Think of a number

The DHSS tables on medical recruitment—a recent addition to the annual sets of published figures—are a delight to browsers and speculators in manpower matters. They give information about numbers of applicants for consultant and senior registrar jobs, unfilled posts, the success rate of applicants by sex and place of qualification, the percentage previously employed within the same regional health authority, and many other intriguing scraps of information (p 905). Trying to assess their meaning and their value reminds me of the story of the man who was told "You don't know what good, clean fun is," to which came the reply "Well, what good is it?"

Minerva¹ will not be the only reader who has puzzled over the condensations that appear from time to time.² The fact that there are more applicants per post in accident and emergency medicine than in general surgery almost certainly shows the large numbers of doctors who would like to transfer to this specialty from a previous choice of career that looks increasingly unlikely to be fulfilled. Not all may be suitable candidates, though according to the tables available most have a higher qualification of some kind. The fact that the average age on appointment to a consultant post is higher than in the crowded and highly competitive specialties again suggests relatively late changes of career intention in many cases, and this is supported by the fact that among successful candidates for consultant posts in England and Wales between October 1980 and September 1981 the mean number of years spent in the specialty was 7-0 and the mean number of years since qualification 15-5 (in general surgery the comparable figures were 10-2 and 12-9).

Other available tables for England and Wales confirm the impression that because a specialty is short of recruits and has vacant consultant posts it does not follow that everyone who shows an interest will be rapidly promoted. Among senior registrars who had spent four or more years since entry to the grade at 30 September 1981 there were 16 in general medicine and 34 in general surgery, but there were also 10 in rheumatology, 17 in anaesthetics, 13 in haematology, eight in histopathology, and 22 in psychiatry. This may speak well for our maintenance of standards, but it bodes ill for some of the doctors in an increasingly competitive postgraduate training market where a change of course becomes not only harder to achieve but less certain to succeed.

Scotland produces its own manpower tables, with helpful comments.³ The figures for 1981 show, relevantly enough, that the longest average length of tenure in the senior registrar grade (54-1 months) was in pathology, and the general comment is made that consultants promoted from the associate specialist grade tend to be older than the average. The smaller dependence on overseas doctors in Scotland to fill the SHO and registrar grades is apparent, but despite a firmer control over SHO posts these grades are still too large in proportion to the numbers of career outliers, so that if Scotland were looked at in isolation the prospects for its own graduates would be even worse than in England and Wales.

Various questions could be asked about medical manpower data. Firstly, do the data really exist? Is there sufficient information, or sufficient detail, to draw valid conclusions or is there merely a temptation to overinterpretation? We have seen examples of this many times in our studies of doctors' career choices, where the apparent trend from two successive small samples may be utterly refuted by the next year's data. Secondly, are the figures being compared really comparable? There are well-known pitfalls in comparing England and Wales data with Great Britain or United Kingdom data, information relating to 30 September with information relating to the calendar year or the academic year, figures for "United Kingdom based" doctors with those for doctors born in Great Britain. These difficulties are compounded when other countries, such as the Republic of Ireland, are brought into consideration and they always need careful thought.

Thirdly, are the data accurate and up to date? They may, of course, be quoted inaccurately; though it should scarcely be necessary to comment on this in a reputable journal, it happens so easily and so frequently that it is always advisable to refer back to the original tables before building too heavy an edifice on the foundation of what has been cited. More significantly, the data may be inaccurate or out of date in the way they are actually collected. Rowell⁴ has commented recently on the misquoting of numbers of dermatologists,⁵ but in the subspecialties of medicine a more important difficulty is knowing how many people are actually engaged in the work in question. The committee on gastroenterology of the Royal College of Physicians of London⁶ concluded that there are about 270 physicians with a special interest in gastroenterology in the United Kingdom, of whom most seemed to devote three to six sessions a week to gastroenterology. This makes an
interest. contrast to the 44 consultants in gastroenterology (as distinct from general medicine) shown in the DHSS’s tables for England and Wales, 1981. Other medical specialties, such as rheumatology and thoracic medicine, have begun to produce valuable information from similar surveys, and Houghton and Richings7 from the DHSS have themselves published a useful survey of a wide range of “medical” specialties. Figures on the international movement of doctors are, almost by definition, either inaccurate or out of date, and new studies on what is happening to the patterns of emigration and immigration, and for what reasons, are badly needed.

