

Recruitment and retention into obstetrics and gynaecology: the influencing factors

The number of UK trained medical students entering obstetrics and gynaecology has fallen dramatically in recent years. Reasons for this are multifactorial, but consultation of the views of over 1500 undergraduates and postgraduates identified concerns over work–life balance, medical litigation and poor undergraduate experience. These negative perceptions need addressing to improve recruitment and to re-emphasize the key attractions of the specialty.

Introduction

Obstetrics and gynaecology recruitment should be thriving. Increases in the number of UK consultant posts in recent years from 1400 to 1700–1800 and further plans to expand to more than 2300 in the specialty over the next few years mean there is likely to be continued demand for doctors who have completed training (Royal College of Obstetricians and Gynaecologists, 2005a).

Despite this seemingly optimistic scenario, the numbers of junior doctors committed to a career in obstetrics and gynaecology who have graduated from UK medical schools has dropped precipitously in recent years. Membership of the Royal College of Obstetricians and Gynaecologists (RCOG) is awarded upon passing the first and second parts of the membership examination, and trainees must at present have spent 4 years working within the specialty before sitting the second part of this exam.

In September 2004, of 171 candidates who were successful in this examination, only 12 had graduated from UK medical schools (7%) and only three of these individuals were male. In May 2005, 11 of 145 who passed were from the UK (7.5%), including four males. These figures would appear to concur with data derived from a

number of previous studies of career intentions of UK medical graduates and their eventual chosen specialties.

The Tenth Report of the BMA Cohort Study of 1995 medical graduates has mapped a decline in those pursuing obstetrics and gynaecology, most marked in males (British Medical Association Cohort Group, 2005). In 1995, 3% of the male respondents professed obstetrics and gynaecology to be their preferred career choice at graduation, a figure which fell to only 0.4% in 2004 (this being a single respondent). The corresponding figures for female respondents were 6.5% in 1995 to 2.8% in 2004.

Obstetrics and gynaecology was not the only specialty to see such differences between career intentions and eventual specialty choice. Surgical and medical specialties and paediatrics all experienced similar downturns, while general practice, anaesthetics and radiology experienced a surge in recruitment. Concerns over competition for national training numbers (NTNs) were felt acutely in the late 1990s in obstetrics and gynaecology; opportunities for flexible training and overall working patterns were considered to be key influences in this cross-specialty cohort study.

The negative implications for the future consultant workforce of these recruitment trends prompted the RCOG in 2004 to commission a working party investigating the reasons for the downturn in recruitment and to identify areas in which positive steps could be taken to reverse this trend (Royal College of Obstetricians and Gynaecologists, 2006). The working party group comprised both consultants and trainees working in varied aspects of obstetrics and gynaecology. Although the group proposed a number of reasons for consideration as to why the specialty was not proving popular, it became clear that

the best people to advise the group would be current medical students and trainees. A survey was therefore commissioned and conducted during 2005 with a number of aims: to identify factors which attract and deter students and trainees from entering or continuing in the specialty of obstetrics and gynaecology, to identify from which sources these groups currently obtain career advice, and to identify areas in which the RCOG could positively influence recruitment and retention.

Subjects and methods

Four target groups were identified: medical students in their final years of training, most of whom had had at least some obstetrics and gynaecology exposure, house officers (HOs), senior house officers (SHOs), and junior doctors working at registrar level. At HO and SHO level, a decision on final career choice was not assumed and so doctors working both within and outside of the specialty were targeted; at registrar level, only doctors working within obstetrics and gynaecology were surveyed, as by that level of seniority few doctors switch career path.

Advice was sought from the UK medical careers research group based in Oxford with regards to the design and structure of the survey.

An online survey was created in which participants could access a secure web site, answering questions sequentially; on completion, answers were returned to a central server for anonymous analysis. An introductory email was compiled explaining the background and reasons for the survey, together with details and links to the web site address upon which the survey was posted. This was sent to ten representative medical schools in England, Scotland and Wales and distributed onwards to medical students. Postgraduate deans distributed

Dr SM Whitten is Clinical Academic Training Fellow and Subspecialty Trainee in Maternal and Fetal Medicine in the Department of Obstetrics and Gynaecology, at Royal Free and University College Medical School, London WC1E 6HX, and **Dr J Higham** is Reader in Academic Obstetrics and Gynaecology at Imperial College Medical School, London

Correspondence to: Dr SM Whitten

Table 1. Who is going to pursue a career in obstetrics and gynaecology?

