Advertisement manager

The advertisement manager is the unsung hero of the production team—without his efforts, the whole show would not be possible. Regrettably, however, it is not a popular job and this is because people imagine that it involves many hours of letter writing, often with little result. But the job can be rewarding and fruitful, and drudgery can be kept to a minimum if the right techniques are used. Letter writing can be dispensed with for selling advertising space, and the telephone used instead. The telephone is the most efficient way of selling advertising space—in our experience it has a success rate of over 50% as compared to 10% for letters.

When you are on the phone, try to put yourself in the shoes of the man on the other end of the line. What information would convince him that it would be a good idea to take an ad? The readership, for example. If a few copies of your magazine lie about hospital reading rooms then you would be justified in saying that your magazine is “widely read by doctors.”

You should always try to present your magazine as favourably as possible, even if you do have to exaggerate somewhat, and if your magazine is still of poor quality then you should try to avoid showing a copy—you can do this if you sell space by phone. Advertisers are more interested in taking space if their product is in some way connected with features in the magazine. If you have a motoring section, for example, dealers will probably be delighted to take ads if you ask them to supply road-test cars. If there's an annual ball coming up soon, try to get a clothes-hire service to advertise, and if you've got a book review section you should have little difficulty in attracting medical publishers.

The main complaint of student editors is that no one will write articles. There are several ways of getting round this problem. First of all, get as many regular features as possible. If someone writes a particularly good piece for one issue, make it into a regular feature. Regular features, once established, almost seem to write themselves and the editor need only send timely reminders as the copy date approaches. These regular features should be put on the same page in each issue to make them easier to find. If you're trying to get anyone to write for your magazine it is best to give them a subject or a title—a man who is asked to write about anything usually ends up writing about nothing.

Another problem is contributors who do not produce their articles on time. If this happens often it is a good idea to produce the article by interviewing the potential author and recording the conversation on tape. This can then be written up either as a formal interview or as an article with a few quotations. Most articles will need to be rewritten to some extent, to make them more palatable, because the average contributor will be inexperienced. Even if you shirk rewriting the entire article, it is often worth rewriting the opening paragraph—as with other activities, the opening line is important and a better one can often be found a few lines further on. The title is important too, and in my opinion it should be eye-catching rather than just informative.

Finally, the last golden rule is perseverance. Even if you have early failures, it is important to keep on trying. What I have described so far is the 1% inspiration. It is up to the student editor to provide the 99% perspiration.

No reprints are available from the author.

Medical Education

Training in the hospital specialties in Britain in 1975

JAMES PARKHOUSE, R A DARTON

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In 1975-7 we conducted a survey of all identifiable senior registrars in hospital specialties to determine the length of their training, the proportion who had changed their choice of specialty, and the amount of movement between health authorities during training. We present here a preliminary report of our main findings: full details will be published elsewhere.

Methods

We asked all employing authorities in Great Britain for the names and addresses of all senior registrars in hospital specialties (excluding

those in dentistry). We sent 2838 questionnaires to senior registrars in post on 30 September 1975, but 319 were discarded because they were duplicates or their recipients were outside the scope of the study. Altogether 1921 of the remaining 2519 questionnaires were returned. Five senior registrars to whom we had not written also replied; they, and five from a pilot study, were included in our analysis of the findings. The overall response rate was 76%. Thirty-four senior registrars who completed the questionnaire were locums. When analysing each item in the questionnaire we excluded respondents who did not answer that particular question.

Results

Table I shows the numbers and sex distribution of respondents by specialty, with the proportions who were born in the UK or Ireland, had changed their career choice at some stage, and had made their final choice of career by the end of the preregistration year. All branches of internal medicine other than general medicine, paediatrics, and ophthalmology are treated as a single group. Similarly, all branches of surgery except general surgery are grouped together.

Comparison of the proportions of men and women respondents with official figures for full senior registrars in Great Britain indicated that the sample obtained was reasonably representative.

