confirmed oedema of the laryngeal wall and the epiglottis, particularly at the level of the hyoid bone, but no fractures were seen. On completion of the orthopaedic procedure, direct laryngoscopy was performed showing complete regression of the oedema and the patient’s trachea was extubated. During postoperative interview the patient agreed to have felt somewhat hoarse on the evening following the traffic accident.

Seatbelts save lives and are effective in reducing the severity of non-fatal injuries but new patterns of injury, including subclavian artery laceration and carotid artery dissection, have been recognized. Linear ecchymosis of the abdominal wall (a positive ‘seatbelt sign’) as a result of wearing a lap belt increases the risk of intestinal and other occult injury. In the present case, the restraining effect of the lap-shoulder belt prevented severe direct laryngeal trauma by contact with the steering wheel or dash board. However, ironically, it led to the linear ecchymosis across the right shoulder and laryngeal oedema was observed.

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ALS training

Editor—Turley and colleagues have highlighted a well-known problem. By completing a 2- or 3-day course on Advanced Life Support (ALS), one cannot expect to retain the skills learned unless you have the opportunity to practice, and this in turn would depend on the area of one’s clinical practice. One of their recommendations, to make ALS training compulsory before granting full registration, is worrying. Not having a current ALS certificate does not necessarily mean that you are an incompetent doctor. Resuscitation is only a small part of patient care. It is not only trainees who should be competent in ALS, but any doctor who is registered to practice.

As mentioned in the letter, there is the obvious problem of funding for provision of ALS for every doctor, which needs to be addressed. A Resuscitation Council approved course costs about £400 per person. What we need is a tailored version of the ALS training. This can be carried out locally with every hospital having their own dedicated resuscitation training officer and a pool of ALS instructors as well. These resources could be used to provide a half-day training every few months for doctors who are not exposed to regular CPR scenarios. This would help to retain skills and reduce the funding problem at the same time.

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Training intensity and consultant support: the Canadian experience

We enjoyed the recent editorial and accompanying article on training of anaesthetists in the UK. The UK anaesthesia training system has traditionally relied on a long apprenticeship with a large volume of cases from which to draw experience by the time of appointment to consultant grade. In the last few years the reduction in both length of training and number of hours worked has resulted in a reduction in caseload. A system that previously relied on volume and duration of training for success is now being undermined.

The Canadian training system differs because, although only 5 yr of residency training are completed, the intensity of teaching both in theatre and by tutorial is much higher than in the UK. For example although Underwood and McIndoe demonstrate that, in Bristol, SHOs are accompanied by a consultant or SpR in 50% of cases in 2004–05, in most Canadian institutions junior anaesthesia trainees will be supervised for all lists by a consultant. Even senior trainees will be accompanied much more than the 40–50% demonstrated.

In addition, daily tutorials and weekly half-day seminar sessions further increase the amount of teaching received. The European Working Time Directive has yet to reach Canada and trainees still work 60–70 h per week for 48 weeks per year. Once Canadian trainees have completed their residency and the Royal College exit exam is passed (FRCPC) they enter consultant practice. In most Canadian
hospitals an informal system of support exists that allows the new consultant to obtain advice and assistance from more senior colleagues if required. This is expected of new consultants and is not felt to indicate lack of confidence or ability. Indeed this culture of teamwork facilitates sharing of knowledge at all levels of seniority. In this way, although volume of cases may not have been achieved by completion of training, the Canadian consultant will have been actively taught during the cases he/she has performed and also will have a support system in place for advice and assistance if required.

Greaves assumes that, although new consultants are less experienced, they are also less confident. In fact, in working in our two institutions over the last few years we have seen a number of fellows who have completed training and appear overconfident despite clear lack of experience. This is certainly a more dangerous scenario than the consultant who lacks both experience and confidence and may be more likely to seek help if available.

In summary, the excellent system for training anaesthetists in the UK is being undermined by reduction in caseload and hours of training. We agree that increases in active teaching as well as a culture that supports new consultants has worked well in Canadian practice and may be required if quality of training is to be maintained.

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