	Very likely and quite likely	Possibly	Unlikely and very unlikely	Total
Fifth year medical student	149 (19%)	280 (35%)	368 (46%)	797
House officer	7 (8%)	15 (16%)	69 (76%)	91
Senior house officer	113 (68%)	11 (6%)	43 (26%)	167
Specialist registrar	376 (94%)	15 (4%)	9 (2%)	400

the survey to HOs and SHOs. Doctors working at registrar level in obstetrics and gynaecology were emailed by their regional RCOG trainee representatives. Paper copies of the survey, with a stamped addressed envelope were sent out where no electronic address was known, particularly relevant to the HOs and SHOs. Reminders were sent out after 1 and 2 months. Examples of the survey are available from the corresponding author.

Results

A total of 2246 individuals viewed the online survey, of whom 1532 (68%) completed at least some of the survey. All questions were completed by 1331 individuals (59% of all those who viewed the survey online), 201 in part. In addition, there were 35 paper surveys returned (from 150 sent out). Information was therefore available from 1567 individuals.

Responses were received from trainees in all 24 deanery regions and from medical students at the ten deliberately geographically spread medical schools. Inter-regional responses were broadly similar in range and detail (Table 1). Of the 1567 initial respondents, 826 (54%) were medical students, 105 were junior HOs (4.5%), 182 (12%) were SHOs and 454 (30%) were at specialist registrar (SpR) level (this last group representing around half of all SpRs in the specialty). Sixty per cent of the medical student group and 61% of the postgraduate group were female. Of the medical students, 89% had already completed their obstetrics and gynaecology module. Of the postgraduates, 5% were HOs on schemes where three 4-month attachments were undertaken. One quarter of these doctors had obstetrics and gynaecology included as one of the attachments, and 60% of the group had already completed this attachment. A total of 24.5% of postgraduate respondents were SHOs working in obstetrics and gynaecol-

ogy at the time of the survey, two-thirds in teaching hospitals and one third in district general hospitals. Of all the SHO respondents working within obstetrics and gynaecology, 83% described themselves as career trainees. A further 4% of the postgraduate respondents were SHOs working in specialties other than obstetrics and gynaecology. SpRs were the largest group of doctors at 44.5% and a further 12% of postgraduates were working in other middle grade positions within the specialty (e.g. clinical fellow, locum appointments for training (LAT)). Of all the junior doctors surveyed, 75% had worked or were currently working within obstetrics and gynaecology. Ten per cent of all respondents were training flexibly.

When asked how likely they were to follow a career in obstetrics and gynaecology, 54% of all medical student respondents replied positively to at least some degree (Table 1). The 98% positive responses rate from SpRs in obstetrics and gynaecology was to be expected as they were already committed to a career by virtue of having a training number. The HOs were working

in diverse specialties with fewer intent on a career in obstetrics and gynaecology, whereas the 74% of SHOs who were keen was a reflection of them being in career posts.

All respondents who replied positively to a career in obstetrics and gynaecology were then asked which three factors they felt were key attractions (Table 2). A number of options were provided and space for additional comments was available. The most popular reason cited was the mixture of medicine and surgery within the specialty (over a fifth of respondents) and almost as important was an interest in the specialty itself, with job satisfaction identified by 17%. A broad choice of special interest areas, the patient population and the opportunity for special interest were also influential. The presence of a positive role model was identified as a key factor by 5% of this group. A handful of the middle grade postgraduate respondents commented that they had already invested so much time in their training that they would be unwilling to change specialty even if they did not enjoy the job. Interestingly, when the responses for each demographic group (student/HO/SHO/SpR) were studied individually, the four most commonly cited factors were similar in all these groups, albeit in different orders.

All those respondents who replied negatively in relation to a career in obstetrics and gynaecology were asked what three factors they perceived as the most important in rejecting the specialty. In this group, there was a wider spread of answers,

Table 2. What attracts people to obstetrics and gynaecology?

