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Training in obstetrics

SIR,—The meeting on recruitment in obstetrics and gynaecology reported by Susan M Blunt attracted a biased group of doctors, largely intent on achieving consultant status.¹ It was hardly surprising that we concentrated on the need for consultant expansion in addressing the need for more manpower. The terms associate specialist and clinical assistant were virtually unheard.

As a profession with a pyramidal hierarchy, medicine must be unique in training all those at the base to expect to rise to the apex and to make practically no provision for any to stay at an intermediate level. It would seem ridiculous if all bank employees expected to become a manager. Can we in medicine be so blinkered as to ignore the valuable resource of those we train who may not wish to climb the pyramid with the inherent risk of falling off? What is it about consultancy that we all want? Not the hours spent in administration, the nights on call, or the remoteness from clinical practice. Perhaps it is status. Doctors are trained to need the respect of the public and their peers and to believe that, in hospital medicine, consultancy is the only way to achieve this.

If we are to attract doctors back into our specialty, and keep them, perhaps we should expand the non-consultant permanent posts and promote them to the ranks of respectability. Or are we such hostages to the need for power that the practice of obstetrics and gynaecology ceases to be sufficiently exciting and challenging in itself?

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- 1 Blunt SM. Training in obstetrics. *BMJ* 1991;303:1416. (7 December.)

More oncologists, please

SIR,—In his plea for more radiotherapists Jeffrey Tobias raised the difficult question of how best to organise the nation's cancer services in the future.¹ He points out the rise in referral rates for radiotherapy and contrasts this with the static number of consultant radiotherapists. By his own admission, clinical oncology has become more diverse with increasingly complex chemotherapy regimens, the development of palliative care, and the need for support services. This has been reflected by the development of medical oncology and palliative care as separate specialties. His suggested solution, however, of more radiotherapists to provide comprehensive cancer care fails to recognise this growing diversification.

Let us take Tobias's example of breast cancer. The past decade has seen the move away from radical surgery to conservative surgery plus radiotherapy. Recently, however, adjuvant chemotherapy has been shown to confer a survival benefit on many patients with breast cancer.² A recent study showed that adjuvant chemotherapy for Dukes's C colonic carcinoma also confers a survival benefit.³ Development of chemotherapy regimens which confer survival benefit is likely to lead to a large increase in the use of adjuvant chemotherapy in the next decade. The number of medical oncologists has remained static in Britain over the past 10 years. Not only are more medical oncologists needed but these posts should be created in many more regions across the country to provide a uniform service.

The future planning of cancer services should reflect trends in treatment and not only appoint more radiotherapists but also build up the developing specialties of medical oncology and palliative care. An integrated national service with all three specialties working together would provide more comprehensive cancer care.

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- 1 Tobias J. More radiotherapists, please. *BMJ* 1991;303:1085-6. (2 November.)
2 Early Breast Cancer Trialists' Collaborative Group. *Treatment of early breast cancer*. Oxford: Oxford University Press, 1990.
3 Moertel CG, Fleming TR, MacDonald JS, Halter DG, Lawrie JA, Goodman PJ, et al. Levamisole and fluorouracil for adjuvant therapy of resected colon carcinoma. *N Engl J Med* 1990;322:352-8.

Parent support groups

SIR,—The editorial by J V Leonard is timely and factual but the subheading—"doctors should work closely with them"—was somewhat misleading as the text discussed only the important aspect of doctors listening to parents and patients.¹ Parent support groups can be a negative influence if professionals are not involved in monitoring the activities. In the same issue the personal view by A Gerrard describes a family that gained in a positive way from the experiences and problems of having a child with a serious metabolic disorder,² and those of us working with families of children with chronic disease have had all the advantage of learning from such encounters. Some families, however, see their problems in a very negative light and remain bitter and angry—unfortunately these families may become very influential in parent groups and are detrimental to parents of newly diagnosed children. Unless professionals are on hand to detect, help, and direct the energies of such people, they can taint and reduce the effectiveness of the group support.

Parents can and do teach professionals and they make powerful allies if they see themselves as such. If they are adversarial their impact will be of greater detriment to fellow families than to professionals and it is our duty to prevent this.

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- 1 Leonard JV. Parent support groups. *BMJ* 1991;303:1152. (9 November.)
2 Gerrard A. We have a metabolic disease. *BMJ* 1991;303:1208. (9 November.)

General practitioners awareness of COSHH regulations

SIR,—R A Cooke and colleagues' comments on general practitioner's knowledge of the Control of Substances Hazardous to Health (COSHH) regulations is borne out by my similar study undertaken last year but extended to assess knowledge of the law relating to health and safety rather than just COSHH.

