EDITORIAL

Wither or whither now training in occupational medicine?

The specialty of occupational medicine in the UK is at a critical turning point. Training is in real danger of disappearing due to the lack of new doctors entering into and successfully completing specialist training. This is at a time when political recognition of the specialty is higher than ever before. This editorial examines what has led us to this crossroads and identifies possible solutions.

In 2007, I wrote an editorial for occupational medicine describing the opportunities and challenges facing us with the advent of Modernising Medical Careers [1]. Even at my most pessimistic, I did not predict the demise of virtually all training in occupational medicine. In 2007, there were 27 new entrants into training in occupational medicine. That same year 29 doctors successfully completed training and achieved Membership of the Faculty of Occupational Medicine (MFOM). In 2014, there were 11 new entrants into training with only 8 doctors successfully completing training and achieving their membership (J. Moore, personal communication). The route into specialist accreditation, namely CESR (Certificate of Equivalent Specialist Registration), has not proved to be a rich source of specialists. During 2014, two doctors were awarded specialist accreditation using this route. It is unlikely that the current approach will be the solution to falling numbers of available specialists. The loss of the Associate of the Faculty of Occupational Medicine (AFOM) examination in 2010 significantly reduced the likelihood of any increase in numbers in the following years. Those doctors who achieve specialist accreditation through the CESR route can currently then apply to the Faculty of Occupational Medicine (FOM) for membership ad eundem. The FOM have recently announced that Associateship is to become available again from 1 April 2015 for those doctors who have passed the Diploma in Occupational Medicine, have worked in the specialty for a year, have support from a practising specialist and have passed the MFOM part 2 [2]. This may increase applications for CESR. It is certainly an improvement on the situation we faced with the removal of the requirement for those not in training programmes that would have come into force in 2017 to have worked full-time in the specialty for 4 years before being eligible to sit MFOM part 2.

Do we need so many qualifications in occupational medicine? This confuses employers, who are largely neither experienced nor knowledgeable about doctors’ qualifications. Is there any evidence employers place any weight on the difference between a diploma, an associate, a member or a fellow of the faculty or a holder of the advanced diploma from Manchester University? Being an accredited specialist in occupational medicine is a requirement for some posts in the National Health Service (NHS) or military but why not simplify it for other employers? Why not scrap the AFOM and separate the joint achievement of specialist accreditation and award of MFOM? The MFOM will no longer be a marker for specialist accreditation in occupational medicine but for employers a diploma will clearly be a generalist with an interest and a member a doctor with evidence of academic achievement to a specialist level. To achieve this change why not accept an AFOM as an appropriate marker of knowledge in lieu of an MFOM part 2 examination and offer transfer for those doctors who currently hold this qualification to MFOM if criteria are met? Suitable criteria would be appraisal, revalidation, evidence of continuing professional development, contribution to the speciality and experience. At a stroke this would simplify matters for employers.

It is not just the absolute number of trainees or available qualifications that are of concern. Traditionally, three trainees were trained in industry for every one in the NHS. Now, the ratio is 1:1. The stated aim by the FOM for its curriculum for specialist training is to produce specialist occupational physicians capable of independent practice in any industry sector by the end of the training. This statement cannot be as easily met by training solely within one industry setting. Training rotations between industry sectors, including the NHS, must be implemented.

There are training opportunities available. The National School for Occupational Health (NSOH) was unable to fill its available vacancies during its first round of recruitment. Similarly, there have been posts in Scotland that have been left fallow due to a lack of suitable applicants. These posts are funded, albeit at a trainee salary point, but remain unfilled. Low levels of recruitment into specialty training is not unique to our specialty but has a greater impact as the majority of occupational physicians work outside the NHS and the military where specialist accreditation is a requirement.

There are also developing difficulties in identifying suitably qualified, competent, able and willing educational supervisors to meet the training requirements of the trainees. In 2015/16, the General Medical Council (GMC) will require all doctors participating in educational activities...
to demonstrate their competence in the relevant areas. The competencies vary depending on the role undertaken. These competencies will be checked at appraisal and the roles will become appointments and recognized by the GMC. The increased requirements will further diminish recruitment into these educational roles. Again, these challenges are by no means unique to our specialty. However, as a small specialty the impact could be significant.

The challenge of getting occupational medicine into undergraduate curricula has been and continues to be very difficult. Significant effort is required to maintain what inputs there are into undergraduate curricula let alone increase inputs or establish occupational medicine in a medical school curriculum where it does not already exist. The development of ‘champions’ as supported by the FOM and the Health & Safety Executive has failed in its aim to increase awareness and recruitment into the specialty.

We know from the recent single organization work undertaken by the Society of Occupational Medicine and the FOM that we are an aged specialty. Urgent steps need to be taken to replace those that are leaving. In recent years we have taken on those who have not been trained in occupational medicine. During this time, the equivalent Faculty in Ireland has successfully grown itself as an international organization for training in occupational medicine. It offers some routes to specialist accreditation that are seen by trainees as less arduous than those offered in the UK by the FOM.