Age—The percentage of respondents aged under 33 years ranged

Department of Anaesthetics, University of Manchester, University Hospital of South Manchester, Manchester M20 8LR

JAMES PARKHOUSE, MD, FFARCS, professor

Department of Econometrics and Social Statistics, University of Manchester, Manchester

R A DARTON, DIPSTAT, MSC, statistician

TABLE I—Specialty, sex, and nationality of respondents and proportion who had changed career during training*

Specialty	No of:		Nationality: % born in UK or Ireland	% Who had changed career choice	% Who decided on specialty at end of preregistration year
	Men	Women			
General medicine	159	12	92	40	49
Ophthalmology	56	7	51	30	66
Paediatrics	73	18	84	33	50
Medical specialties	218	22	68	59	19
General surgery	136	0	83	18	84
Surgical specialties	245	1	81	37	35
Anaesthetics	153	73	80	43	48
Radiology	101	23	69	48	43
Radiotherapy	27	4	45	59	18
Obstetrics and gynaecology	100	7	82	33	45
Pathology	174	59	68	53	40
Psychiatry	186	74	61	42	53
Total	1628	300	74	42	45

*Only respondents who answered all the relevant questions were included in this table.

from 24% in obstetrics and gynaecology to 67% in anaesthetics. Ophthalmology, general surgery, the surgical specialties, and radiotherapy all had less than 40% of respondents under 33; radiology, general medicine, and pathology all had over half. For all specialties 47% of respondents were aged under 33.

Marriage—Altogether 88% of the men and 63% of the women were known to be married when they completed the questionnaire. There were relatively more married women in some specialties than others (78% married in pathology, 50% in paediatrics, 25% in general medicine). Three of the four women in radiotherapy were married but only one of the seven in obstetrics and gynaecology. Of respondents who answered the relevant question, 24% of men and 14% of women were known to have more than two children.

Career choice—Altogether 41% of the men and 49% of the women had changed their specialty at least once (including those who had reverted to their original choice). No fewer than 30 respondents in general surgery and 22 in psychiatry had decided on their career before entering medical school. As a percentage of the final total in the specialty, however, the proportion of doctors who had made a firm choice by the end of the preregistration year was highest in general surgery (table I). In the medical specialties 72% of respondents who did not change their minds about their careers had decided what to do before becoming registrars, compared with only 27% of those who did change their minds. Changes from general medicine or a medical specialty to another medical specialty were common, as were changes from general surgery to a surgical specialty or from one surgical specialty to another. Many anaesthetists had changed from general surgery, general medicine, and general practice, and some women anaesthetists had changed from paediatrics and obstetrics and gynaecology. There were 32 women, in various specialties, whose previous career choice had been paediatrics; this was the biggest loss of women from any single specialty, accounting for 22% of all women respondents who had changed—a much higher drop out rate than for men in paediatrics. Among men, the largest loss was from general surgery, where 118 former aspirants were working in other specialties. Taking men and women together, the largest loss was from general practice into various hospital specialties (15% of all those who had changed their choice).

The commonest reasons for men changing their specialty were newly discovered abilities or limitations and discrepancies between ambitions and career opportunities. For women family or personal commitments featured almost as highly as reappraisal of abilities and limitations.

Problems—If general medicine, paediatrics, general surgery, and obstetrics and gynaecology are classed as competitive and the remainder as non-competitive specialties, 43-47%* of UK and Irish respondents in competitive specialties and 33-35%* in non-competitive ones had had difficulty in obtaining appropriate appointments. The proportion of foreign respondents who were in the competitive specialties (14%) was much smaller than that of UK and Irish respondents (30%), but they had had much more difficulty than UK and Irish respondents: 48-52%* in both competitive and non-competitive

*The first figure assumes that all those who declined to answer the question had no difficulty; the second figure assumes that the same proportion as of those who answered had difficulty.

specialties had had difficulty in obtaining appropriate appointments. Also, a smaller proportion of women than men were working in the competitive specialties (12% as compared with 29%), but they had had less difficulty than men in both specialty groups.

Ambitions—Altogether 39% of men and 33% of women respondents hoped to obtain teaching hospital posts, while 46% of women and 38% of men were primarily interested in non-teaching hospital posts. Interest in teaching hospital posts was greatest in radiotherapy, ophthalmology, the medical specialties, and surgery. A combined academic and NHS appointment appealed to 17% of respondents. A higher proportion of men than of women showed interest in purely academic posts.

LENGTH OF TRAINING AND MOVEMENT DURING TRAINING

Graduates of UK or Irish medical schools were divided into those who had taken a direct path to a senior registrar post—that is, two preregistration posts followed by senior house officer (SHO) and registrar posts (one or more in each grade), with no change of career and no other posts lasting longer than three months duration—and those who had not. Locum senior registrars were excluded from this analysis.

