Recruitment and Training in Community Medicine — A Decade's Experience

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It is now ten years since the inaugural meeting of the Faculty of Community Medicine of the Royal Colleges of Physicians, the first MFCM examinations and the first registration of Fellowships and Memberships of the Faculty with the General Medical Council. With the help of Lord Rosenheim the Faculty had however been established and many of its foundation Fellows and Members elected two years earlier.

The new specialty comprised several heterogeneous groups of doctors including medical officers of health, those administering the hospital service, those employed at the Department of Health and Social Security, the Scottish Home and Health Department, the Welsh Office and Northern Ireland Department of Health and Social Services, those in the medical services of the armed forces and those in academic departments of community medicine whose main interest was usually epidemiology or operational research. To assimilate doctors with such divergent areas of responsibility into one specialty was a daunting task. In addition, community physicians have had to guide the profession through two reorganisations and help it to adjust to a period of severe recession in place of continuous expansion and limitless finance which had been its staple diet since the establishment of the National Health Service in 1948.

Although the specialty has developed an attitude of extreme modesty and self-criticism, its contribution has been remarkable considering the lack of proper training available until a decade ago. Moreover, it has had to face and live with much disharmony within the Health Service, which has led to the rapid growth of private medical care.

Although some doctors wishing to pursue a career in community medicine prepare themselves for the Part I MFCM examination and largely arrange their own Part II project and service training, the majority in England and Wales are employed as registrars by health authorities and attend the MSc course at the London School of Hygiene and Tropical Medicine or the University of Manchester, the MPH course at Leeds or one of the three consortia training schemes.

The 1983 report of the joint working party set up by the Regional Medical Officers and the Community Medicine Consultative Committee[1] indicated that a minimum intake into the specialty of 80 trainees per year is necessary to fill the 200 existing career vacancies for Specialists in Community Medicine (SCMs) and those which will arise from death or retirement in England and Wales. This article describes the work of one of the three consortia, the Midlands and South Western Inter-Regional Training Scheme, which the joint working party suggested should aim at an intake of 26 trainees per year.

The Scheme

Geographically, the scheme covers the Oxford, South Western, Wessex and West Midlands Regions and the whole of Wales apart from Clwyd and Gwynedd. The participating universities are Oxford, Bristol, Wales, Southampton, Exeter and Birmingham. Reading also contributed until the DHSS withdrew the funding of its operational research unit. Twenty weeks of modular training, covering Appendix I of *Specialist Training in Community Medicine* [2], is provided by the universities and a further week by the DHSS. Between modules, registrars receive in-service training as outlined in Appendix II of *Specialist Training in Community Medicine* [2]. Approximately one-third of the in-service training is at the Regional Health Authority and the remaining two-thirds is normally split between two disparate but geographically adjacent districts. During in-service training registrars spend about half a day each week with their academic tutor. The scheme is of two years' duration and after passing the Part I MFCM and approval by a Senior Registrar Assessment Committee the trainees are upgraded to senior registrar.

Recruitment

Since the scheme started in 1973, 132 doctors have been accepted for training (Table 1). It will be seen that it has never been possible to reach the target of 26 per year; in fact even if this number of suitable candidates applied it is at present doubtful whether so many posts could be

Table 1. Entrants to Midland and South Western Inter-Regional Training Scheme in Community Medicine by year, age and sex.

	Total	M	F	Mean age (years) Total	M	F	Age range (years) 20–29	30–39	40–49	50–59
1973	7	3	4	35.4	35.0	35.8	3	2	2	—
1974	11	7	4	37.9	36.1	38.5	2	5	3	1
1975	8	4	4	36.3	33.5	39.0	3	2	2	1
1976	5	3	2	31.2	27.0	37.5	3	1	1	—
1977	11	7	4	33.1	34.0	31.5	4	6	—	1
1978	10	6	4	32.8	33.3	32.0	4	4	1	1
1979	9	4	5	31.3	28.8	32.4	4	4	1	—
1980	9	8	1	34.6	34.5	25.0	2	5	2	—
1981	14	9	5	33.6	35.1	31.2	7	3	3	1
1982	12	8	4	32.8	33.5	31.8	4	6	1	1
1983	18	8	10	30.7	29.5	31.7	10	7	1	—
1984	18	10	8	31.1	32.9	29.0	7	10	1	—
	132	77 (59%)	55 (41%)	32.8	32.9	32.7	53	55	18	6

funded or satisfactory service placements arranged. Initially there was a great shortage of acceptable applicants but over the last four years the number and quality of candidates have improved greatly. This is thought to be due to several factors. First, greater undergraduate exposure to the specialty, second, the intense competition in the major clinical specialties together with worldwide over-production of doctors, third, a growing appreciation that community medicine is an interesting, challenging and important specialty, and fourth, the increased female intake into the profession, many of whom find community medicine best suited to their professional aspirations and family commitments. However, more male (59 per cent) than female (41 per cent) doctors have entered training; it will be seen that the mean age of males and females has been similar and that entrants are a little younger now than they were when the scheme started. This is due mainly to the diminishing numbers of mature senior clinical medical officers wishing to obtain the MFCM and become community physicians and to fewer older general practitioners seeking to transfer to community medicine.

Of the 132 entrants, 66 had obtained higher qualifications before starting training in community medicine; 21 held the MRCP, FRCS, FRCOG, MRCOG or MRCGP, 6 had doctorates of medicine and 2 of philosophy, 21 had degrees of BSc or B Med Sci, 4 had obtained the DPH, 16 the DCH, 17 the DRCOG and 8 held other diplomas.

