The evolving specialty of community medicine in Canada

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INTRODUCTION

Community medicine in Canada has its origin as a specialty in the 1970's and stems from a long and honourable tradition in public health practice which is now outmoded and no longer meets the significant challenges that face contemporary society. The forces that prompted the need for rethinking and reshaping can be traced to several events viz, de-emphasis of institutional health care; avoidance of hazardous life styles; prepaid, universal medical care in a cold economic climate; firm governmental commitment to community health and the reshaping of legislation which will truly reflect the role of the modern public health agency and provide a clear mandate to boards of health in the delivery of those programmes which are considered basic by health professionals. As Canada attains self-sufficiency in training its own physicians, a virtual embargo has been placed on the entry of non-Canadians seeking employment in any medical discipline in all provinces. The nature and magnitude of the problems of manpower, supply and training in this country are briefly described.

THE SUPPLY OF COMMUNITY MEDICINE SPECIALISTS

Community medicine physicians are to be found engaged in activities in traditional public health, maternal and child health, planning and evaluation of health services, epidemiology (including clinical), environmental and occupational health, at the federal and provincial levels (with the Department of National Health and Welfare and the Ministries of Health), at the local level, e.g. of a city or a district composed of counties, with research agencies and foundations, armed forces and university departments.

In preparation for the National Workshop on Supply and Training of Local Public Health Physicians held in Ottawa in January 1981, background data were obtained from all Provinces (with the exception of Quebec) of the extent of community medicine manpower shortages at the local level. It was estimated that in the nine responding provinces there would be in the order of 18 vacancies in 1981 out of a total of 140 full-time positions. At the present time, about 70 per cent of local public health officers have the DPH or equivalent only, with an additional 14 per cent holding the Fellowship in Community Medicine of the Royal College of Physicians and Surgeons of Canada. In four provinces (British Columbia, New Brunswick, Nova Scotia and Manitoba) salary incentives are attached to the Fellowship in Community Medicine.

There is considerable provincial variation and flexibility of funding provided for trainees. However, the matter of financial support while in training is a vexed question where there are limitations on governmental funding and community medicine trainees must compete, de facto, with trainees from the clinical disciplines for the support available.
Somewhat belatedly, provincial and federal governments have recognized the parlous condition of manpower at the community health level and attempted to seek causes for the decline in numbers and quality and institute appropriate remedies. As one indicator of the decline in vigour of the specialty, it was noted that 60 per cent of local public health physicians are over 50 years of age. The overly-mature demographic configuration of the manpower pyramid has not been altered, to date, by recruitment of any significant numbers of young physicians. It has been shown that in Canada only 1 per cent of medical students interested in specialty training expressed a primary attraction towards any aspect of community medicine.¹ In spite of this well-recognized pattern and attempts by academic departments of community medicine to increase the attractiveness of their wares, the established clinical specialties and the newly-emerging subspecialties exert powerful appeal with their implied ‘hands-on’ satisfactions and high earnings. There is no reason for optimism that this prevalent attitude towards community medicine will change significantly in the immediate future unless clear role models of community health physicians and career paths are presented to medical students and trainee physicians in family practice or other areas of specialization. In this respect, the Province of Quebec has been particularly successful through the creation of community health departments in hospitals under the direction of community medicine physicians with the status of chiefs of clinical service.

GRADUATE TRAINING IN COMMUNITY MEDICINE

There are essentially two routes along which the aspiring community health physician may proceed in order to qualify, viz (1) by way of a Master’s Degree, similar to the DPH or MPH, offered by the Universities of Toronto and Montreal (which formerly had Schools of Public Health, now discontinued) and capable of being completed by full-time candidates in under 24 months; and (2) the Fellowship in Community Medicine of the RCPS(C) through academic training provided by departments of community medicine in several universities in association with acceptable field-work.

It is interesting to note that the pre-Workshop survey of community health physicians in the provinces showed that 43 per cent of respondents recommended a training course of less than 12 months; 45 per cent recommended 12—24 months for completion with only 8 per cent advocating the training for the Fellowship in Community Medicine over 4 years as a requirement for practice at the community level. However, the delegates at the Workshop drawn from all branches of community medicine, recommended that academic training should cover 1 year with the individual provinces deciding on the duration of field-training in approved teaching health units. It is generally agreed in Canada that before embarking on training as community medicine specialists at the local level, physicians should have several years of experience in family medicine practice as a prerequisite. If the foregoing recommendations regarding prerequisite and pattern of training gain national acceptance it is difficult to predict the numbers of community health physicians who may wish to acquire the Fellowship and what may motivate them to do so other than a legal requirement and/or financial incentive. In order to assess the nature of the Fellowship training and examination in community medicine and permit international comparisons, a brief description will be given.

Fellowship in Community Medicine

The specialty qualification in community medicine is one of the many clinical options offered by the Division of Medicine of the Royal College of Physicians and Surgeons of Canada. This training period, covering 4 years after graduation from medical school, must include:
1. Two years in a Royal College-approved, university-sponsored programme that includes course work in the sciences basic to community medicine and experience and responsibility in community medicine, including a field of concentration such as: public health, administration of health services, maternal and child health, epidemiology, clinical preventive medicine, health education, mental health, occupational medicine and environmental health.

2. One year of approved training that may include general community medicine or a field of concentration—internal medicine, paediatrics, obstetrics and gynaecology, psychiatry—or other approved training appropriate to the area of concentration chosen.

3. One further year of training that may include additional training as in (2), an approved programme of research training and experience relevant to community medicine and/or an approved course of study in community medicine at a hospital or institution in Canada or abroad.

Candidates who have satisfactorily completed two years of family medicine training in a programme approved by the College of Family Physicians of Canada may be deemed to have fulfilled requirements under (2) and (3) above.

After satisfactorily completing a training programme, each candidate is required to pass a written and oral examination with emphasis on epidemiology, statistics, social sciences and administration and policy making. In the examinations, the physician must demonstrate a clear understanding of the interrelationship of the above topics and their application to community medicine.

Since the first examination in the specialty of Community Medicine of the Royal College was offered in 1976, there has been a significant increase in the numbers of physicians taking the Fellowship. There is reason to believe that this trend will continue as a result of the following: substantial improvement in the general physician—population ratio; saturation of clinical specialties; the existence of family medicine training programmes; the increasing numbers of female students; attractive financial support during graduate training in community medicine; enhanced training programmes and career structures.

It is fair to say that the specialty of community medicine is in a state of healthy and vigorous transition in Canada. The basic training programmes which will lead either to a Master's Degree or the Fellowship are assuming formats capable of attracting able candidates and meeting national and provincial health needs.

Although no formal links exist between the Fellowship programme of the Royal College of Physicians and Surgeons of Canada and the Faculty of Community Medicine (United Kingdom), some 32 physicians practising in Canada hold Fellowship or Membership in the Faculty. It is clear that this is an association which all enjoy and provides an important means of information exchange in fields of common interest.

REFERENCES


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