

In 1978-87, case fatality rates for all hospitals combined were 39.7% at 30 days and 56.9% at one year (table). In 1988-97, the corresponding figures were 32.9% and 48.9%. The table shows that case fatality rates were lower for the region's teaching hospital (I) than for all other hospitals combined. Significant differences were also seen between individual non-teaching hospitals. Variation between the teaching hospital and individual non-teaching hospitals reduced over time.

Differences in case fatality rates during the first 30 days accounted for the differences between hospitals and most of the difference over time (table). For 1988-97, the low case fatality rate for in-hospital deaths in hospital III within 30 days, calculated without data linked to death certificates, was as high as that in other hospitals when linked data were used. Otherwise, case fatality rates for in-hospital deaths were good predictors of hospitals' relative rankings when rates were calculated with data linked to death certificates (Spearman's rank correlation coefficients between in-hospital deaths and deaths anywhere at 30, 90, and 365 days were 0.83, 0.86, and 0.88 in 1987-98 and 0.93, 0.81, and 0.71 in 1988-97).

Age and sex standardised case fatality rates at 30 days in 1978-87 and 1988-97 were 33.2 and 24.7 in people <75 years and 27.5 and 19.8 in those <65. Differences between hospitals for case fatality rates in patients <75 and <65 years were similar to those found for patients of all ages, although with diminishing statistical power not all comparisons reached significance (see tables A-C on bmj.com).

Comment

Case fatality rates after hospital admission for stroke were high: about half of all patients died within one year. Differences in case fatality rates over time, and between hospitals, might be explained by differences in the case mix and particularly by differences in the severity of stroke and the extent to which patients were managed at home rather than in hospital. For these reasons, differences are hard to interpret. If the differences can be attributed to standards of care, rather than case mix, their impact is greatest in the acute phase of care: the reductions over time, and the differences between hospitals, were predominantly seen in fatality rates within 30 days of admission.

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Career choices of United Kingdom medical graduates of 1999 and 2000: questionnaire surveys

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The career choices of doctors at the end of their preregistration year have been studied for doctors who qualified in the United Kingdom in 1974, 1977, 1980, 1983, 1988, 1993 and 1996.¹⁻⁴ We report here on the graduates of 1999 and 2000.

Participants, methods, and results

The survey population comprised all graduates from all medical schools in the United Kingdom in 1999 and 2000. We used graduation lists from each medical school to compile our database. The doctors were sent a questionnaire towards the end of their preregistration year; non-respondents were sent a maximum of four reminders. As in earlier surveys,¹⁻⁴ graduates were asked to state up to three choices of long term career in order of preference and to indicate whether they intended to practise medicine in the United Kingdom for the foreseeable future. We grouped career choices specified by the respondents into 14 mainstream specialties based

on those defined in the Todd report.⁵ We used χ^2 statistics and adjusted residuals to compare cohorts.¹

The two cohorts consisted of 8661 graduates, of whom 23 were unregistered at the time of the surveys. Of the 8638 who were registered, 20 declined to participate, two were known to be dead, and 122 were untraceable. The remaining 8494 comprised 4104 men and 4390 women, of whom 5702 (67.1%) replied. The proportion of women graduates who responded was significantly higher than that of the men (73.7% v 60.1%, $\chi^2=175.9$, $df=1$, $P<0.001$).

The table shows the junior doctors' first choices of long term mainstream specialty and compares them with the respondents of 1996 (table). We found no difference in the distribution of first choices between the graduates of 1999 and 2000 ($\chi^2=14.1$, $df=13$, $P>0.05$) and a significant difference between those of 1999 and 2000 combined and 1996 ($\chi^2=83.5$, $df=13$, $P<0.001$). Choices for general practice increased, whereas choices for hospital medical specialties, surgical

First choice of long term career of United Kingdom medical graduates during their preregistration year. Values are numbers (%) of respondents

	Men			Women		
	1996 (n=1395)	1999 (n=1162)	2000 (n=1306)	1996 (n=1531)	1999 (n=1656)	2000 (n=1669)
General practice	198 (14.2)	205 (17.6)	228 (17.5)	386 (25.2)	477 (30.5)	531 (31.8)
Medical specialties	348 (24.9)	239 (20.6)	288 (22.1)	380 (24.8)	344 (22.0)	385 (23.1)
Surgical specialties	449 (32.2)	361 (31.1)	390 (29.9)	178 (11.6)	176 (11.2)	178 (10.7)
Paediatrics	65 (4.7)	47 (4.0)	45 (3.4)	158 (10.3)	118 (7.5)	124 (7.4)
Accident and emergency	44 (3.2)	43 (3.7)	29 (2.2)	38 (2.5)	57 (3.6)	40 (2.4)
Obstetrics and gynaecology	24 (1.7)	6 (0.5)	12 (0.9)	91 (5.9)	47 (3.0)	54 (3.2)
Anaesthetics	96 (6.9)	97 (8.3)	120 (9.2)	111 (7.3)	108 (6.9)	115 (6.9)
Radiology	28 (2.0)	23 (2.0)	33 (2.5)	22 (1.4)	40 (2.6)	44 (2.6)
Pathology	20 (1.4)	13 (1.1)	14 (1.1)	21 (1.4)	29 (1.9)	30 (1.8)
Psychiatry	56 (4.0)	49 (4.2)	51 (3.9)	56 (3.7)	63 (4.0)	56 (3.4)
Public health medicine	4 (0.3)	5 (0.4)	4 (0.3)	5 (0.3)	5 (0.3)	7 (0.4)
Other medical choices	25 (1.8)	27 (2.3)	34 (2.6)	53 (3.5)	48 (3.1)	58 (3.5)
Specialty not stated	22 (1.6)	28 (2.4)	27 (2.1)	19 (1.2)	35 (2.2)	34 (2.0)
Non-medical	16 (1.1)	19 (1.6)	31 (2.4)	13 (0.8)	18 (1.2)	13 (0.8)

Small numbers of doctors gave equal first priority to two (or, in rare cases, three) specialties. These choices were given a weight of one half or one third in the above totals, which were rounded when necessary.

The smaller number of men responding from the 1999 and 2000 cohorts compared with the 1996 cohort reflects a higher overall response rate and a higher proportion of male graduates in the 1996 cohort.

specialties, paediatrics, and obstetrics and gynaecology decreased (the latter halved). Differences between men and women in choices of specialty remain substantial.

Of the graduates from 1999 and 2000, 10.3% (583) “definitely” or “probably” did not intend to practise medicine in the United Kingdom for the foreseeable future. Including those who were undecided, 25% (1418) had doubts about practising medicine in the United Kingdom. The corresponding figures were 9.0% (263) and 22.2% (648) for the 1996 cohort and 9.7% (251) and 24.3% (631) for the 1993 cohort.

Comment

The percentage of newly qualified doctors intending to enter general practice has increased from 20% in 1996, the lowest percentage recorded in our surveys, but remains much lower than the figure of 40-50% of the qualifiers of the 1970s and 1980s.¹ Concerns about career prospects in obstetrics and gynaecology have reduced the numbers choosing this specialty to the lowest ever recorded in our surveys. Changes in choice for other specialties are less striking.

The government is substantially increasing the number of places at medical schools. Knowledge of

young doctors' career choices will help planners to anticipate whether future service requirements in different specialties will be met from United Kingdom sources.

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