Flexible specialist training compared with full-time training

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The educational and training quality of flexible training posts compared very well and in some instances was better than that obtained in full-time training. The hours of work were fewer, but as a proportion not as small as is sometimes recognized by the Colleges and is comparable with many full-time training programmes in other European Union countries.

INTRODUCTION

The flexible (part-time) training scheme (Department of Health and Social Security, 1969) was introduced to reduce wastage of medical manpower and to meet the needs of junior doctors unable to train full-time for a well-founded individual reason (Department of Health and Social Security, 1979) (in the majority of cases raising a family; Goldberg and Maingay, 1997). The scheme provides funded educationally approved part-time training opportunities tailored to the training needs of the individual and bearing in mind possible geographical constraints.

As the proportion of women in the medical profession has risen and the scheme became more successful, it has become more popular. In the North Thames region the number of doctors on the scheme has risen by approximately 30% each year for the past 4 years, until now there are 192 altogether, 141 of whom are in higher specialist training.

The reforms to specialist training, introduced in the UK following the Calman report of 1993 (Department of Health, 1993) allowed adoption by the UK of the European Directive on medical education. The minimum duration in years of full-time specialist training for each specialty is now clearly defined by the Royal college concerned. The Royal colleges, which set the standards for higher specialist training, require trainees on flexible schemes to take their part in out-of-hours work, and credit part-time training strictly pro rata to the proportion of full-time training undertaken.

The definition of full-time training has altered considerably over the last decade, both in the UK and in the rest of Europe (Department of Health, 1987; NHS Management Executive, 1991). The introduction of the New Deal on junior doctors' hours in 1991 limited the maximum contracted hours for junior doctors in the UK to 72 hours (40 standard and 32 additional duty hours; ADHs), and the hours actually worked to 56 hours a week. This is considerably more than in most countries in the European Community (Coshape Limited, 1994), although less than many trainers and trainees think necessary to gain experience (Crofts et al, 1997), particularly in the surgical specialties.

We carried out a survey of all trainees, full-time and flexible, in the North Thames region to enquire about their hours of work and to gather their opinion of the experience and training they were receiving. North Thames has 7.4 million inhabitants and over 5000 doctors in training, making it the training region with the highest population, and the largest number of medical trainees in the UK. It offers a variety of training opportunities ranging from those in London teaching hospitals and postgraduate institutes to those in district general hospitals sited in urban, rural or in severely deprived inner city areas. Analysis of the data collected gave the opportunity, for the first time, to compare training acquired in a full-time post with that obtained on a flexible basis.

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METHOD

We surveyed trainees of all grades and all specialties in 58 of 60 trusts in North Thames. We used a confidential questionnaire loaded onto portable electronic survey units, followed up by postal questionnaires. The questionnaire was originally developed for senior house officers (Paice, 1998) and modified to be applicable to all grades and all specialties.

The questionnaire was sent to the home addresses of all 141 higher specialist trainees on the flexible scheme with additional questions relevant only to flexible training. Both surveys were carried out during the winter of 1996/7. The data were analysed using SPSS 7.5. A detailed description of the methodology of the survey has been reported (Paice and Craig, 1997).

For the purpose of this report, the responses from only the higher specialist trainees (specialist registrars, registrars, senior registrars, honorary registrars) will be considered.

RESULTS AND ANALYSIS

The respondents

The general survey resulted in 1207 responses from full-time higher specialist trainees (target sample 1613, response rate 74.8%). The flexible scheme survey had 120 responses from part-time higher specialist trainees (target sample 141, response rate 85.1%).

Gender, place of qualification and specialty distribution of flexible and full-time higher specialist trainees are shown in *Table 1*. The proportion of full-time trainees in major teaching hospitals or postgraduate institutes was 55.1% compared with 57.3% for flexible trainees. Flexible trainees had been

qualified longer than those in full-time training. The median time from qualification was 8.0 years for full-time trainees (7.0 years for UK graduates and 10.0 years for others) and 11.0 years for flexible trainees (10.0 years for UK graduates and 13.5 years for others). Flexible trainees' current post were supernumerary in 108 cases (90%). The remainder of their posts were job-shares or reduced sessions in an established post.

