

Violence towards doctors in Turkey

Sir,

Last year Zahid et al (Vol 60(6), 1999, p. 414) published their interesting study on violence towards doctors, the results of which were quite striking. Their data suggested that 1 in 11 doctors experienced physical violence at work. We also performed a similar questionnaire study among 67 doctors working in the surgical department of our hospital, which is the largest general training hospital in Turkey.

Unlike Zahid et al's study, our study included the emergency surgical department as well as that which carries out the routine surgical procedures. We found that nearly half of our doctors (47.8%) had been subjected to physical (not verbal) violence by patients or their companions at least once.

Although most of these assaults were experienced in the emergency department, some violence was recorded on the wards. Whittington et al (1996) also reported that most of the violence towards medical staff took place in polyclinics and clinics.

Our study also showed that almost half of doctors (49.3%) suffered from psychiatric problems because of difficulties associated with working as a doctor, such as long working hours, busy night shifts, low salaries and physical assaults. These difficulties were often encountered on a daily basis. Most of the doctors almost always felt tired and 26.9% had sleeping disorders.

Three quarters of respondents stated that their profession negatively affected their private life. As a consequence 58.2% of the doctors in the general surgery department said they had thought about changing their profession at least once.

These kind of studies clearly show that medical doctors are faced with some serious problems, in addition to those associated with treating often seriously ill patients, which are frequently ignored.

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Whittington R, Shuttleworth S, Hill L (1996) Violence to staff in a general hospital setting. *J Adv Nurs* 24: 326-33

Praise for flexible training

Sir,

The two articles on flexible training in the February issue of *Hospital Medicine* by Goldberg and Paice (Vol 61(2), 2000, p. 125) and Peters et al (Vol 61(2), 2000, p. 129) are enormously encouraging. Peters et al provide reassuring data highlighting the positive attitudes of consultants and full-time trainees towards flexible training. However, in this survey the flexible trainees themselves still believed that

their training is perceived by full-time trainees and consultants to be suboptimal.

The survey was limited to four specialities, and confirmed that flexible training is still regarded as inappropriate in some specialities. Negative attitudes to flexible training were more prevalent in obstetrics and gynaecology than in paediatrics, psychiatry or anaesthetics. However, this may relate as much to the smaller percentage of flexible trainees in this speciality compared to psychiatry and paediatrics, as to its 'acute, surgical' nature.

This is analogous to previous beliefs regarding the suitability of some specialities for women. As the numbers of flexible trainees increase, positive attitudes prevail and perceived barriers decrease.

Within the medical sub-specialities, the percentage of flexible trainees is closely related to the percentage of female specialist registrars (SpRs) and consultants in that speciality (Table 1). Overall 6-7% of SpRs in medicine are training flexibly but this ranges from 24% in palliative medicine, 10% in rheumatology, to 1% in cardiology.

In specialities where the proportion of female trainees is well over 50% and the demand for flexible training is high, the creation of supernumerary training posts cannot continue indefinitely. It is therefore encouraging that Goldberg and Paice have successfully introduced job-sharing, using funded, educationally approved full-time posts. Trainees in the Thames regions in job-sharing posts were as satisfied with their training as their colleagues in full-time or supernumerary posts. Important in the success of the

job-sharing scheme was the stipulation of a minimum of six sessions to allow overlap time both for adequate handover and educational activities. These extra sessions were funded by the post-graduate dean's flexible training budget.

The continued promotion of flexible training is essential to ensure that doctors who might otherwise leave to fulfil domestic or other commitments are encouraged to continue their training. Acceptance of flexible training is increasing and the training and clinical experience are comparable to full-time training. However in the long term, a trade-off between 'flexibility' and 'availability' may be necessary to ensure that all those who wish to train on a part-time basis are afforded the opportunity. Job-sharing and 'fixed flexible' posts (when a flexible trainee moves on, the post is filled by another flexible trainee) may be the way forward.

Catherine Nelson-Piercy

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Correction

In the article *Repaglinide: a novel oral antidiabetic agent* (Vol 61(2), 2000, p. 112) a space was provided for the absolute *P* value of patients with type 2 diabetes controlled on metformin and repaglinide. The figure provided was, however, an absolute value. We apologise for any confusion or inconvenience caused.

TABLE 1.
The number of flexible trainees in relation to the number of female specialist registrars (SpRs) and consultants

Speciality	% of female consultants	% of female SpRs	% of flexible SpRs
Palliative medicine	51	78	24
Clinical genetics	47	70	28
Audiological medicine	39	60	0
Dermatology	35	60	14
Genitourinary medicine	29	58	9
Nuclear medicine	28	33	0
Rehabilitation medicine	28	27	4
Rheumatology	19	45	10
Geriatrics	18	37	5
Clinical neurophysiology	18	12	0
Oncology	13	40	8
Paediatric cardiology	13	31	15
Endocrinology and diabetes	10	34	6
Respiratory medicine	9	24	4
Infectious disease	8	15	5
Renal	7	31	3
Cardiology	7	12	1
Gastroenterology	6	25	5
Neurology	5	22	5
Clinical pharmacology	3	38	0