Length of training

Length of training is shown in table II. For UK or Irish graduates who progressed as directly as possible the minimum time taken to become a senior registrar was three years (2.6 years in training posts) and the maximum time was nine years for men and 12 years for women. When non-standard career progression was taken into account, the time taken to become a senior registrar was as much as 23 years for men and 26 for women. Male foreign graduates took a mean of 9.7 years to become senior registrars compared with 6.9 years for male UK or Irish graduates. Not all of this time was necessarily spent in Great Britain.

TABLE II—Length of training

	Mean duration (and range) of post held (years)		Mean years (and range) from graduation to senior registrar grade (mid-year to mid-year)	
	Men	Women	Men	Women
UK-Irish graduates (direct)	5.0 (2.6-8.0)	4.7 (3.4-6.3)	5.3 (3.0-9.0)	5.3 (3.0-12.0)
All UK-Irish graduates	6.4 (2.6-23.0)	6.8 (3.0-24.0)	6.9 (3.0-23.0)	7.9 (3.0-26.0)
Foreign graduates	8.9 (3.0-21.5)	7.4 (2.8-12.3)	9.7 (3.0-24.0)	9.0 (4.0-21.0)
Total	6.8 (2.6-23.0)	6.9 (2.8-24.0)	7.4 (3.0-24.0)	8.1 (3.0-26.0)

For men the average length of training before becoming a senior registrar varied from 5.0 years in chemical pathology to 8.6 years in radiotherapy and plastic surgery, 9.8 years in cardiothoracic surgery, and 10.4 years in venereal disease. The figures for women were harder to interpret, as they were often based on few individuals. For the specialties with more than five women respondents, the shortest mean period was 6.3 years (in medical microbiology) and the longest 9.7 years (in adult psychiatry). Only in radiology and ophthalmology was the mean time for women shorter than for men (there were only seven women in ophthalmology); the longest periods for women were in psychiatry, histopathology, paediatrics, and obstetrics. The differences in length of pre-senior registrar experience between UK-Irish and foreign graduates was greatest in the medical specialties, general surgery, and medical microbiology, especially for men. The specialty with the most uniform length of pre-senior registrar experience for all respondents was paediatrics, with a range from 7.1 years for male UK-Irish graduates to 8.9 years for female UK-Irish graduates (there were only 7% of foreign graduates among the respondents). The widest spread was in general surgery, where there were only a few foreign graduates, and in radiology, where the mean pre-senior registrar periods ranged from 5.8 years for UK-Irish women graduates to 11.3 years for foreign women graduates (18% of women and 25% of men in radiology were foreign graduates).

Movement during training

Movement between area and regional health authorities (AHAs and RHAs) was counted from the first British post held up to and including the first established senior registrar post. Thus, if a respondent remained in the same AHA this was counted as zero movement. For foreign graduates, all moves before coming to Britain were disregarded and the first move counted was the move to a post in Great Britain or Ireland from a post abroad.

In most specialties, women moved more often than men, although most of the differences were fairly small (table III). Foreign graduates moved slightly less between AHAs than UK or Irish graduates. An average of four or more moves between AHAs was observed for both men and women in paediatrics and obstetrics and gynaecology, for men in surgery, and for women in ophthalmology and chemical pathology.

TABLE III—*Movement between health authorities during training*

	Mean No (and range) of moves between RHAs		Mean No (and range) of moves between AHAs	
	Men	Women	Men	Women
UK-Irish graduates (direct)	1.8 (0-6)	1.6 (0-4)	2.3 (0-7)	2.3 (0-6)
All UK-Irish graduates	2.8 (0-12)	2.9 (0-10)	3.4 (0-14)	3.6 (0-11)
Foreign graduates	2.8 (0-9)	2.9 (1-9)	3.3 (0-10)	3.5 (1-10)
Total	2.8 (0-12)	2.9 (0-10)	3.4 (0-14)	3.6 (0-11)

Discussion

Since the inception of the NHS it has been the general intention that senior registrar training should be preceded by SHO and registrar work, the nominal tenure in these grades being one year and two years respectively. In practice, these have always been recognised as minimum and not average times.

