

# Letters to a Young Doctor

## Some other jobs in medicine

PHILIP RHODES

### Occupational medicine

Occupational medicine is a distinctive branch of medicine because it deals with the health of people at work. Large industrial firms and other firms may employ doctors full-time to advise on health and arrange for the first-aid treatment of injuries, screening for disease in the workforce, control of injurious agents used in manufacture, and in general making the workplace safe. Relationships have to be built up with general practitioners, hospitals, and agencies in the area. Several government organisations employ occupational physicians, too. Some smaller firms employ general practitioners part-time to advise them on health at work.

There is now a faculty of occupational medicine in the Royal College of Physicians, which you should contact for information about the examinations and the experience needed to obtain the membership (MFOM). The postgraduate dean can arrange for advice to be given locally about a career in occupational medicine, and several regions have appointed an adviser in occupational medicine. It is still probably wise to have a fairly general experience of medicine and obtain the MRCP (membership of the Royal College of Physicians) before switching to occupational medicine at the equivalent of senior registrar level.

### Medical communication

A visit to any medical library will show the large number of journals, books, audiovisual aids, and videotapes now being published. The communications industry is developing rapidly. It is vital to the progress of medicine and needs doctors of high intelligence, discernment, and probity. Editors and their staffs wield great power in deciding what to publish and in calling for articles and chapters on subjects they think important at a given time. This is a difficult career on which to advise in general. The recourse must be to the postgraduate dean, who will be able to arrange for appropriate advice, perhaps from some reputable editor.

### Military services medicine

The military services require a cadre of doctors to look after personnel and their dependents. These doctors maintain a core of service in the Navy, Army, and Air Force that can be expanded in case of war or other emergency. The doctors practise medicine with an eye on its adaptation to military needs, which are varied, as consideration of the environments of soldiers, sailors and airmen will quickly show. There are psychological, physical, ergonomic, physiological, and toxic problems to be advised on,

solved, and averted. These may be specifically military, but there are also the general problems of medicine to be dealt with as well.

Each of the services maintains hospitals that are in every way comparable with civilian district general hospitals, are staffed by service doctors and nurses, and have educational programmes for their junior staff to allow them to read for higher diplomas. Doctors in these hospitals are closely integrated for both service and education with their local civilian colleagues. Indeed, many of them care for the local civilian population too. There are therefore many careers to be followed in the military medical services, in specialties as well as in general practice. Naturally these are somewhat different from those in the National Health Service since the doctors also must discharge their military duties wherever these may call them. Inevitably, medical training may be disrupted, but there are compensations in service life. Information about service careers should be sought from the War Office, Admiralty, or Air Ministry. Advertisements appear regularly in the medical journals such as the *BMJ* and the *Lancet*.

The services need some doctors who will serve only for a short time and will not make service medicine their ultimate career—that is, short service commissions of varying duration in years. They offer a time away from the routines of the NHS in an interesting new environment, and at the end of service there is a quite large tax-free gratuity. Such schemes may extend back into the undergraduate years when the services may offer cadetships to selected students. These pay fees and give an income during the clinical years in return for signing a contract to serve in the chosen service for a given duration of time.

It is very important not to accept such cadetships without a great deal of thought. The danger is not the scheme but you. The money may be a lure that is hard to resist, especially when you are a penurious student. But by taking the money you are mortgaging your future, so you must be sure that you really wish to work in the services, at least for a short time. You must not get tied into a service career that you might find irksome, partly because you are tied by a firm contract. If you are fairly sure that you will like the life then by all means join. On certain days the services allow you to see the nature of the work before you enlist. They do not want reluctant doctors, who are in it only as time-servers to get the money.

Once you are in one of the services you must work just as hard for a higher diploma as you would in civilian life. Without such a diploma you will not be able to advance either in the services or on your return to the NHS. Life in the services can be seductively pleasant and not conducive to academic work. But when your career is in medicine there is no relaxing to be had anywhere.