Factor	Medical student	House officer	Senior house officer	Specialist registrar	Total
Mixture of medicine and surgery	307 (24%)	19 (29%)	75 (20%)	246 (22%)	647 (23%)
Interested in specialty itself	259 (21%)	5 (8%)	82 (22%)	237 (21%)	583 (21%)
Job satisfaction	200 (16%)	15 (23%)	50 (14%)	206 (18%)	471 (17%)
Broad choice of activities within speciality	160 (13%)	14 (22%)	50 (14%)	147 (13%)	371 (13%)
Patient population	102 (8%)	4 (6%)	15 (4%)	73 (6%)	194 (7%)
Opportunity to develop special interest areas	57 (5%)	1 (2%)	43 (12%)	108 (10%)	209 (7%)
Positive role model	75 (6%)	1 (2%)	22 (6%)	41 (4%)	139 (5%)
Other*	101	6	33	74	214
Total	1261	65	370	1132	2828

Other* were opportunities for flexible training and in research, hours, pay, career progression, an interest in global medical health and having already committed to the specialty.

with less distinct peaks compared to the positive group (Table 3). However, when issues concerned with terms and conditions of service were grouped together (working conditions, hours, and shift working), this was identified as the single biggest concern across all groups, accounting for a quarter of respondents. Fears regarding litigation were mentioned by 13% of the total group. The importance of the undergraduate experience was emphasized by the fact that 11% had considered this not neutral but actually off putting. Seven per cent of the total group would not consider a career in the specialty since they did not enjoy surgery, and a similar number felt that the patient population and demands were too great.

Other concerns identified by a minority were: being resident on call as consultant, domestic circumstances, preferring another

subject, lack of or poor teaching, bad experience as a male working within the specialty, lack of practical experience, lack of responsibility as a junior in the specialty, and other consultant working conditions. Once again, the most commonly cited negative reasons were common across all groups, although in slightly different proportions.

All respondents were asked whether and from where they had received career advice (Table 4). Fourteen per cent had received no advice at all. The most common sources of advice were the consultant or senior tutor (27%) and their junior colleagues (26%). Fewer than perhaps expected had received career advice from official sources such as the medical school careers service and the BMA, while less than 2% had had contact with the RCOG. Some individuals had received advice from a variety of sources.

All respondents were asked what the RCOG should be doing to improve recruitment and retention. Many of these free text responses had common themes including the provision of clear career information, the identification of positive role models, efforts to improve the labour ward experience for students of both genders, to recognize that male students and doctors are, at present, made to feel particularly unwelcome in the labour ward; to improve flexible training opportunities and finally to recognize that SHOs are currently demoralized, lack practical experience and need motivation to continue within the specialty.

Discussion

This survey canvassed the contemporary views regarding obstetrics and gynaecology of more than 1500 individuals, as a time when recruitment is disturbingly low. Over 900 of these individuals had at least some positive attitude to the specialty of obstetrics and gynaecology, which is encouraging for the future. E-mail is clearly the best way to reach large cohorts of people, especially when they can be grouped and targeted, such as SpRs in training or at a medical school, and this is the likely reason for the higher response rates from these two groups.

Obstetrics and gynaecology is one of a number of acute clinical specialties that has experienced an apparent downturn in popularity among UK-trained medical students over recent years. In 2006, Turner et al, as part of the UK Medical Careers Research Group, identified falling numbers choosing obstetrics and gynaecology as a career from 4.2% of 1996 graduates, to 2.2% in 1999, rising only slightly to 2.8% of 2002 qualifiers.

Only 0.8% of male graduates of 2002 chose obstetrics and gynaecology compared with 4.1% of women. More women are entering medical school, and this survey captured the views of 60% of female undergraduates, but these figures greatly amplify the gender gap and demonstrate a potential feminization of obstetrics and gynaecology. However, there are still substantial numbers of males in the training grades, so the profession will certainly not become all female overnight. If overall obstetrics and gynaecology recruitment trends for both men and women are not reversed, however, numbers are inadequate

Table 3. What detracts people from obstetrics and gynaecology?

Factor	Medical student	House officer	Senior house officer	Specialist registrar	Total
Hours/shifts/conditions combined	222 (24%)	42 (26%)	31 (26%)	6 (42%)	301 (25%)
Litigation	119 (13%)	28 (17%)	10 (8%)	0	157 (13%)
Bad undergraduate experience	115 (12%)	12 (7%)	6 (5%)	2 (1%)	135 (11%)
Patient population/demands	69 (7%)	9 (6%)	3 (2.5%)	0	81 (7%)
Don't like surgery or the specialty	67 (7%)	7 (4%)	7 (6%)	0	81 (7%)
Other*	340 (36%)	65 (40%)	62 (52%)	6 (42%)	453 (37%)
Total	932	163	119	14	1228

*Others varied widely but included social and domestic circumstances, consultant working and resident on call, bad undergraduate experience as a male and perceiving the specialty as one only for women, wanting to do either obstetrics or gynaecology (not both) and having been specifically discouraged from the career.

