Medical workforce and the gender shift

Barbara Clay

The future medical staffing for the NHS needs to take account of the demands of doctors for a humane lifestyle and the service demands of all groups of patients. The increasing numbers of female practitioners and the reduction in hours required by new legislation will be important influences. Suggestions are made about possible future working patterns.

The New NHS (Department of Health, 1997) emphasizes the need for a modern, dependable service with 'integrated care based on partnership and performance', not only 'tailoring the NHS to meet the needs of individual patients, with excellence guaranteed to all patients' but with 'local doctors and nurses in the driving seat'. If the 'pursuit of quality and efficiency must go together for the NHS to provide the best for patients' then the NHS must also ensure that the workforce available is used to its maximum potential.

A multicultural society must also be sensitive to the demands of the ethnic minorities. Their representation and that of women remain inequitable within the current workforce.

The New NHS (Department of Health, 1997) emphasizes the need for devoting a high priority to human resource development and to family friendly employment policies. Clinical governance arrangements in trusts, as proposed by *A First Class Service* (Department of Health, 1998a), demand prompt and effective interventions which require a skilled workforce available at the right time.

Student numbers have been increased and nationally more than 50% are now female. In some medical schools, notably Nottingham, 75% of graduates are female. In addition, the present senior medical staff who are in the retirement age range are overwhelmingly male. It becomes obvious that the workforce of the future will be predominantly female (*Table 1*). The Department of Health *Statistical Bulletin* (1998b) comments that the proportion of female hospital consultants grew from 14% in 1986 to 20% in 1997, and recent increases in numbers of women in the junior grades suggest that this percentage will rise further. Of paediatric specialist registrars, 52% are women, although in gynaecology only 42% are women and in surgery only 12% (NHS Executive, 1998).

However, the NHS statistics also demonstrate that the ethnic mix remains disproportionate, with evidence that white UK applicants to medical school are significantly more likely to be accepted than those of ethnic minorities. In particular the black students of African origin are under-represented. Recent comment suggests this is partly related both to exam results and to cultural expectations in different ethnic groups, but also to higher entry requirements being demanded of these groups (Women in Medicine, 1998). If we are to improve not only the health of the nation but also the health of the ethnic minorities then these are important recruitment issues for the next decade.

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LOOKING TO THE FUTURE

The NHS of the new millennium will need to balance the demands of the service with the changing profile of the medical graduates available. Given the cost of training, £49 000 per student per annum (or approximately £250 000 in total), the service needs to retain every available UK graduate. It will be important to ensure that doctors from Europe and overseas who decide to work in the UK have good induction to the NHS and specialty training at both basic and higher levels to the same standards as UK graduates. Many overseas doctors currently drift aimlessly at senior house officer (SHO) level and their skills are therefore misused without their benefiting from good training.

ISSUES AND POSSIBLE SOLUTIONS

Doctors who are not working

It was noted in the work of Lambert et al (1996) that of a cohort graduating in 1983, more women than men were not in practice, although the differences were small. They also noted that a higher proportion of women than men were working in medicine within the NHS. Recent work from the North West Region surveying graduates of 1980–89 demonstrated

TABLE 1.
The changing workforce: breakdown of hospital medical staff by gender

	1986	1991	1992	1993	1994	1995	1996	1997
Female	10 900	13 720	14 110	14 840	15 360	17 000	17 930	19 220
Male	25 450	27 210	28 180	28 960	29 300	30 870	31 550	33 430

From NHS Executive (1998)

that 18% were not working in the NHS, of which 53.2% were women, most of whom wished to return to work (Harvey et al, 1998). They were mostly not working for domestic reasons, while the men had found work outside the NHS. In general practice it was found in the Trent region that a considerable pool of doctors not working as principals gave the out-of-hours commitment as the major factor for their decision (Baker et al, 1995). Importantly, women are less likely than men to be principals (Johnson et al, 1998).

The gender shift

Flexible training has shown a steady increase in numbers from 749 trainees in 1994 to 1245 trainees in 1998 in England and Wales (unpublished data, B Clay, 1994–1998). In 1998, 19 of these were at preregistration house officer grade and 345 at SHO grade while the majority (881) were specialist registrars. This trend appears likely to continue in the short term as the number of female graduates increases. It is of concern that, in some deaneries, waiting lists have been introduced because of insufficient funding.

We need to cherish our entire professional workforce and to trace and chase trained people, nurses and doctors alike, persuading them that a return to work within the NHS is both worthwhile and rewarding.

THE EU WORKING TIME DIRECTIVE

There will be changes in demand for flexible training, most likely a decrease, from both men and women when the EU Working Time Directive 93/104/EC comes into force. This legislation should be considered an opportunity rather than a threat, allowing for constructive thought about the restructuring of posts. Although the Directive for a 48-hour working week at first sight suggests the need for a huge increase in manpower, this may not need to be all medical. Should immediate out-of-hours emergency care be provided by an unsupported, often unsupervised SHO? Well-trained non-medical staff, perhaps paramedics or nurse practitioners, might offer as good or better service in some areas.

Are more specialties likely to move to a shift system? Isobel Allen (1994) showed that 67% of doctors preferred a shift system to the current rota arrangements and, moreover, that a larger proportion of women (73%) than men (59%) preferred this option. This pattern could be the more family-friendly option and give both partners the opportunity to share childcare.

