TALKING POINT

Clinical practice and community medicine

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The idea for a study of the attitudes of trainees and recently appointed specialists in community medicine arose out of discussions I had with successive classes of trainees on the MFCM course run by the Southern Universities Consortium. The object was to determine whether trainees considered it desirable that specialists should have the option of continuing to practise clinical medicine on a part-time basis.

Method

I obtained the names and addresses of people believed to be training for the MFCM in 1978 from the Faculty of Community Medicine of the Royal Colleges of Physicians of the United Kingdom and the British Medical Association. Each of the 206 was sent a questionnaire and a covering letter which explained the object of the survey and gave an assurance that expressions of opinion would be treated as confidential. Non-responders were sent a reminder. One hundred and thirty-one answers were received to the first letter and 18 to the second, giving a total response rate of 72.3%. Several of the non-responders were probably overseas students who had given a temporary address in Britain and who had returned abroad. If it had been possible to identify overseas students with certainty and exclude them the response rate would have been substantially higher. At the time the questionnaires were answered, 84 respondents (45 men and 39 women) were still in training and 65 (50 men and 15 women) were specialists in community medicine with consultant or honorary consultant status. Three who had returned to clinical posts outside the specialty were excluded from the analysis.

Results

Trainees and specialists and men and women were considered separately. As no significant differences were found between them the four subgroups have been considered together in the analysis.

Table I shows the number of years of full-time clinical work (excluding the preregistration year) completed by the respondents before taking up their current post. Just over half had five or more years of full-time clinical experience after registration (50.3%), about one-fifth had three or four years' experience (22.9%), and a further fifth (20.8%) had two years' full-time clinical experience or less.

In the next section of the questionnaire respondents were asked about the option to practise personal clinical medicine by specialists in community medicine. They were asked how in their opinion such an option would (a) affect the attainment of

TABLE I—Number of years of full-time clinical work (excluding the preregistration year) before training

Years	No (%) of respondents
< 1 or 1	15 (10.1)
2	16 (10.7)
3	19 (12.8)
4	15 (10.1)
5-9	49 (32.9)
10-19	23 (15.4)
20+	3 (2.0)
No information	9 (6.0)
	149 (100.0)

the objectives of the specialty; (b) affect recruitment to the specialty of community medicine; (c) affect working relationships between specialists in community medicine and other medical practitioners; and (d) affect working relationships between specialists in community medicine and persons in other disciplines in the health service. Most respondents thought that such an option would be helpful (table II), and in relation to its effect on recruitment and relationships with other specialties more than two-thirds considered it would be helpful. The greatest

TABLE II—Answers to questions on effect of practising part time

	(a) Attainment of objectives	(b) Affect on recruitment	(c) Relationships with other specialties	(d) Relationships with other disciplines
	%	%	%	%
Help	83 (55.7)	109 (73.2)	101 (67.8)	81 (54.4)
Hinder	30 (20.1)	10 (6.7)	17 (11.4)	21 (14.1)
No effect ..	23 (15.4)	20 (13.4)	22 (14.7)	37 (24.8)
Do not know ..	11 (7.4)	9 (6.0)	6 (4.0)	8 (5.4)
Not answered ..	2 (1.3)	1 (0.7)	3 (2.0)	2 (1.3)
	149 (99.9)	149 (100.0)	149 (99.9)	149 (100.0)

degree of polarisation of attitude was seen in answer to the question about the effect clinical practice might have on the attainment of the objectives of the specialty. Here 55.7% thought it would help but 20.1% thought it would hinder attainment. The question on working relationships with persons in other disciplines within the Health Service attracted the highest proportion of neutral comments.

The next question asked whether the terms of the contract for specialists in community medicine should encourage or discourage the part-time practice of clinical medicine. Almost two-thirds of the respondents (95) thought the contract should encourage such practice while almost one quarter (32) took the opposite view. The interpretation of these answers is complicated by an error in the design of this question in that there was no provision for a neutral answer, a fact commented on by several respondents. Nevertheless, 18 of the respondents commented that the contract should permit part-time practice but neither

encourage nor discourage it. One hundred and twenty-eight (85.2%) of the respondents stated that they would have no objection to colleagues in community medicine practising clinical medicine part time. Only 13 (8.7%) said they would object.

Thirty-eight (25.5%) of the respondents (18 trainees and 20 specialists) said that they were currently working part time in clinical practice. Of these, nine did sessions in general practice (not all of which were remunerated), seven did hospital sessions, seven worked as clinical medical officers, 11 did various combinations, three worked in occupational medicine, and one was in the armed Forces.

Trainees were asked whether or not they would welcome an opportunity to practise clinical medicine when they had taken up a specialist post. Fifty-three (63.1%) said yes, 25 (29.8%) said no, and the remainder were uncertain or provided no information. Of those who answered yes, 14 (26.4%) wished to do sessions in general practice, 16 (30.2%) hospital work, nine (17.0%) work as a clinical medical officer, four (7.5%) occupational medicine; the remainder wished to work in miscellaneous fields or gave no information.