A questionnaire was distributed to 86 general practitioners attending a research meeting of the Royal College of General Practitioners in Birmingham on November 1990. A total of 52 (60%) were returned from the attendees, of whom all held either the MRCGP or the FRCGP. Forty one (79%) of those who completed the questionnaire recognised that if a member of their staff had an accident which resulted in a fractured ulna then

it should be reported, but only one correctly stated that the accident should be reported under RIDDOR (Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations) to the Health and Safety Executive. No general practitioner correctly recognised that an accident to a member of staff resulting in a five day absence for a bruised foot without bones being broken was also reportable under the same regulations.

Although 47 general practitioners worked in practices with more than five employees, only 25 (53%) had a written safety policy as required under the Health and Safety at Work Act 1974, and only 24 (46%) displayed a notice or gave out a leaflet outlining basic health and safety arrangements as required under the same act.

Procedures to account for staff in the event of a fire on practice premises and guidance on the management of a sharps injury were present in 62% (32) and 73% (38) of practices respectively.

Turning to COSHH, 23 (44%) general practitioners had heard of the regulations, compared with 59% in Cooke *et al*'s study, but only nine (17%) had undertaken any assessments.

As in Cooke *et al*'s study the survey yielded a poor response rate but those who did reply did not seem to be aware of the requirements of the Health and Safety at Work Act or the need to report specific types of workplace accident.

Health and safety legislation is increasing in volume with the consultative documents on visual display units and manual handling being released next year, both of which will affect all employers including general practitioners. Cooke *et al* have already suggested where guidance can be obtained, but inclusion of health and safety law in trainee and postgraduate education could also be of benefit.

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4 Health and Safety at Work Act 1974. London: HMSO, 1974.

Unemployment rates: an alternative to the Jarman index?

SIR,—Brian Jarman comments on the advantages of using unemployment as a measure of deprivation.¹ We wish to respond to what he perceives to be the drawbacks of the unemployment variable.

He points out that unemployment applies only to the economically active population and does not count children and elderly people. This is to miss the point somewhat. In our study we used the unemployment rate as a proxy for deprivation in a geographical community.² It was used in a population context. There was no requirement to count subjects at risk or any implication that the link between unemployment and ill health is necessarily causal. What was shown was a strong correlation between high unemployment rates and high morbidity for the population as a whole, at small area level. The association demonstrably applies to children and elderly people. Despite the inclusion of the lone elderly variable in the Jarman index the correlation with rates of admission to hospital in those aged over 75 was stronger with unemployment in each of the years 1981, 1985, and 1990 than with the Jarman index. The differential was even greater for admission rates in those aged under 15, with an R value of 0.769 with the unemployment rate in 1990 compared with 0.494 with the Jarman index.

Though we accept Jarman's point that constructing the denominator at electoral ward level is

difficult, some county councils routinely produce unemployment rates to this level. We used these rates and showed their association with morbidity. The main issue in respect of the denominator is not that it is difficult to construct but that if comparisons are to be made between localities care needs to be taken to ensure that the method of construction is consistent.

Jarman points out that his index was developed as a measure of general practitioners' opinion of what influenced their workload. If that was all the index purported to measure we would have no quarrel with it. He goes on to say, however, that the objective in developing the measure was to concentrate general practice resources more into underprivileged areas. The assumption that general practitioners' opinion of their workload equates with underprivilege in a locality is a great leap.

Our reason for carrying out our study was health authorities' increasing use of the Jarman index as a measure of deprivation influencing their allocation of resources. It is not clear from his letter whether Jarman agrees that this use of the Jarman index is inappropriate.

We agree with Jarman that this issue is not an academic exercise and has real implications for resource allocation. We disagree with his view that the index used is less important.³ It is important that the appropriate measure is used in the appropriate context. This makes a real difference to resource distribution.⁴

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RCGP approaches 40

SIR,—In his editorial celebrating the fortieth anniversary of the Royal College of General Practitioners Andrew P Haines refers briefly to the need for the college to widen its horizons beyond the United Kingdom.¹ The international committee has the remit: "To promote health care internationally..." Several current activities support this remit, including the appointment of fellows, of whom there are currently four assisting governments and general practitioner bodies in Kuwait, Malta, Portugal, and Saudi Arabia to develop systems of primary care appropriate to the country's needs.

The college has responded to requests from the World Health Organisation, the Department of Health, and the British Council to advise and give practical assistance to several central and eastern European countries that are attempting to re-orientate their systems of primary health care. This month a conference entitled "General Practice in the New Europe" was held at the college.

The college is supporting Action in International Medicine in establishing district health systems in Third World countries and is also helping the Voluntary Service Organisation to promote its work in underdeveloped countries. Through international scholarships the college has supported general practitioner exchanges and assistance to and from developed and underdeveloped countries in all parts of the world.

Many governments are looking to Britain for advice and assistance in the provision of a cost effective and appropriate system of primary health

care. I believe that the college can help. Its members have much to offer and much to learn from international activities.