Of all the senior registrars who answered our questionnaire only 11% had progressed directly from a UK or Irish medical school through SHO and registrar posts without change of career. These respondents took a mean of over four years, excluding the preregistration year, to become senior registrars. The average for all the senior registrars who replied was seven to eight years from graduation. The ages of senior registrars ranged well into the 50s, and some had taken over 20 years to become established in the grade. Late decisions on career choice or changes of choice, were associated with longer times spent in the junior hospital grades. Any policy that encouraged or enforced an early commitment to a specialty would therefore result in more rapid throughput and a smaller number of SHO and registrar posts needed to accommodate a given number of graduates. Changes in career and occupancy of posts outside the normal training progression were also the main factors behind an increased amount of movement between health authorities during training.

These findings are important in relation to career structure policy and medical manpower planning. Many of the senior registrars who completed the questionnaires made personal comments, both in praise and in condemnation of the existing state of affairs, and their comments will be evaluated in the full report.

We are grateful to the Nuffield Provincial Hospitals Trust, who provided financial support for the project. Professor Gordon Forsyth acted as co-director of the study and Mrs Margaret Potton as research assistant; Mrs Mavis Howard and Mrs Janet Black carried out much expert secretarial work. We thank the North-western Regional Health Authority for providing computing and data processing facilities and to employing authorities throughout Great Britain for supplying names and addresses of senior registrars. Most of all, we thank our respondents for their time and patience, and for the frankness of their comments.

(Accepted 5 January 1979)

What is the treatment of choice for vaginal candidiasis in the mentally handicapped virgo intacta?

There may occasionally be a case for taking antifungal agents by mouth. Nystatin can be so used and also amphotericin B. Their prime use is to try to clear the gut of candida, and little may reach the vagina. Reinfection of the vagina, however, may be from the gut, so there may be a place for using the drugs in genital candidiasis. Naturally, oral treatment is more effective when combined with local pessaries and creams. Only very rarely is an experienced gynaecological ward or outpatient sister defeated in administering vaginal treatments. Some patients undoubtedly need her skilled care, obtained by admission to hospital. And in really intractable cases an anaesthetic can be given so that the vagina can be scrubbed out with an antiseptic and then filled with an appropriate medicament. Thereafter there must be scrupulous attention to perineal hygiene, perhaps supplemented by antifungicides given by mouth.

A middle-aged man had his coccyx excised after nine months of persistent pain. The pain still persists on sitting down and is also accompanied by excruciating shooting pains in the rectum. What might be the cause of these pains, and what investigation and treatment are advised?

Obviously a careful clinical examination must be conducted to exclude some obvious local disease such as a rapidly growing invasive carcinoma of the rectum or prostate which would account for these symptoms. Presumably such gross lesions have already been considered and eliminated from the differential diagnosis. Rectal crises of tabes dorsalis are nowadays exceedingly rare and indeed I have never encountered an example. There may be Argyll Robertson pupils and absent knee jerks, although there may be only visceral manifestations of this rarity. Most patients fitting this description, however, are examples of proctalgia fugax—severe, intermittent episodes of rectal pain, which may last from a few minutes to half an hour and

which occur particularly at night. There are no physical signs, and the cause is completely unknown, although spasm of the levator ani is the most popular theory. The patient's personality and lack of obvious disease make psychogenic origin of this condition the other probability. Treatment is unsatisfactory. Inhalation of amyl nitrate, a hot bath, firm pressure of the fist against the buttocks, or insertion of a finger into the anus are found helpful by some patients but not by others.

Is oral choline likely to be of benefit in cerebellar dysfunction due to multiple sclerosis or vertebral artery deficiency?

Oral choline has been found to be of benefit in only one reported case of cerebellar disorder so far. It is under trial in other patients, with cerebellar disorders of various aetiologies, and the results will be published in due course.

Corrections**Prescription for a better British diet**

In this paper by R Passmore, Dorothy F Hollingsworth, and Jean Robertson (24 February, p 527), Dorothy F Hollingsworth should have been described as secretary general of the International Union of Nutritional Sciences, c/o Institute of Biology, 41 Queen's Gate, London SW7 5HU.

Alcoholism: a medical or a political problem?

We regret that an error occurred in this article by Professor R E Kendall (10 February, p 367). In the section "Results of treatment" Abstem is shown as the proprietary name for disulfiram. Abstem is citrated calcium carbimide, and the sentence should have read: "... sedative drugs to cover withdrawal and citrated calcium carbimide (Abstem) tablets thereafter. . ."