RESPONDENTS' COMMENTS

The final section of the questionnaire was left open for comments on the survey subject and 106 (73.8%) respondents used it; 52 (49.1%) of the comments were classified as favourable to part-time clinical practice by community medicine specialists, 28 (26.4%) were unfavourable, while 26 (24.5%) were neutral or irrelevant to this issue.* A striking feature of the comments was their strength. This was true of both of the main schools of thought and shows a remarkable degree of polarisation of views. The principle reasons given in support of part-time clinical practice were that it would improve relationships with other clinicians, increase credibility, increase realism and insight into clinical problems ("help to keep the community physician earth-bound"), help recruitment, and improve job satisfaction.

A succinct expression of the case for part-time clinical practice in community medicine was given by one respondent: "Without clinical involvement I do not feel community physicians can be fully effective in their role of measuring need, planning of health services, or evaluating the efficiency or effectiveness of services. Neither will they gain the respect of clinical colleagues and be effective in providing the essential link between clinical doctors and other Health Service workers especially administrators in the planning machinery. Furthermore, I feel liaison with the public will be greatly enhanced by clinical involvement of community physicians."

The most common argument against part-time clinical practice was that "it is better to do one job well than dabble in two." With this view were associated doubts about the ability to maintain competence and keep up to date clinically, particularly with advances in treatment, if practice was on a part-time basis. Other respondents disagreed, pointing out, for example, "that many women practise clinical medicine part time effectively so why should not community medicine specialists"? Another view held strongly by some was that clinical practice hinders objectivity and distracts from the main issues and giving it up "helps people discard blinkers." Other arguments advanced against clinical practice were that it was vain to seek credibility by "tinkering with clinical practice"—the effect would be the reverse of what was intended—and that while encouragement of clinical practice might encourage recruitment this "expedient would be shortsighted."

The argument against clinical practice was well put in the following quotation: "The practice of community medicine requires a full-time professional approach and involvement with personal clinical medicine has the danger of narrowing one's focus subtly towards particular subjects and ideas. I would prefer that specialisation into community medicine would come after a broad background in clinical medical fields when some application of the problems by various areas of

medicine has been obtained, rather than risking the development of an amateur and part-time attitude to community medicine."

Three general points occurred in the comments, though they were only indirectly relevant to the issue under consideration. There was an anxiety that community medicine specialists were in danger of being identified with work which, as one respondent put it, "could be more appropriately carried out by administrators, economists, or sociologists." The results of a recent survey of the work of the community physician in England suggest that this fear may not be groundless. In it Donaldson and Hall found that 60% of the ascribable task time of community physicians was devoted to administration, of which 27% was described as "routine."¹ Another anxiety concerned the lack of clinical experience of some trainees; one respondent thought that at least five years of clinical experience was desirable, preferably encompassing both hospital and general practice. Another thought that it was fruitless to insist that trainees, especially married women, should defer entry to community medicine in order to obtain wide clinical experience. Such experience could be obtained better by creating training posts in community medicine with a substantial component of clinical responsibility. Five respondents said that their training in community medicine would (or actually did) have the effect of improving their clinical practice, and with this in mind one respondent suggested that senior house officer rotations should include an attachment in community medicine.

Comment

Most respondents thought that an option to practise part time should be encouraged, and that it would help the specialty to achieve its objectives, encourage recruitment, and improve working relationships with colleagues. An overwhelming majority said they would have no objection to colleagues practising part-time clinical medicine, and a majority of the trainees said that they would welcome an opportunity to continue to practise when appointed to specialist grades. I wonder whether the Working Party on the State of Community Medicine, which recently published a report² without a recommendation on this issue, was aware of the strength of feeling among trainees and recently-appointed specialists. All those eligible for the survey had committed themselves to train for the specialty, whatever reservations they may have had about the prospect of giving up clinical practice on appointment to a specialist post. In view of their opinions it is possible that substantial numbers of potential recruits are discouraged from starting any training for the same reason.

Medicine is entering a harsh era of restricted budgets and if it is to advance and extend the available preventive and therapeutic techniques doctors will need to identify waste and discard ineffective practices. Classical epidemiological techniques will be needed, for example, to identify soluble health problems and to evaluate current methods of prevention and treatment. In addition, medicine will require skilful management of human and material resources.

Few would deny the need for a group of medical personnel with special training in these techniques and skills. Their success will depend, however, not only on their mastering these skills but on the degree to which their work meets their professional aspirations and is seen to leaven medicine from within rather than to belabour it from without. On both counts, the evidence of this survey suggests that a contractual option which encourages some remunerated clinical work for those who wish it should be considered. A more important matter, not considered, is how the perspective of medicine which takes into account the whole population's health needs and which examines critically the shortfall in present practice may become part of every doctor's training and practice.

References

- ¹ Donaldson, R J, and Hall, D J, *Community Medicine*, 1979, 1, 52.
- ² *British Medical Journal*, 1979, 1, 503.

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*In view of the subjective element in this classification I invited a colleague to categorise the comments independently. He found that 63.0% were favourable, 17.0% were neutral or irrelevant, and 16.0% were unfavourable.