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1 Haines AP. The RCGP approaches 40. *BMJ* 1991;303:1213-4. (16 November.)

Special representative meeting and the political process

SIR,—The pussyfoot approach is about as effective in medical politics as treating appendicitis by fanning the umbilicus with a wet straw hat.

Having been elected in accordance with the Trade Union Act of 1984, the BMA's council has decided to hold a special representative meeting next year.¹ This will inform the public of the effects of last spring's drastic changes in the NHS, but there are now signs of an attempt to reverse that decision. Tony Keable-Elliott fears that a special representative meeting "will involve the BMA in taking a political stance" and that unpleasant consequences will follow.²

Fears of being accused of taking a political stance did not noticeably inhibit the BMA from expressing the profession's opinion in the days of David Lloyd George (Liberal), Aneurin Bevan (Labour), Dennis Vosper (Conservative), Kenneth Robinson (Labour), Richard Crossman (Labour), Barbara Castle (Labour), and Kenneth Clarke (Conservative). It is difficult to work out why anyone would wish to suppress information that only the profession can provide, particularly in respect of the quality of the care that the public receives.

Doctors are in a unique position to observe the work of the NHS, seeing the effects of both success and failure on each patient. Over the past few months they have also seen the results of administrative change on the patient, on the organisation and efficiency of the service, and, much more importantly, on the effectiveness of the service. Doctors, both individually and collectively, have a compelling duty to report, accurately and explicitly, their observations to the public.

Recently antipathetic sections of the press have made one or two attempts to accuse the BMA of misrepresenting its members' views. This accusation falls flat in the light of the BMA's democratic structure even if there is not going to be a referendum. Every member has the right (and, dare I say, duty) to provide his or her representative with facts, figures, observations, and opinions; the representatives can then speak and vote accordingly.

The council should have the moral courage to avoid the pussyfoot approach, eschew vacillation, and stick to its decision.

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1 Beecham L. Chairman of council meets the PM. *BMJ* 1991;303:928. (12 October.)

2 Keable-Elliott T. Special representatives meeting and the political process. *BMJ* 1991;303:997. (19 October.)

Behind the speaker

SIR,—The late Professor Dick Scott would surely have warned to Tony Smith's remarks on the art of lecturing.¹ Scott, the first person in the world to hold a chair of general practice and himself never entirely at ease on the podium, would often proffer the following advice to would be speakers. "If you're asked to speak for an hour you could probably manage at a pinch with two or three

days preparation. For a half hour lecture you would need at least a couple of weeks' notice to be on the safe side; for a 15 minute talk a month is required—and if anyone ever asks you to speak for a shorter time than that, refuse."

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1 Smith T. Behind the speaker. *BMJ* 1991;303:1207. (9 November.)

The health of Europe

SIR,—The successful negotiation of a new European treaty at Maastricht last month marks another important step in the creation of (in the words of the treaty), "an ever closer union among the peoples of Europe."

It also ushered in a new period in cooperation between the 12 member states of the European Community in health matters. The treaty contains a new chapter on public health in which the 12 commit themselves to cooperate and to coordinate their policies and programmes to prevent disease, particularly the major health scourges, including drug dependence. I warmly welcome this development.

This is not an entirely new departure. For some years the community, with the strong support of the United Kingdom, has implemented health programmes, including those on AIDS and cancer and projects to help the elderly. But this has been done on an ad hoc, uncoordinated basis. The new treaty chapter provides an opportunity for member states to develop a framework within which they can help each other through sharing ideas, exchanging scientific information, providing early warnings of the outbreak of disease, and implementing concerted efforts to inform the people of Europe how they can promote their own health and wellbeing.

This does not, of course, mean that member states will no longer remain free to pursue their own policies. They will—but through coordination of their efforts; and the European Commission will have the role of promoting closer relations between member states. Together states should be able to achieve more than they can separately. Indeed, it should be a test of the value of any community activity that it achieves more than member states can on their own.

Nor does the enhanced role of the community mean that member states will have to tailor their health care systems to a European blueprint. European health care systems are richly diverse, and each country rightly values the benefits of its own system. The public health chapter therefore excludes any power to harmonise the laws and regulations of member states, so the funding and structure of the NHS will not be altered by the treaty.

In responding to the new health chapter the community needs to recognise that other international organisations of which the United Kingdom is an active member, especially the World Health Organisation, have a record of achievement in international health. The community should build on and complement those achievements—not seek to duplicate them. For that reason the United Kingdom pressed for and obtained a provision in the health chapter that the community should foster cooperation with international organisations working in public health.

The treaty signed at Maastricht offers an important opportunity for all of us in the community to develop an effective framework for cooperating in public health between member states, supported by the European Commission. I look forward to the United Kingdom playing its full part.

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