Fourthly, given that the figures are reasonably reliable, what do they denote? Most are produced in the form of averages, aggregates, or percentages, and this may tell us little about the range and the spread, or about the problems of the individual unit and district. I seem to have said many times that a 4% growth in the number of consultants has little meaning when brought down to the district level of a clinical service where there are two paediatricians and the question is whether to appoint a third. The current Government “target” for doubling the number of consultants and changing the junior to senior ratio from 1:8:1 to 1:1:8 raises many questions of this kind. Should each region aim at this ratio, or even each district? Or is it meant as a national average within which considerable regional variation might occur? How much will specialties vary in their ratios? How will the ratios of juniors to seniors be reconciled with the need for increased numbers of senior registrars to fuel the consultant expansion? Coupled with what figures may denote, in a kind of chicken and egg relation, is the concern that they may generate. The latest figures given in response to a parliamentary question8 show a substantial rise in the number of doctors registered as unemployed persons. Nobody doubts that there are unemployed doctors, any more than doctors have a generally privileged position in the employment market compared with most people in the community. That fears and anxieties exist is self-evident. Among those who are good enough to respond to our inquiries about career preferences comments begin to appear about future prospects: “Unemployed, as it looks now.” The vast bulk of the actual employment is “frictional” and the overwhelming majority of our respondents who have had periods away from work have been bearing children, coping with domestic commitments, studying for examinations, and so forth. But the need to do something urgently about the career structure is unmistakable.

Finally, there is the root question which seems sometimes so far away as to be almost imperceptible: what do medical manpower figures really mean? When all is said and done how do we know how many doctors we need to have, and what constitutes “enough”? We can set targets and priorities, and identify deficiencies—for instance, in health education, prevention, and occupational medicine—but, as Tudor Hart10 and Holdstock11 have pointed out, it is hard to see how these priorities may be assessed against the background of continuing economic depression, huge Falkland Islands’ bills, and a massive national commitment to defence expenditure in general. If our philosophy as a nation is to lead us blunderingly into spending more money on defence, rather than on non-military priorities such as education, doctors, and other health workers, we may have to adjust our manpower plans accordingly. But for the moment the plans have been made: the numbers of British medical students began to increase after the Todd Report of 1968 and the graduates that we have willed upon ourselves, for right and proper reasons, are now beginning to fill up the system. The fact that regional growth money has been further restricted does not mean that the problem of the career structure will go away. It makes it more urgent. The number of career outlets—for consultants and general practitioners—must somehow be increased in order to prevent a total sitting up of the over-large registrar grade with British graduates. This increase in career outlets must be achieved without a great increase in the total number of doctors in the system and all this must begin to happen now, while it is still only 10 or 15 years too late. Otherwise, the “I told you so!” who have argued for a reduction in the size of the medical schools—usually for the wrong reasons, and sometimes through misinterpretation of the data—will have a field day at the expense of our embittered medical graduates and our deteriorated medical services.

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Breech: vaginal delivery or caesarean section?

Ten years ago Moir thought that caesarean section was justified in 10% of breech births in Britain.1 In practice nowadays, probably some 4% of breech presentations are delivered by caesarean section,2 and in some centres the proportion is much higher (personal communications). Reports from other countries confirm the trend. The recent consensus report on caesarean section in the United States noted that breech presentation was one of the four main conditions responsible for the rapidly increasing section rate in that country.3 According to Quilligan and Zuspan,4 the practice in the United States in the past five years has been to deliver most breech babies by caesarean section—their section rate for breeches is currently 72.5%. Similar support for a high section rate is given in the authoritative Williams’ Obstetrics, where the editors Pritchard and MacDonald5 record that in their own unit in Dallas the abdominal delivery rate for breech presentation is 75%. From the Groote Schuur group of hospitals in Cape Town de Groot6 reports a section rate of 65% to 83%.

Among the reasons for this trend are the increasing safety of the operation, the highly skilled care available in neonatal intensive care units leading to better immediate and long-term prospects for the smallest breech babies, and the understandable disinclination of today’s obstetricians to undertake