### Pharmaceutical industry

The pharmaceutical industry is vital to the NHS. It prosecutes a great deal of research into drugs at very high cost, which would

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not be forthcoming from anywhere else. Politically it sometimes seems to be under a cloud because of doubtful ethics in the advertising and selling of their products. Sometimes there is criticism of the profits they make. Yet the industry is responsible for most of the major therapeutic advances in medicine. Certainly it makes advances available to a wide medical public by marketing.

Doctors are obviously needed in the industry in both laboratory and clinical work, and to maintain liaison with doctors in all fields of medicine. Doctors in the industry are also needed to assess medical publications and the worth of the ideas they contain to see if they might be exploited, for the benefit of the public and the firm. Moreover, these doctors carry a heavy responsibility in writing up drug information sheets for doctors who will prescribe their products and so in providing unbiased information in a commercial world. Doctors of high calibre are needed, and normally will be expected to hold higher degrees or diplomas. Advertisements for vacant posts appear regularly in the medical journals. Anyone who is interested might also write to the medical director of any of the major pharmaceutical companies for career advice.

### Law and medicine

The law is intertwined with medicine in forensic medicine, forensic psychiatry, in the medical defence societies, and in the persons of coroners, police surgeons, and prison medical officers. The way into these careers is usually by general medical training, taking a higher diploma, and then entering the specialty. The first contact for information will usually be the postgraduate dean.

The person with a medical degree is fortunate in having a qualification which opens many doors, all of which lead into rooms of fascination and interest. You should have sampled the contents of many of the rooms as an undergraduate. After graduation you must decide which room you wish to enter finally. It ought not to be difficult because there must be something out there in the future that you will like, enjoy, and be happy in, and in which you will make a satisfying and useful career.

In the next few articles I shall discuss how to plan to take higher qualifications.

## For Debate . . .

### Asthma in New Zealand

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In September 1982 I spent almost three weeks in New Zealand at the invitation of the Asthma Foundation. The main purpose of the visit was to provide a focus for the first medical educational exercise by the foundation, and to draw attention throughout New Zealand to the recently formed foundation together with the well established regional asthma societies. It was hoped that by exchanging views with physicians and general practitioners, and by addressing public meetings of asthma societies in most of the major centres of population, I could contribute to a better understanding of what was widely acknowledged to be a serious health problem in New Zealand.

Even before my tour was arranged I had read an article in the *Lancet* entitled "Has the change to beta-agonists combined with oral theophylline increased cases of fatal asthma?"<sup>1</sup> and although I did not agree with this hypothesis for reasons that I shall specify later, the authors' statement that 20 patients had died from asthma in Auckland between October 1980 and January 1982, a number considerably greater than the previous death rate, had obviously alarmed not only the medical profession but also the general public, who learnt about the article in the lay press. After I arrived in New Zealand I soon discovered that the recent increase in asthma mortality was not confined to Auckland. Until 1977 the number of deaths certified as having been due to bronchial asthma had fluctuated between

60 and 120 for the whole country (population 3.2m) but between 1977 and 1981 it had risen to almost 300. An article in the *BMJ*<sup>2</sup> that analysed death rates from asthma in New Zealand in the 5-34 age group until 1979 reported a similar trend. The authors put forward three possible explanations for this new "epidemic" of deaths from asthma, which has not been observed in any other country. Firstly, the prevalence of asthma in New Zealand might have increased and, secondly, asthmatic patients there might be developing a more severe form of the disease. Although neither of these two possibilities could be excluded, no population based studies of asthma morbidity were available to support them, and aetiological factors peculiar to New Zealand did not appear to have assumed greater importance recently. The third and most likely explanation was that the increased mortality was related to changes in the management of asthma.

In my discussions with respiratory physicians in New Zealand I concentrated on therapeutic management, and I shall now try to analyse in what respects their policy has recently diverged from that in the United Kingdom.

### Hyposensitisation

Although a few physicians, most of whom practise outside hospitals, are enthusiastic advocates of hyposensitisation and other forms of immunotherapy, I did not get the impression that it was widely employed in New Zealand. Although there is a danger that patients so treated might be denied more effective forms of treatment at a stage when these were urgently

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