TABLE 1.
Gender, place of qualification and specialty distribution of respondents

		Type of training		
		Flexible	Full-time	Total
Gender	Male	3 (2.5%)	820 (67.9%)	823 (62.0%)
	Female	117 (97.5%)	387 (32.1%)	504 (38.0%)
Place of qualification	UK	86 (71.7%)	799 (66.2%)	885 (66.7%)
	EEC	6 (5.0%)	86 (7.1%)	92 (6.9%)
	Overseas	28 (23.3%)	322 (26.7%)	350 (26.4%)
Specialty group	Psychiatry	19 (15.8%)	127 (10.5%)	146 (11.0%)
	Obstetrics and gynaecology	8 (6.7%)	99 (8.2%)	107 (8.1%)
	All medical specialties	19 (15.8%)	287 (23.8%)	306 (23.1%)
	Anaesthetics	15 (12.5%)	150 (12.4%)	165 (12.4%)
	All surgical specialties	9 (7.5%)	243 (20.1%)	252 (19.6%)
	Paediatrics	22 (18.3%)	69 (5.7%)	91 (6.9%)
	Others	28 (23.3%)	232 (19.2%)	260 (19.6%)

TABLE 2.
Additional duty hours (ADHs) contracted weekly

		Type of training		
		Flexible	Full-time	Total
ADH group	0	21 (20.6%)	134 (11.4%)	155 (12.1%)
	1–8	14 (13.7%)	122 (10.3%)	136 (10.6%)
	9–16	42 (41.2%)	51 (4.3%)	93 (7.3%)
	17–24	18 (17.6%)	145 (12.3%)	163 (12.7%)
	25–32	7 (6.9%)	647 (54.9%)	654 (51.1%)
	33–43	0 (0)	80 (6.8%)	80 (6.2%)
Total		102	1179	1281

TABLE 3.
Frequency of on-call if on rota

		Type of training		
		Flexible	Full-time	Total
Rota	1:2	3 (2.6%)	0 (0)	3 (0.3%)
	1:3	8 (7.0%)	24 (2.7%)	32 (3.2%)
	1:4	8 (7.0%)	277 (31.6%)	285 (28.8%)
	1:5	19 (16.7%)	243 (27.7%)	262 (26.5%)
	1:6	44 (38.6%)	131 (15.0%)	175 (17.7%)
	1:7	31 (27.2%)	47 (5.4%)	78 (7.9%)
	1:8 or more	1 (0.9%)	154 (17.6%)	155 (15.7%)
Total		114	876	990

Working patterns

The number of contracted standard hours worked by flexible trainees ranged from 20 to 32.5 hours per week (mean 25.2 hours, median 24 hours) compared with 40 hours for full-time trainees. The range of contracted ADHs and the frequency of on-call rotas for flexible and full-time respondents are shown in *Tables 2* and *3*.

Sixty-one (51%) flexible trainees were contracted to work a total of 38 or more hours per week, including both standard hours and ADHs. Twenty-five flexible trainees with no contracted ADHs reported working an on-call rota of 1:6 or 1:7. Working in excess of contracted hours most days or most weeks was reported by 72% of full-time trainees and 62% of flexible trainees. There was no significant difference between the groups in the reported intensity of work when the results were corrected for specialty.

EDUCATIONAL QUALITY

Specific educational objectives or training goals

Flexible trainees were much more likely to have discussed their educational objectives with their consultant at the start of the post (*Table 4*). They were also more likely to have had useful feedback on their progress from the consultant. They were less likely to feel forced to cope with problems beyond their competence or experience (*Table 5*).

Clinical experience

Their rating of the hands-on experience flexible trainees were acquiring in the post did not differ significantly from full-time trainees.

There was no correlation in either group, or within any specialty, between the number of ADHs in a post and the rating of hands-on experience. Despite working fewer hours, flexible trainees spent more time in absolute hours on formal educational activities, whatever their specialty. Mean hours per week of formal education attended were 3.45 (95% confidence intervals 3.19–3.71) for flexible trainees compared with 2.75 (95% confidence intervals 2.65–2.85) for full-time trainees.

DISCUSSION

These results suggest that the flexible training scheme for higher specialist trainees offers an educational framework, consultant supervision and practical hands-on experience which compares well with that offered to full-time trainees.

Those on the scheme worked fewer hours but, when on-call was included, over half the flexible trainees were contracted for at least the 38 hours that would constitute full-time training in some other parts of Europe (Coshape Limited, 1994). In addition, both full-time and flexible scheme trainees were regularly working in excess of their contracted hours.

