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Letters to a Young Doctor

Try not to get locked into a specialty

PHILIP RHODES

Getting locked into a specialty in the first few years after registration is a constant problem. If you specialise too early you may be unable to get out of the specialty and into another, and unable to progress to the consultant post you desire because the specialty is overcrowded. You may move in and out of specialties with comparative ease at senior house officer grade, but it becomes harder as a registrar, and harder still as a senior registrar, when you may become identified with your subject. For example, a person who has spent several years in orthopaedic surgery, either as a registrar or senior registrar, will find it nearly impossible to obtain a post in general surgery since he will then be competing with those who are ascending the general surgery ladder. His chances in specialties even further removed from orthopaedic surgery, such as obstetrics and gynaecology, medicine, or pathology, are often negligible. There was a time when it might have been possible to enter general practice after realising that you were a failed specialist, but the training for general practice has altered. It is now a specialty in its own right and is becoming more and more difficult to enter; the competition is often severe.

There are many degrees of getting "locked in" without having much hope of moving either laterally or onwards. For instance,

it might be very valuable to spend a year as a registrar in cardiology if you are going to be a physician. This makes the post part of a defined path to a career. But if you stay for two years—or worse, three—then it may be impossible to get back into general medicine in a good job. You may have branded yourself as wanting a consultant post in cardiology by having stayed too long. You ought to know that the competition for posts in that subject at senior registrar and consultant level is very severe. Similar considerations apply to almost any narrowly specialised job. At the right time and for the right length of time they are fine, but you must beware of drifting into them without careful thought and just carrying on in the same post because you like it, and become more and more comfortable. Drifting can wreck your career. Instead, your career deserves careful planning.

As you get closer and closer to applying for consultant posts you will have to estimate the chances of getting one. For this you will need an appropriate copy of *Health Trends*, which is published quarterly by the Department of Health and Social Security. Once a year in *Health Trends* they publish "Medical and dental staffing and prospects in the NHS in England and Wales," an analysis of hospital posts by specialty, sex, and grade. They also give the estimated number of retirements from each specialty over certain years. For instance, volume 14 number 2 of May 1982, page 31 gives the following tables:

These tables alone are not enough to help you. You must learn the numbers of likely candidates for the possible vacant posts. This has to be done from the main tables, which give all grades of staff in all the disciplines. To take the example of anaesthesia, 387 is given as the number of senior registrars in post. Then you

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have to assume that each person will be in post for about four years, so that the number of doctors who are ready to proceed to consultancy will be roughly $387/4=96$. There would therefore be many more people available than there will be posts vacant (roughly 39), and the competition would be severe.

For mental handicap there are 20 senior registrars in post. Five might therefore be available for the estimated posts falling vacant at consultant level of roughly nine a year.

In general medicine there are 215 senior registrars. Fifty-three might therefore be ready each year for the roughly 29 posts available in 1982-6 or the roughly 19 available in 1987-91. In general surgery the position may be similar since there are 196

TABLE I—Expected numbers of annual retirements of permanent paid medical and dental consultants by specialty on the basis of current retirement rates: 1982-1986

Estimated No of retirements per annum	Specialty
30-39	Anaesthetics, mental illness
20-29	General medicine, general surgery, radiology
10-19	Child and adolescent psychiatry; ear, nose, and throat; histopathology; obstetrics and gynaecology; paediatrics; traumatic and orthopaedic surgery
5-9	Dermatology, geriatric medicine, haematology, mental handicap, ophthalmology, radiotherapy, rheumatology and rehabilitation and oral surgery
<5	Accident and emergency, blood transfusion, cardiology, cardiothoracic surgery, chemical pathology, clinical neurological physiology, clinical physiology, forensic psychiatry, genitourinary medicine, infectious diseases, medical microbiology, nephrology, neurology, neuropathology, neurosurgery, paediatric surgery, plastic surgery, psychotherapy, urology, orthodontics

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TABLE II—Expected number of annual retirements of permanent paid medical and dental consultants by specialty on the basis of current retirement rates: 1987-1991

Estimated No of retirements per annum	Specialty
40-49	Anaesthetics
30-39	Mental illness
20-29	General surgery, obstetrics and gynaecology, radiology
10-19	Child and adolescent psychiatry; ear, nose, and throat; general medicine; histopathology; ophthalmology; traumatic and orthopaedic surgery
5-9	Accident and emergency, chemical pathology, geriatric medicine, haematology, medical microbiology, mental handicap, paediatrics, radiotherapy, rheumatology and rehabilitation, and oral surgery
<5	Blood transfusion, cardiology, cardiothoracic surgery, clinical neurological physiology, clinical physiology, dermatology, forensic psychiatry, genitourinary medicine, infectious diseases, nephrology, neurology, neuropathology, neurosurgery, paediatric surgery, plastic surgery, psychotherapy, urology, orthodontics

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senior registrars in post, so that 50 might be available each year for roughly 29 posts.

These examples must suffice. There is no substitute for working out these prospects for yourself, for only you can decide whether you will accept a particular degree of competition. But it is worth bearing in mind that somebody will win through, and it might very well be you if you are sufficiently well motivated, work hard, and have an eye to the proper progress of your training and education.

In the next article I shall discuss moving along the difficult path from registrar to senior registrar.

Family Medicine

Thamesmead: dream to reality

P M HIGGINS

Thamesmead, as imagined in 1963, was to be a "new town" within the boundaries of London. This new community of 60 000 people from inner London would come under the authority of London County Council (now Greater London Council) and the two local boroughs, Greenwich and Bexley. On this large area of land traffic would be segregated from housing. The architecture would be based on an industrial system with lakes, waterways, and walkways to give a distinctive character and set higher standards of amenity for public housing. Private development would be encouraged in order to ensure a balanced community; new jobs and new houses would be provided together; churches and facilities for shopping, recreation, and education (including a polytechnic) would be concentrated in the centre, of which the focal point would be a yacht marina. This would be the first stage in a cycle of urban renewal around London.

General practice was in a sad state at the time, and these

imaginative proposals caught the attention of two men in the department of medicine at Guy's Hospital Medical School: John Butterfield, professor of experimental medicine, and Robert Smith, a general practitioner who was seconded to the department by the Wellcome Foundation. Here was a chance to develop a comprehensive health service with a special emphasis on primary care for a large population in a capital city and also provide a teaching unit in the community for Guy's medical and dental students.¹ With a grant from the Nuffield Foundation a general practice research unit was set up to make proposals.

Smith and his colleagues set out their ideas²: better co-ordination between the three branches of the National Health Service, closer links between hospital and community medical services, and the integration of general practice with the personal health services provided by the local authority. Curative medicine and preventive medicine would thus be brought together. A main health centre would provide a large number of services—consultant clinics, diagnostic radiology, facilities for teaching and research, local authority clinics, and dental and ophthalmic services. Four teams of doctors, health visitors, and nurses based at the main centre would each look after an area of the community. At four or five centres scattered throughout Thamesmead they would run child health and antenatal clinics

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