Higher medical training in venereology*

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SUMMARY In a review of the organisation of higher medical training in Britain leading to accreditation for those intending to specialise in venereology within the National Health Service suggestions are made for improving the present system. These include the enrolment of trainees in general medicine as well as in venereology to ensure a broad general experience of medicine. The establishment of an agreed curriculum in venereology for trainees is thought desirable. Improvement in undergraduate education in venereology is necessary if recruitment of trainees to the speciality is to be increased.

The diploma courses in venereology are mainly attended by foreign graduates; the numbers are likely to be reduced by the recent heavy increases in fees. Although adequate practical experience of the tropical venereal diseases cannot be provided, these courses give a good general experience of venereology as ideally practised, much of which is relevant to the conditions under which the overseas trainees will have to work on return to their own countries. Secondment of our own trainees to work in centres in developing countries as an approved part of their training would benefit both them and their hosts.

Introduction

At present there are two quite separate forms of postgraduate training in venereology in Britain. For those who wish to make a career within the National Health Service a three-year period of general professional training, during which the MRCP or equivalent examination is passed, is followed by higher medical training in an approved senior registrar post for up to four years. Courses leading to a diploma in venereology are held in Liverpool and London. Places on these courses are mainly filled by postgraduate students from abroad, some of whom also obtain the diploma of dermatology before returning home to practise dermatovenereology. Currently, the diplomas in venereology are not recognised as a higher qualification for those practising in Britain, although a thorough knowledge of the management of the venereal and other sexually transmitted diseases is necessary to pass these examinations.

Diploma courses

Having considered for some time whether the clinical material available for teaching purposes in England was appropriate for those who return to the tropics to practise, I had the opportunity last year of obtaining some statistics to compare with our own (table I) while on visits abroad.

The figures for England are taken from the annual report of the chief medical officer of the Department of Health and Social Security for the year 1978.¹ The difference in disease incidence between England, India, and Thailand appears to be considerable. We lack the 10-11% of tropical diseases but, apart from these, the table shows a progression from India, where most patients have genital sores of one sort or another and syphilis is still rife, to Thailand, where only a few patients have genital sores and granuloma inguinale is very rare. There, urogenital discharges are the commonest type of disease, with gonorrhoea causing the majority of such infections; these are a legacy from the Vietnam war. In England the venereal diseases are numerically only a minor problem and non-specific genital infections comprise almost half the number of cases of other sexually transmitted diseases. Nevertheless, great strides are being made in the tropics, and standards are

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*Higher medical training in venereology*TABLE I *Percentage distribution of sexually transmitted diseases in three countries*

Diseases	England	India	Thailand
Syphilis	1.1	10.7	1.3
Chancroid		8.4	8.3
Lymphogranuloma venereum		1.3	2.6
Granuloma inguinale		0.7	
Gonorrhoea	14.3	6.5	25.4
Non-specific genital infections	24.1	4.1	11.7
Other sexually transmitted diseases	24.7	32.2	22.1
Other conditions	35.8	36.1	28.6
Grand totals	402 162	452 640	700 216

improving, with more of the other sexually transmitted diseases being diagnosed and treated.

Because the standards vary so much between clinics in each country it is probably fairer to compare the clinical material available for teaching in three centres of excellence: a large clinic attached to a London teaching hospital (personal communication), the Institute of Venereology in Madras,² and the Middle Road Hospital in Singapore³ (table II). If the mean number of cases seen per week at these centres are compared, the main difference between London and the other centres lies in the differential diagnosis of genital sores, London lacking the tropical diseases. Nevertheless, in London and Singapore there are more cases of genital herpes than of primary syphilis, ratios of about 9:1 and 5:1 respectively, while in Madras the ratio is 1:1.3. The London clinic provides the largest caseload of all the other conditions recorded at the three centres, with an excess of non-specific genital infections (although increasing numbers of these cases are now being diagnosed throughout the tropics), and of genital candidosis which remains an uncommon condition at the other centres.

Thus the clinical material available in London is relevant to the practice of postgraduate students when they return home in all aspects save that of the tropical venereal diseases.