Table 4. Did the respondents receive career advice?

Factor	Medical student	House officer	Senior house officer	Specialist registrar	Total
Junior colleagues (SHO/SpR)	539	70	115	185	909 (26%)
Consultant/senior tutor	459	64	127	328	978 (27%)
RCOG Careers Advice	28	4	4	19	55 (1.5%)
BMA	95	10	4	7	116 (3%)
Medical schools	255	38	29	32	354 (10%)
Students/colleagues	444	15	37	58	554 (16%)
Friends/family	309	33	53	129	524 (15%)
Other (colleges, career fairs, books, internet)	20	1	1	3	25
None	36			12	48 (14%)
Total					3563

BMA = British Medical Association; HO = house officer; RCOG = Royal College of Obstetricians and Gynaecologists; SHO = senior house officer; SpR = specialist registrar.

to replace the existing consultant posts and thus obstetrics and gynaecology will continue to rely upon doctors who are internationally trained for UK service delivery.

Despite being sent to a wide variety of both undergraduate and postgraduates, some common themes emerged. Key positive elements of this study concurred with those reported earlier in the Turner et al and the BMA Cohort Study reports (BMA Cohort Group, 2005; Turner et al, 2006); the mixture of medicine and surgery, an inherent interest in the specialty and overall job satisfaction were indicated. One of the key positive features identified by respondents in this survey was that of the broad choice of areas in which one gains experience as a trainee, and the potential to work in any of these areas as a consultant. Today's junior doctors and medical students wish flexible working patterns to be an attainable goal for all, whether male or female. It is clear that in order to make the specialty fit as many personal circumstances as possible, different career pathways and eventual consultant working roles should be available to trainees. The RCOG published the report of the working party into *The Future Role of the Consultant* in December 2005, and this sought to address this issue by detailing a variety of job plans around which consultants may wish to work in the future, with the breadth of activities described being much broader than the generalist in obstetrics and gynaecology (Royal College of Obstetricians and Gynaecologists, 2005b). Only 10% of those questioned were training flexibly and there is clearly a demand for this. Creating such opportunities is likely to be beneficial to recruitment.

Given that these have remained pretty constant positives among respondents, it is important to determine what is off-putting and preventing the translation of these interests into sufficient numbers choosing a career in obstetrics and gynaecology. Job dissatisfaction emerged as the key issue in those who cited negative factors, with issues such as terms and conditions of service, many of which the specialty alone cannot tackle and are being universally applied to hospital posts. Obstetrics and gynaecology was one of the first to embrace and become acutely affected by these changes, yet the perception remains that it is worse off in this respect. There is now also increasing competition from primary care

with its undoubted lifestyle and considerable financial benefits. Other key negative themes were fears regarding litigation; even though complaint culture appears ubiquitous across medicine, obstetrics and gynaecology is still associated highly with this. Interestingly, it was less of a concern for those actually in clinical practice. A potent time to influence recruitment is during undergraduate attachments and the reasons why some have a bad experience need to be investigated. Tensions do appear to arise still on the labour ward. Experience on the labour ward is a key influencing factor, and it is clear that many students are put off the specialty because of unwelcoming attitudes among both medical and midwifery staff in this setting:

'As a student the consultants are very unapproachable, expect a lot, rude and generally mean. This alone has put me off obstetrics and gynaecology for life!'

'I wish the RCOG would do something about giving structure to the simultaneous training of midwifery students and junior doctors. At the moment the training clashes and of course the midwives always prefer to train their own students than the junior doctors.'

There must be a responsibility among both these groups to ensure that medical and midwifery students are given equal encouragement and support in this area, and a joint working party of the RCOG and the Royal College of Midwives has been set up to look at the clinical learning environment among students in both professions.

The experience which a medical student gains during clinical attachments in general was found to have a significant impact upon perceptions of the specialty as a career. Within the group surveyed, 54% of medical students stated that they would consider the specialty as a career choice, yet these figures are not at all representative of the eventual numbers of junior doctors who enter the specialty. Clearly there is work to be done to translate these initial perceptions towards a career in the specialty into reality and reverse negative comments such as:

'[We need a] more positive undergraduate experience. In general, midwives and obstetrics and gynaecology junior doctors tend to be unpleasant to medical students.'

