Health and Social Service Journal*, 1973, 83, 1524.
- 2 Bispham, K., Thorne, S., Holland, W. W., in *Challenges for Change*, ed. G. McLachlan, London Oxford University Press, 1971.
- 3 Rowe, R. G., and Brewer, W., *Hospital Activity Analysis*, London, Butterworths, 1972.
- 4 Acheson, E. D., *Medical Record Linkage*, London, Oxford University Press, 1967.
- 5 Medical Research Council, *British Medical Journal*, 1973, 1, 213.

SIR.—Mr. R. R. L. Pryer (14 July, p. 104) is to be congratulated on his stand over confidentiality. In my experience patients are already suffering from unethical disclosure of medical information. Loss of confidentiality is an inevitable consequence of our state N.H.S., which reeks of totalitarianism.—I am, etc.,

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Prophylactic Antibiotics in Caesarean Section

SIR,—While approving of the note of caution in your leading article (23 June, p. 675) about the possibility of breeding existing organisms selectively by antibiotic prophylaxis, I wonder whether you have not been guilty of some wishful thinking. You say: "Many hospitals have introduced an antibiotic policy controlled by an infection officer. This has often been conspicuously successful in reducing the emergence of antibiotic-resistant bacteria." There are many of us who would be glad to have clear published evidence for the success of such policies, but so far as I know there is not much available.—I am, etc.,

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Bone Disease in End-stage Renal Failure

SIR,—The results reported by Dr. Joan P. Ingham and others (30 June, p. 745) concerning the incidence of osteoporosis, osteomalacia, and osteitis fibrosa in end-stage renal failure are interesting, but one wonders how meaningful they are.

The high incidence of osteoporosis (11 out of 46 patients) is surprising and is presumably partly due to the fact that osteoporosis was diagnosed when the total bone index was 21.8% or less in males and 16.7% or less in females. These figures were apparently based upon findings in a limited number of control subjects, and other workers in