TABLE II *Mean number of cases per week seen in three clinics*

Diseases	London	Madras	Singapore
Primary syphilis	1.8	13.4	0.7
Chancroid		20.1	13.3
Lymphogranuloma venereum		5.4	0.5
Granuloma inguinale		6.9	
Genital herpes	17.5	9.7	3.3
Genital warts	19.1	8.4	11.1
Gonorrhoea	96.3	14.7	6.4
Non-specific genital infections	101.2	11.2	6.8
Trichomoniasis	30.6	10.0	2.6
Genital candidosis	41.3	0.4	1.1

In future possibly fewer Asians will enrol for the British courses. Several diploma courses in venereology have been, or are being, set up in India and South-east Asia, which will attract entrants from that part of the world. A course leading to a diploma in dermatology will also soon be established at the Institute of Dermatology in Bangkok.

Two criticisms of the British courses were made when I was abroad. Firstly, the increases in fees for foreign students seeking postgraduate training in Britain were excessive and bound to curtail the numbers able to come from the Third World countries. Secondly, from senior specialists, the facilities in Britain are too sophisticated so that when students returned home they were frustrated by the lack of facilities under which they had to practise, although those who had been on the courses said they had enjoyed them.

While it was generally believed, especially by those advising their governments, that junior specialists should study in their own countries, it was also felt that there was a case for more senior specialists in venereology and microbiology to visit Britain for short sabbaticals to study new and developing techniques and treatments at first hand. Nevertheless, all the specialists with whom I spoke agreed that there was a need for the continued cross-fertilisation of ideas between European and tropical trainees and junior specialists. This, they thought, would be better achieved by Europeans visiting the tropics rather than vice versa, so that they could gain experience in tropical diseases and impart knowledge of the newer techniques and treatments used in Europe.

Training for a career in Britain

Training for career posts in Britain is controlled by the Joint Committee on Higher Medical Training (JCHMT). This is a joint committee of the Royal Colleges of Physicians of Edinburgh, Ireland, and London, and the Royal College of Physicians and Surgeons of Glasgow. Its small secretariat has offices in the London college. The executive consists of representatives of the four colleges, a medical co-ordinator, a post held by the Linacre Fellow of the London college who acts as a link between the executive and the specialist advisory committees (SACs), and representatives of the Association of Clinical Professors of Medicine and of Paediatrics, the Conference of Postgraduate Deans, the Royal College of Pathologists, and the Faculty of Community Medicine. The full committee consists of the executive and a representative from each of the 19 SACs with observers from the various health departments, the Medical Research Council, and a recently

appointed consultant. It publishes a training handbook,⁴ which includes training programmes for all the specialties and lists of approved senior registrar posts. Previously the full committee met twice a year. More recently the full committee, now with two members from each SAC, meets annually.

The SACs are responsible to the JCHMT for providing visitors to posts whenever educational approval or reapproval is being sought for the training of senior registrars in their specialty. They also make recommendations to the JCHMT on the suitability of trainees for enrolment into higher medical training and on its completion for accreditation as specialists.

At present the SAC on venereology consists of four members elected by the Council of this Society, two by the Royal Colleges of Physicians (to date always members of the Society) and one by the Royal College of Obstetricians and Gynaecologists. The adviser to the chief medical officer of the Department of Health and Social Security is also co-opted. Members of the SAC serve for up to four years and elect their own chairman and secretary, who may serve longer. I have been informed recently that the colleges wish to increase the numbers selected by themselves and to cut down the numbers elected by others, and to limit the time served by chairmen and secretaries.

All the senior registrar posts in venereology have now been visited by the JCHMT over the past five years, and these are being revisited by teams who will recommend to the joint committee whether educational approval can be maintained for another five years, for fewer than five years, or withdrawn. Should approval be withdrawn from a senior registrar post, it is laid down that the incumbent has security of tenure and can continue in training, and having completed higher medical training can be accredited, but the post cannot be used for further training until it has been reapproved.

One of the criteria for educational approval to be given to a post is that the department should be attached to a medical school to ensure a close collaboration with other academic departments in their postgraduate activities. It is laid down that a trainee should be supervised by at least two consultants, each being in the clinic for at least five sessions a week. The workload needs to be of sufficient volume and variety to give the necessary all-round experience. This poses a problem for some clinics where early syphilis is rarely seen. Library facilities within the clinic need to be comprehensive, as far as specialist journals and textbooks are concerned, and should include up-to-date publications in allied specialties. Study leave for trainees should not only be available but should be taken and used for study.