Working patterns

Much stress has been placed by medical royal colleges on the need for all trainees, whether full-time or part-time, to gain experience of working at night and at weekends. The justification for this is not clear and the emphasis on this was modified at the time of the New Deal. The most recent National Confidential Enquiry into Perioperative Deaths report (NCEPOD, 1996) indicates that only 1% of emergency surgery is carried out after midnight and before 7am, and a proportion of that would be done more safely by more senior staff the following morning.

Many of the tasks performed by junior doctors at night could safely have been deferred or carried out by appropriately trained non-medical staff. Experience is best gained under consultant supervision, not when alone and overtired (Borman and O'Grady, 1997). The question, 'But who will do the out-of-hours work?' is valid, but should not be allowed to confuse the issue of what constitutes essential training.

Many full-time trainees at specialist registrar grade are now contracted to work only 32 or 36 standard hours a week. This is to make up for the intensity of work experience during their night on-call. A flexible trainee's standard working week might thus be considered pro rata to the 8- or 9-session post rather than a 10-session post.

The Council of the European Community adopted Directive 93/104/EC in November 1993 concerning certain aspects of the organization of working time. The aim was to encourage improvements in the working environment to ensure better protection of the safety and health of workers. The activities of doctors in training were excluded from this Directive. The maximum working hours laid down by the Directive was 48 hours per week and was opposed by the British Government on the grounds of cost implications.

Separate discussions continue, however, between the European Commission and the Permanent Working Group (PWG) of European Junior Hospital Doctors in order to come to some negotiated solution. At this time the Junior Doctors Committee of the British Medical Association continues to press for inclusion of doctors in training within the Directive. If this were implemented, it would have a major impact on the management of postgraduate training for doctors, and it would have repercussions on what is currently accepted as flexible training and on the demand for flexible training.

TABLE 4.
Responses to the question 'Did you discuss your educational objectives with your consultant at the beginning of the post?'

		Type of training		
		Flexible	Full-time	Total
Objectives	Yes	98 (83.1%)	582 (49.6%)	680 (52.6%)
	No	20 (16.9%)	558 (47.5%)	578 (44.7%)
	Don't know	0 (0)	34 (2.9%)	34 (2.6%)
Total		118	1174	1292

TABLE 5.
Responses to the question 'How often do you feel forced to cope with problems beyond your competence or experience?'

		Type of training		
		Flexible	Full-time	Total
Cope	All the time	0 (0)	17 (1.5%)	17 (1.3%)
	Daily	0 (0)	30 (2.6%)	30 (2.4%)
	Weekly	10 (9.2%)	162 (13.9%)	172 (13.5%)
	Monthly	30 (27.5%)	389 (33.4%)	419 (32.9%)
	Never	69 (63.3%)	566 (48.6%)	635 (49.9%)
Total		109	1164	1273

Quality of training

Part-time training posts have in the past been constructed on the basis of the individual trainee's needs, and approved by colleges on a personal basis. This required prior discussion between the trainer, regional advisers and educational supervisors. Hence the practice of setting educational objectives for flexible training has been observed for more than 20 years. The posts were arranged primarily for training purposes, not to fulfil a service need. Specialist registrar training is seeking to incorporate some of these areas of good practice into the new training schemes, making these more responsive to trainees' needs (Department of Health, 1996).

There has often been concern that flexible trainees might have poorer quality 'hands on' clinical experience than their full-time counterparts. This study does not support this view, there being no significant difference between the groups in the reported opportunities and intensity of work.

Opportunities to attend formal educational activities were greater for flexible trainees in absolute terms, even

though they were working fewer hours each week. This is likely to be because they are in supernumerary training posts or if they are in job share posts, each will have additional sessions per week (Goldberg and Paice, 1997).

CONCLUSION

Since the educational quality of flexible specialist training posts compares favourably with that of full-time trainees, and since the hours of work of full-time trainees in other parts of Europe equate more closely to those of flexible trainees than of full-time trainees in Britain, surely it is time that the whole question of duration of training was reconsidered.

Assessments of competence and performance, as well as calculations of time served, should determine when a trainee can be deemed to have completed higher specialist training. It would be helpful if colleges would define the requirements for full-time training in terms of standard working hours and on-call commitments so that the pro-rata equivalent for flexible trainees could be calculated. In the longer term it should be recognized that 'educational criteria and their effective application must be the major determinants in assessing the duration of specialist training' (Shaw, 1996). HM

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KEY POINTS

- Flexible training is becoming more common.
- Flexible trainees work a median of 38.5 hours a week.
- Flexible training programmes offer a quality of education which compares well with full-time training.
- Assessment of competence and performance as well as time served should determine when a trainee has completed training.