Goldberg and Paice (1999) showed that 51% of flexible trainees were contracted to work 38 or more hours weekly, which in some parts of Europe would constitute full-time training. Trainees have commented that the number of hours of work is less important than the flexible arrangement of those hours. Although salary and conditions are big issues, one of the biggest deterrents to returning to work, even part time, is the poor availability of good childcare matching doctors' work patterns, and its high cost. The Working Family Tax Credit system being introduced will help very few doctors in training.

SPECIALTY CHOICES

Women appear pragmatic in their choice of specialty. The largest numbers of female flexible trainees are found in anaesthesia, with its well defined sessional commitments; paediatrics and obstetrics and gynaecology still attract women trainees despite the present difficulties in the latter and psychiatry remains popular. Of the surgical specialties, ophthalmology and ear, nose and throat are popular, perhaps for the lower incidence of night calls than experienced in general surgery and orthopaedics, both of which still have difficulty in recruiting more women.

These choices are also seen in the overall numbers of women in higher specialist training, both full time and part time, while high representation in radiology and pathology may reflect the very structured training available in these disciplines and the possibilities here for long-term limited session contracts (*Table 2*). Men still predominate in the major medical and surgical specialities and the high profile options such as neurosurgery.

STRUCTURE OF TRAINING

Competency-based training

There is a need to move more towards competency-based training rather than the current time-served pattern and moreover that it should be 'fit for purpose'. For example, a plastic surgery trainee may not need such extensive training in general surgery.

Routine and 'out of hours' experience

Clearly the Royal Colleges will need to be persuaded to reconsider curricula, to define the full time week for training purposes and specify what experience is essential out of hours for adequate training and learning. If the out of hours commitment required for training is identified for each specialty then funding for these hours should be incorporated within the postgraduate deans' medical and dental education levy (MADEL) budgets.

Service out of hours required by the trusts should be funded by them and worked either by doctors in training or career grades or by other qualified staff, as appropriate, under separately negotiated contracts. This would ensure continuity of experience over the long term and especially at times of changeover of

TABLE 2. Percentage of hospital registrars who were female (full and part-time) 1997

Specialty	No.	%
All specialties	3 850	34
General medicine group	800	31
Paediatrics	470	52
Accident and emergency	70	30
Surgery group	300	12
Obstetrics and gynaecology	390	42
Anaesthetics	570	36
Radiology group	230	43
Clinical oncology	90	64
Pathology group	280	49
Psychiatry group	600	47

From Department of Health (1998b)

'the house' when the inexperience and unfamiliarity of new medical staff may cause some risk to patients.

LIFETIME WORKING PATTERNS

Family concerns

Many men now wish to have greater involvement in family activities, including ongoing responsibilities for childcare. Fathers are now asking to take time away from work in order to help their partner with the care of the new baby. Some businesses already provide paternity leave opportunities. EU legislation may soon make this a requirement for the NHS too.

Retirement age

The trend towards early retirement also reduces the available medical workforce. Reasons given for these decisions emphasize the increased stresses of work associated with increased consultant responsibility as juniors' working hours have reduced (Hospital Consultants and Specialist Association, 1995). Today the average age for retirement is only a little over 60 years. Senior staff also need to be cherished and retained.

If restructuring of junior doctors' posts is inevitable under the Working Time Directive, then perhaps consultant posts and contracts also demand attention. A 'wind-up/wind-down' pattern might be established. Less-than-full-time consultant posts could be made available. These would appeal to young consultants with families as well as to older consultants.

In response to risk management issues it is now not uncommon for older consultants in acute specialties to stop being on-call. Should a reduction to half time be offered as a routine option at the age of 60 years? This would encourage the appointment of additional consultants and help the needed, but as yet inadequate, consultant expansion. It would also enable trusts to introduce to the team younger consultants who would, within a few years, be very likely to be willing to increase sessions as the clinical demand increased and their families matured.

CONCLUSION

The NHS has a reputation for giving the best value for money in health provision among the developed nations but it has its acknowledged shortcomings. It benefits from a committed professional staff who can, with increased numbers and appropriate help, meet the demands of *The New NHS* and *A First Class Service*. The changing demands of the patients can only be met by a well trained, high quality, professional staff who have a right to a good quality of life, both professional and personal. New employment legislation will have to be observed but the service can and must retain its staff by giving due consideration to their training and employment needs, personal and professional development, and aspirations.

The changing profile of the workforce can help match the demands of the population more appropriately. However, a review of recruitment, employment practices, methods of training and of providing the service is necessary in order to both provide what the patients need and to reduce the loss of significant numbers of expensively and highly trained men and women from the service. **HM**

Conflict of interest: none.

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KEY POINTS

- Fair recruitment policies should be implemented.
- Opportunities for less than full time work for both men and women in training and all career grades could help the overall medical manpower situation, improve retention in employment, encourage consultant expansion and maintain overall quality of care.
- The retainer scheme for hospital specialties should be modified to provide funded opportunities fairly, as in the new general practice scheme.
- Crèche and after school care facilities should be universally available at appropriate hours.
- Women should be encouraged to enter specialties where they are under-represented.