Locally it is important that trainees join in the post-graduate activities of other hospital departments.

The visiting teams will also be looking into research facilities, including collaborative work in laboratory medicine, and for evidence that trainees do get experience in emergencies. This may entail their staying in residence when on call. Trainees should rely on their postgraduate deans for advice about their training programmes rather than contacting the SAC direct.

Once in post a senior registrar should enrol for higher medical training. Unless a trainee enrolls he cannot later seek accreditation as a specialist. The trainee applies to the secretary of the JCHMT for an enrolment form, who forwards the completed form to the SAC for consideration at their next meeting. If accepted, the form is returned to the JCHMT who notify the trainee.

So far our trainees only enrol with the SAC on venereology, but it is obvious that the four years' higher medical training in venereology alone is excessive; on average they obtain consultant posts within three years. Trainees in the other medical specialties, having obtained the MRCP, still have to enrol with the SAC on general (internal) medicine as well as that of their chosen specialty, and they manage to complete their higher medical training under the two advisory committees within four years.

Before approving an application the SAC looks for evidence that general professional training has been completed and the MRCP or equivalent higher qualification has been obtained. To date if such formal evidence is lacking then information is sought from those who supervised the trainee's general professional training as to its suitability. Ours is the only specialty in which this procedure has been necessary. The SAC can recommend retrospective recognition for periods of time spent in venereology at registrar grade after a higher qualification has been obtained.

The byword of higher medical training is flexibility, each programme being tailored to the individual trainee's needs. Periods spent abroad studying in approved clinics is welcomed, but the agreement of the SAC must be sought beforehand if such periods are to be recognised. If the SAC has doubts about any part of a training programme they can interview the trainee or discuss them with the supervisor.

On completion of their four-year period of higher medical training, or to date on obtaining a consultant post, trainees should apply to the secretary of the JCHMT for an accreditation form. The completed form is returned to him and forwarded to the SAC for its consideration. If the application is approved then a certificate of accreditation is signed by the

chairman of the SAC and by the chairman of the JCHMT and forwarded to the trainee.

Is accreditation necessary? In theory, yes. Without it a consultant is not recognised by the JCHMT as a trainer of senior registrars. Lack of accreditation by a consultant could therefore deprive a training post of educational approval. In some instances when the SAC does not believe that the full period of higher medical training has been completed, they may defer accreditation for such periods as they may consider necessary, so called proleptic recognition. In future it is expected that only those possessing a certificate of accreditation will be considered for consultant appointments in the NHS. It is of no use for EEC purposes. To date the EEC only recognises the combined specialty of dermatovenereology, and its possession does not automatically entitle the holder to a consultant post in the National Health Service.

How far has the need for enrolment and accreditation been recognised by our trainees and recently appointed consultants? According to JCHMT records, which may be a little out of date, 56% of our senior registrars in training in 1980 had not yet enrolled and 27% of consultants appointed since 1976 had not applied for accreditation. Five of these are in departments with senior registrars in training.

Recruitment

Unfortunately venereology still does not appear to be very popular among British graduates. Parkhouse and his colleagues⁵ noted that only one (0.1%) among 1101 responders had made venereology their first choice of specialty, while according to information on trainees and consultants appointed since 1975 (kindly supplied by the JCHMT) only 59% of our current trainees are British graduates. Lack of interest in our specialty may be due to the fact that few doctors apparently like dealing with basically healthy people or those having social problems⁶ and that, in essence, describes our patients. We are, therefore, recruiting from only a small proportion of graduates, few of whom had enough training in the subject as undergraduates to stimulate their interest sufficiently.⁷ From information supplied by Professor M W Adler it appears that medical schools providing a total of 10 hours' or less teaching on venereology to undergraduates produced, on average, one trainee per medical school between 1975 and 1980, while those providing over 20 hours of tuition produced an average of two trainees per school. The need for adequate undergraduate training in the specialty appears obvious.

In a survey carried out in 1979 on doctors qualified between two and 20 years, Hutt and her colleagues⁶ noted that while overall 75% of responders

had chosen their specialty within five years of qualification, a large proportion of those in venereology were among the 6% of men and 19% of women who had taken 10 years or more. In 1978 the mean age of those appointed as consultant venereologists was 43.8 years.⁸ Hutt and her colleagues⁶ also noted that for 50% of those in venereology it was their second choice of specialty. This trend may well increase because, according to the JCHMT data, 70% of our trainees in 1978 were making venereology their second choice. While most of these doctors come to terms with the change and add lustre to the specialty, there remain a few who only see a shortage specialty as a means of financial security.

