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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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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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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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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 questionniare 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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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