The falling numbers of trainees and the demographics of our specialty are the greatest threat to our specialty since its inception. The challenges are multifactorial and therefore there is no one solution. Yes, there are changes that the FOM must make to facilitate access to training and qualification but in my view, not all should make it easier to enter into specialty training. There should be a requirement for all entrants to higher specialist training in occupational medicine to possess a higher qualification, e.g. Membership of the Royal College of Physicians or Membership of the Royal College of General Practitioners. With the change suggested above some entrants to specialist training may already have MFOM. Transferrable competencies must be identified and accepted. This has the added benefit of reducing the assessments required during training and increasing the likelihood of successful completion of training. For the rest, the type and number of assessments required during training need to be reviewed with the aim of reducing the requirements. Overall, these changes will both increase the quality of applicants and facilitate transition through training. In all likelihood, this will lead to a higher quality of specialists.

The solutions do not live only with the FOM. Even if all the changes were introduced, part of the solutions lie with practitioners. There must be at least one specialist trained to replace each of us, or our numbers decrease. Not all doctors are able, willing and have the necessary competencies to contribute to this. Therefore, the burden falls on a smaller number of suitably trained and qualified doctors. However, all doctors working in our specialty must support recruitment into training posts. While the NSOH may improve the quality of training, it may also struggle to recruit into areas away from London. The most successful recruitment is through local engagement. It is beholden on all of us to raise awareness of our specialty at every opportunity. Similarly, we must offer trainees access to our specialty at the correct point in their career—medical students, young doctors and those who are late in seeing the attraction of our specialty and facilitate a career change. The recent advert by NSOH described the family friendly nature of the working arrangements in our specialty. I think that this is a key message in order to recruit today’s doctors. One of my colleagues describes occupational medicine as the hidden jewel of medicine. We need to get this message out at every opportunity.

There are examples around the country of getting the message out in a variety of ways. In South East Scotland, we offer a 2-day introductory course to occupational medicine to doctors soon to complete their general practice training. In addition, we offer fellowships in occupational medicine for recently qualified general practitioners across Scotland. The posts are funded by and based in NHS occupational health departments. The posts are 12 months duration, half-time and have the achievement of the diploma in occupational medicine as a marker of success. There are undoubtedly other examples from around the country that can be gathered and used to build the awareness of our specialty. If we are not to wither, we must set SMART objectives for recruitment into speciality training. The FOM has the requirement to set the standards, set the examinations and award qualifications in occupational medicine. The FOM must urgently look at how this is done and identify what barriers there are to achieving qualifications and specialist accreditation in occupational medicine. Recruitment needs to be done through local contacts. The FOM’s regional specialty adviser structure needs to be tasked with working with the Society of Occupational Medicine regional groups to attract new blood into the specialty. Those specialists who work in industry posts need to make contact with the local NHS occupational health department to offer support, assistance, rotations and ideally training posts for doctors. If we can offer this type of training, it will become increasingly attractive for trainees, who will then educate their contemporaries,
and we will meet the FOM requirements to produce doctors able to work in any industry sector as specialists in occupational medicine.

It is the responsibility of each and every one of us to promote the specialty, to contribute to training and to leave our legacy. Ask not what your specialty can do for you.

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References

Mellifluous

Mellifluous or pleasingly smooth or musical to hear. From the late 15th century and the late Latin, mellifluus from mel ‘honey’ and fluere ‘to flow’. Synonyms: sweet-sounding, sweet-toned, dulcet, honeyed, mellow, soft, liquid, soothing, rich, smooth, harmonious, tuneful, musical.

He had the most wonderful speaking voice I have ever heard. If ever a voice deserved the term mellifluous it was his, but it was also authoritative without being autocratic, knowledgeable without being condescending. It was a voice you could believe in. I could hear it in my mind clearly even though I had not actually heard it for many years. I first heard it as a teenager and it played an important part in my choosing science and so medicine rather than art. To me he was the voice of science as well as ‘the first invisible star of television’.

Paul Vaughan, who died in November 2014, was the voice of Horizon and Kaleidoscope. He was an Oxford wartime graduate, self-taught orchestral clarinettist and author of award winning books. After a job with a pharmaceutical company, he joined the British Medical Association (BMA) as their youngest staff member despite not having a science degree and became their press officer. His recollections of the BMA were published as Exciting Times. He was also the voice who told us ‘The future’s bright, the future’s Orange’.

I wanted to hear his voice again and followed a link to the BBC archive. Serendipity perhaps or maybe just the space time continuum linking everything together as it likes to do but I found myself watching ‘Death of the working classes: Why do the working class in Britain die young?’ an episode of Horizon first broadcast in 1988. It presents stark facts about the health risks of lower social class and how of 78 diseases coded by the Office of Population Censuses and Surveys 65 had significant correlations to occupation with only one, malignant melanoma, more frequent in the professional classes. In the documentary there are still shipyards on the Tyne and weaving sheds in Burnley. A young Michael Marmot features and there is an interview with Sir Douglas Black, author of the original Black report in 1980. The Black report demonstrated that although overall health had improved since the introduction of the welfare state, there were widespread health inequalities and that the gap between social class V and I was widening not reducing as was expected. The BBC website notes that ‘government statistics released in November 2007 show that this health divide still persists. In 2001–03, men aged 25–64 working in routine occupations (for example, bus drivers, refuse collectors) had a death rate 2.8 times higher than that of men working as large employers or higher managers’. It is sobering to see that despite this knowledge, over thirty years later nothing has changed.

Paul William Vaughan, broadcaster and writer, born 24 October 1925; died 14 November 2014. The Horizon programme can be accessed at http://www.bbc.co.uk/archive/working/5019.shtml

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