So far there has been some flexibility in the recognition of higher qualifications obtained by our trainees before they have entered higher medical training (even to the extent of accepting training that had not led to a higher qualification), but this cannot be expected to continue for long, because only in venereology is the JCHMT encountering this problem. The proportion of entrants with a higher qualification has risen from 30% of those enrolled during 1975-6 to 89% during 1979-80, but we must not be satisfied until all the entrants for training in venereology are seen to have completed their general professional training, as is expected of the trainees in every other medical specialty.

Career prospects

Venereology is no longer a shortage specialty; the Medical Manpower Division of the DHSS has forecast that for the years 1982-90 the expected number of consultants retiring will be less than five a year.⁹ These will be very lean years compared with those of plenty, such as 1978-80, when 24 consultant posts were filled. In addition, according to figures obtained from the JCHMT, there were 36 senior registrar posts in Britain in 1980. Given that there are about 120 consultant posts, the ratio of consultants to senior registrars is about 3.3:1. This is too low, and will ensure that only a minority of trainees will obtain consultant posts on completion of their period of higher medical training. Trainees with the MRCP can be assured of obtaining a consultant post. Of those in training in 1978, 83% of those with the MRCP had become consultants by 1980 compared with 55% of those with the MRCOG and only 35% of those without a recognised higher qualification. Supervisors of trainees lacking the MRCP need to give them every encouragement and opportunity to obtain it, if they are to have a real chance of becoming consultants.

This leads to the conclusion that improvements are needed in recruitment to the specialty, and in our higher medical training generally, to ensure that all

senior registrars receive the high standard of training currently provided for only a few, and that a start should be made as soon as is possible. Before any changes can become effective, however, there are two prerequisites. To recruit more British graduates there needs to be a marked increase in the amount of teaching in venereology provided for undergraduates in many medical schools. This need has already been clearly stated.^{7 10} Furthermore, the ratio of consultant to senior registrar posts must be increased from approximately 3·3:1 to about 7:1 if all senior registrars are to obtain a consultant post on accreditation. Currently some good potential recruits are deterred, or advised against joining the specialty, because of the uncertainty of obtaining a consultant post.

Some suggestions for improving the present system

Basic to any improvements that may be made in training is the necessity of ensuring that all senior registrar posts are truly supernumary. This will entail improving the staffing levels in those clinics having trainees but will ensure that appointments committees are no longer pressurised to make an appointment at any price, merely to have someone to carry out a service commitment without any hope or expectation of providing adequate training; they can therefore be more selective in their choice of trainees.

Complaints have been made to me from time to time at the JCHMT and appointments committee meetings that some of our trainees and consultants lack that sound knowledge of medicine normally expected of physicians. It does appear that the standing of our specialty among our peers is not as high as would be wished. This, in part, could account for the fact that only 21·7% of our consultants in England and Wales have a distinction award,¹¹ a proportion significantly below the overall average of 34·3% ($\chi^2_1 = 7·0$; $0·01 > P > 0·005$). For this reason, among others, I would like to see our trainees enrolled in general (internal) medicine as well as in venereology, especially those whose general professional training did not include experience in acute medicine. Almost all other trainee physicians do this and manage to complete their training in four years, and it has become obvious that most of our trainees in the past have obtained consultant posts within three years. Certainly, if it does not prove possible for them to be enrolled, I think that they should be seconded to work full time in acute medical units for a period of at least 12 months during their training.

The possibility of European trainees and recently appointed specialists spending a period of time studying in clinics in the tropics has been mentioned. This would have to be approved by the SAC. Only in this way will they gain experience in the tropical venereal

diseases and other exotic conditions which are seen in Britain from time to time, but whose diagnoses may be missed or mistaken. Very few such diagnoses were made in England during 1978¹ (table III) and very few trainees will have had the chance to see any of these conditions other than yaws. Possibly of greater importance would be the experience of practising, learning, and teaching abroad, and of mixing with peoples of different cultures on their home ground. This would benefit not only the trainees but the health services of the countries concerned. Such visits abroad should be made towards the end of training when the trainees will be well experienced. These visits should be funded centrally and the Government pressed to accept financial responsibility for them.