Wastage

Seventeen (12.9 per cent) of the 132 entrants have left the specialty; 13 of the 17 transferred to general practice before vocational training became mandatory. In two the change resulted from failure to pass the Part I MFCM examination and in another two because of difficulty over the Part II dissertation; 6 of the 13 had already passed the Part I examination and the demands of Part II coupled with a reluctance to relinquish clinical work and the attraction of the higher income and tax allowances in general practice appeared to be the major influences. The other 4 of the 17 lost to the specialty included one who has transferred to audiological medicine, one to genito-urinary medicine and two to occupational medicine. One of the latter was working in the Employment Advisory Service when he joined the scheme in order to obtain the MFCM, but he was unsuccessful in the examination. He has since obtained the MFOM and DIH.

A wastage of 12.9 per cent is considerably lower than that envisaged by the joint working party of the Regional Medical Officers and Community Medical Consultative Committee[1] and in the 1980 report of a Joint Working Group entitled *Recruitment to Community Medicine*[3], who assumed a trainee wastage rate of 45 per cent. The low wastage is thought to reflect increasingly stringent selection of entrants.

Progress of Trainees

Of the 132 trainees, 36 have not yet been in the scheme long enough to sit the Part I examination, 48 have completed Part I but have not yet obtained Part II, while 26 have obtained Part II. Eleven have not passed either Part I or Part II but are still in the specialty and 11 of those who have left the specialty had not passed any part of the examination.

Of the 115 remaining in the specialty, 37 have already achieved SCM (consultant equivalent) status, of whom one has died and 3 are overseas; 6 who have SCM or equivalent status were unsuccessful in the Part I MFCM examination despite repeated efforts, being appointed SCM because it was felt that the scheme had given them sufficient knowledge and experience to enable them to fulfil their duties and that their personal qualities fitted them for the job (Table 2).

The interval between passing the Part I examination and completing Part II is shown in Table 3. The delay has been a source of some anxiety and appears attributable to several factors; first, with the present staff shortage in the specialty senior registrars have been overburdened with service work and are often called upon to fill vacant DMO posts on a locum basis. Second, some projects chosen have by their nature required several years to elapse

Table 2. Progress of 132 entrants into scheme.

Passed Part I MFCM		48
Completed MFCM		26
Not passed Part I MFCM but still in specialty—		
as consultant or equivalent	6	9
as SCMO	3	
Left specialty—		
with Part I MFCM	6	17
without Part I MFCM	11	
Consultants (DMOs, SCMs, Senior Lecturers or equivalent)		37*
Senior Registrar or Lecturer		31
Registrar—		
Not yet 2 years in post	36	44
Failed Part I MFCM once	1	
Failed Part I MFCM twice	1	
Passed Part I MFCM and awaiting Senior Registrar Assessment Committee	5	
Passed Part I MFCM gaining further clinical experience in general practice	1	

*Includes 1 died, 3 abroad and 5 not yet completed Part II and on a special salary scale

Table 3. Interval between passing Part I and obtaining Part II of the MFCM examination.

Years	Number of Trainees	Mean age at entry to scheme
0	1	43.0
1	1	32.0
2	5	38.0
3	4	30.0
4	10	32.2
5	1	28.0
6	1	37.0
7	1	26.0

before the information sought could be available. Third, other projects have been intended to serve also as MD theses and their magnitude has inevitably involved several years' work. Fourth, some senior registrars have not decided on a Part II project until they have been in post some little time and fifth, within the Faculty there has been some delay in granting approval to project protocols and in assessing dissertations. Delay in obtaining Part II did not appear to be age-related. Senior registrars are currently urged to give priority to and to complete their Part II during their first year in post and to select their project and get its protocol approved immediately they pass Part I or before.

Failure to pass Part I is age-related, the mean age of those who are successful being 31.7 years as compared with 41.5 years in those who fail. It appears more difficult for the mature general practitioner or senior clinical medical officer to grasp the skills required of a community physician today.

Discussion

The current situation suggests that recruitment to community medicine is improving and that the trend is likely to continue and accelerate.

The Faculty of Community Medicine is to be congratulated upon setting up a satisfactory Membership Examination in only a little over ten years. It is hoped that the Faculty will continue its efforts to reduce delays in the second part of the examination and that its assessors will adopt realistic standards. If this can be achieved, there should be no delay in advancement to SCM status for the foreseeable future and the use of the special salary scale should rarely be required. While in general it is probably wise and kind to dissuade mature doctors from entering the specialty because of the examination difficulties that they may encounter, a mean age at entry of over 30 indicates that nearly all those recruited to the specialty will have had much more than the one mandatory year of post-registration clinical experience. In these circumstances four or five years of training in community medicine should suffice. Even this means that the average trainee will be about 37 before becoming an SCM and will have only 28 years in a career post before him, or 23 if he retires at 60 as so many do.

While the standard of the National Health Service will always depend on the skill and devotion of its clinicians, nurses and paramedical personnel, it is unrealistic to think of any increase in the funds that can be made available to it for many years, if ever. In these circumstances the community physicians' skills of epidemiology, statistics, health services management and research, information systems, planning, manpower, health care evaluation and the behavioural sciences provide the essentials of good housekeeping. The Royal Colleges of Physicians of London, Edinburgh and Glasgow have every reason to be proud of the progress and achievements of the Faculty they helped to establish ten years ago.

References

1. *Recruitment and Training in Community Medicine* (1982) Report of Regional Medical Officers/Community Medicine Consultative Committee Working Party.
2. *Specialist Training in Community Medicine* (1982) The Faculty of Community Medicine.
3. *Recruitment to Community Medicine* (1980) Report of Joint Working Group from the Profession and Central Government Departments.