One strength of this study was the cross-sectional results across all groups relevant to recruitment, although a weakness was that completion of the study obviously could not be enforced. The respondents to this survey therefore could have been representative of two extremes of the spectrum; those with a committed interest and intention to pursue the specialty as a career may have been more detailed with their positive responses, while those uninterested in the specialty may have not completed or responded at all. However, detailed comments were received from the half of respondents who had negative perceptions. Strongly voiced opinions often related to the experience of males (although gender issues were not specifically sought in the survey), with illustrative comments such as:

'It is difficult as a male medical student to study obstetrics and gynaecology, as we are at a disadvantage right from the word go! During my training a number of my male colleagues noticed that the female students were getting more practical experience in clinics and theatre as women were happier being examined/observed by another female compared to a male medical student.'

'I enjoyed the speciality but it seems like it is a dying subject for males, in general women prefer to see women, and as a male I feel I am always at a risk of getting sued.'

'It's hard to gain a real taste of obstetrics and gynaecology due to patients refusing male medical students to see clinical examinations and procedures. It is not stressed enough that we need to learn and are tomorrow's doctors.'

Work-life balance is a key concern to today's young doctors, and obstetrics is a specialty which will always have a component of night work. This survey identified concerns over working conditions, shifts and hours as the key issue among all respondents, with a quarter of all respondents stating this as the main reason why they felt trainees might be put off entering the specialty. While there is little that can be done to influence the awkward timings of nature, night time work could be reimbursed both in pay and time off in lieu terms to make obstetrics and gynae-

ology more attractive as a career. Also the other aspects of the specialty need to be promoted that can be chosen and that can be consistent with office hours, such as outpatient-based gynaecology.

In their contemporaneous survey of attitudes towards the specialty as part of the UK medical careers cohort, Turner et al identified additional concerns among medical students regarding the perception of inadequate numbers of career posts following the restrictions in numbers placed during the late 1990s. It is clear, that despite such numbers having now re-expanded, those giving career advice may still be tainted by this negative perception. In addition, the middle-grade trainees who students come into contact with during their clinical attachments form a key influence and it is clear that they are not all happy with their own working conditions. This needs addressing, although there are no obvious rapid fixes.

Trainees currently working in the SpR grade have been through the implementation of the European working time directive, and one of the key areas of concern among this group remains the difficulties which junior doctors experience in terms of continuity of care for patients and contact with their senior colleagues (SM Whitten, unpublished data, 2005). Anecdotal evidence from consultants also suggests that the lack of a regular trainee serves to dissociate trainees from trainers and negatively impacts on apprenticeship training. Advice on ways of organizing working patterns is vital so that some continuity is maintained making the day-to-day job rewarding to trainees (and their trainers) in the future.

The opportunity for the RCOG to increase its profile in relation to giving appropriate and realistic career advice is clear, with only 1.7% utilization at present, and the significant minority receiving no

advice. Improving web-based information, a new prospectus and a presence at national and regional career days is already in hand, as is a scheme to have a recruitment champion within all departments, with such individuals acting both as an information source and hopefully a positive role model.

This survey was encouraging in general; the specialty would appear to remain attractive, with interesting and varied subject matter and range of activities. However, these positives need to be seen to outweigh the negatives in order to reverse the recent trends and turn the tide in recruitment.

Conclusions

Recruitment into obstetrics and gynaecology from UK-trained medical students is presently at one of its lowest ever reported levels and the current reliance upon internationally trained doctors continues. The impact of career selection among medical students is not always immediately obvious, with the delay to entry into specialty training. With planned changes to post-graduate medical training as a result of the introduction of the modernising medical careers programme, junior doctors may be faced with having to make a more definite choice of career at an earlier stage than at present. This is one of a number of specialties facing a crisis in the next 10 years if current recruitment trends are not reversed

now. It is imperative for the future of the specialty of obstetrics and gynaecology that the concerns of medical students and junior doctors are addressed in order to make the specialty a rewarding and productive career choice in the future. **BJHM**

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Conflict of interest: none.

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KEY POINTS

- Medical students and junior doctors cite common themes when considering obstetrics and gynaecology as a potential career choice.
- Factors influencing students and junior doctors towards obstetrics and gynaecology as a career choice include the mixture of medicine and surgery and the broad choice of activities within the specialty.
- Factors deterring students and junior doctors from a career in obstetrics and gynaecology centre around working terms and conditions, fear of litigation, and a poor undergraduate experience.
- Career advice is obtained from a number of different sources, with clear opportunities for improvement.