TABLE III *Tropical venereal diseases and treponematoses reported in England in 1978*

<i>Diseases</i>	<i>Men</i>	<i>Women</i>
Chancroid	43	4
Lymphogranuloma venereum	26	1
Granuloma inguinale	11	3
Tropical treponematoses	740	400

We recruit trainees with a wide variety and amount of general professional training. Therefore, a curriculum needs to be drawn up to ensure that on accreditation all will have a high standard of knowledge and experience in all aspects of the specialty and are competent to take charge of a clinic on their own. Such a curriculum will need to be both comprehensive and authoritative so that completion of all its components is seen as necessary and useful by both trainees and their supervisors. It should also ensure that trainees know what will be expected of them from the outset and will be able to assess the suitability of the programme mapped out by the supervisor. The academic department of genitourinary medicine at the Middlesex Hospital might consider undertaking the preparation of such a curriculum as part of their educational responsibilities.

The guidelines for training as set out in the Joint Committee's training handbook⁴ are naturally sparse. Among obligatory experience I believe it is essential for our trainees to be familiar with the immediate and later management of emergencies, such as pelvic inflammatory disease and Reiter's disease; this may require them to be resident when on call. Opportunity for research is mentioned, but not how to organise research and use statistical methods. Fortunately, most universities run courses on these subjects. Contact tracing, its needs and techniques, is not mentioned although it is vital for disease control. It is hoped that in the future short residential courses

on contact tracing will be held for senior registrars at the National Training Centre at Harrogate.

Experience in a number of other specialties is recommended, but minimum periods of such experience could well be laid down in the light of current practice. Nowadays I think that attending a course on psychosexual medicine could replace experience in psychiatry, while attendance at a family planning course is essential to all those who do not have the MRCOG.

In my experience few trainees get much instruction or practice in clinic management or administration, and few areas have management courses. The understanding of committee procedures and an understanding of administrators' problems may not appear of importance to trainees but can be vital to their work when they become consultants. The *Special Treatment Clinic: A Design Guide*¹² provides information on recommended staffing levels and the amount of accommodation according to the caseload and is essential in the planning and organisation of a special clinic.

Training programmes are supposed to be tailor-made to suit each senior registrar according to their past experience. With an accepted curriculum in general use it will be possible for the supervisor, trainee, and possibly the postgraduate dean to devise appropriate programmes. I would like to see programmes being sent to the SAC for their approval when the trainee is enrolled for higher medical training and postgraduate deans maintain an informed interest throughout the training period. On appointment, senior registrars should be informed that the first year is probationary, after which their progress will be assessed. At present, such assessment is carried out at only some medical schools, but it should be universal. It should be thorough, and the committee have before it not only a report from the trainee's supervisor but others from all the specialists concerned in the first year's training. The appointment should be terminated if progress is not considered satisfactory, otherwise training will continue. This might be an appropriate time for the trainee to be seconded to an acute medical unit, which will need to have been arranged well in advance by the postgraduate dean, possibly at the time of enrolment.

Finally, how are we to assess the all-round ability of our trainees before they are accredited as specialists? Only a few venereologists who passed the old Edinburgh MRCP examination, specialising in venereology, have provided evidence of having completed higher training in medicine and venereology. Should our trainees sit a test based on the curriculum? I have spoken to several of those concerned with the diploma courses and they are generally agreed that, as currently organised, it would not be possible for

all the trainees in Britain to sit these examinations, although an examination organised nationally might prove feasible. But do we need, and can we afford, yet another postgraduate diploma or certificate?

Discounting an examination, I would suggest that the SAC should receive, with the application for accreditation, a detailed report on the whole of the training period, which should provide sufficient evidence that the programme agreed upon at enrolment has been completed satisfactorily. A certificate of accreditation should not be given merely on the basis of a trainee having occupied a senior registrar's post for a set period of years but on the basis of having completed a satisfactory training programme.

I hope that my thoughts and suggestions for changes in higher medical training in our specialty will be considered as constructive and, if not generally accepted, will lead to others devising improvements which will be to the benefit of the specialty, to the doctors working in it, and to our patients.

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