Perceptions of flexible training in medicine

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Most flexible trainees believe that their full-time colleagues perceive flexible training as flawed in some way. However, most consultants and full-time trainees actually view flexible trainees and their posts in a positive light.

INTRODUCTION

Approximately 3.7% of junior doctors nationwide are currently in flexible training posts (Clay, 1998). 'Flexible' medical training is defined as that undertaken by those training less than full-time (Allen, 1992). This group of trainees is predominantly female (97.5%, Goldberg and Paice, 1999; 97.2%, Norcliffe and Finlan, 1999) since for many women with domestic commitments, the availability of part-time training and flexible working hours are important factors in their choice of career (Redman et al, 1994).

Much of the recent research into flexible training has focused on the experiences and beliefs of the individual trainee. Frequently, this work highlights the belief among flexible trainees that full-time colleagues, both consultants and trainees, think of flexible working patterns as reflecting diminished commitment and lack of ambition (Allen, 1994; Fiander, 1995; Norcliffe and Finlan, 1999). Such beliefs have been attributed to a prevailing 'paternalistic' culture in medicine (Gibson, 1997) and the 'mystique of stamina, fierce dedication and stoic endurance' that permeates the medical hierarchy, marking those who make unconventional career decisions as weak and unsuited to leadership roles (Showalter, 1999).

Critics of flexible training have claimed that it compromises continuity of care (Manning, 1998) and allows trainees to 'hide from patient needs' (Kumar, 1997). Successive cohort studies of part-time working by the Policy Studies Institute have reported a persisting belief that certain specialties are inherently unsuited to part-time training. In particular, acute and surgical specialties are singled out because of the perceived need for on-call duties, out-of-hours duties, maintenance of surgical skills and the protracted length of training (Allen, 1994). Indeed, surgical specialties, where the long hours culture remains, have very few flexible trainees (Merrick, 1997).

Accounts of hostility towards flexible trainees — perceived or otherwise — are counterpointed by many reports of positive experience. Goldberg and Paice (1999) noted that the flexible trainees in their study were more likely to establish and monitor their educational objectives for their post than full-time trainees, and that full-time and flexible trainees experienced a comparable quality and intensity of clinical work. Over 90% of the respondents of Norcliffe and Finlan's survey expressed a willingness to recommend flexible training to their colleagues, while Gibson (1997) argued that part-time working confers the personal benefits of reducing stress and increasing fulfilment, while encouraging the individual doctor to conceive of medicine within a broader, more humanistic context.

It is imperative then that flexible trainees are fully accepted as integral team members and afforded the same opportunities to realize their full potential as full-time trainees. The attitudes and views of full-time staff towards flexible training are critical in determining whether or not this can be achieved. The study described here sought to elicit the experiences and attitudes of flexible trainees alongside those of their full-time trainee counterparts and consultants working in four specialities.

METHOD

A postal questionnaire was devised in order to survey the views of consultants and trainees in obstetrics and gynaecology, anaesthetics, paediatrics and psychiatry in the mid-Trent region. The latter three specialties have been identified previously as having relatively high proportions of flexible trainees (Goldberg and Paice, 1999) and might thus be thought to provide a more sympathetic environment for less than full-time working. In contrast, obstetrics and gynaecology was selected on the basis of Fiander's (1995) study that highlighted perceptions of an unsympathetic environment specialty.

A focus group was conducted with five training programme directors in order to identify the primary barriers to flexible training. The discussion elicited a series of prevalent attitudes relating to the perceived advantages, disadvantages and equality of status of flexible training. These attitudes were used to inform the development of the series of items used in the questionnaire.

The questionnaire sought to establish both attitudes towards the quality of flexible training and perceptions of the impact of flexible training on educational and clinical activities. Demographic characteristics, current work role, experience of flexible training and views on how flexible training might be improved were also surveyed. The questionnaire included a mix of quantitative (tick-box) questions, Likert-scale response items and quali-

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tative, open-ended questions, and was completed anonymously.

RESULTS AND ANALYSIS

Questionnaires were dispatched to all 142 consultants and 300 trainees in anaesthetics, obstetrics and gynaecology, paediatrics and psychiatry in the mid-Trent region, including specialist registrars and senior house officers. A total of 108 returns from consultants and 177 returns from trainees were recorded, giving response rates of 76.1% and 59% respectively. One questionnaire from a consultant and thirteen from trainees were returned incomplete and were thus unprocessed. *Table 1* shows numbers of usable questionnaires returned from each speciality by gender and grade.

Experiences of flexible training

Approximately an eighth of the trainees surveyed (12.4%) identified themselves as 'flexible'. The predominantly female nature of this sample — all but one in fact — is concordant with that noted in previous studies. Nearly three-quarters of the consultants (72.2%) were either working with a flexible trainee presently or had done so in the past. Only 3.2% of the consultants had themselves considered training flexibly, while over a fifth of the full-time trainees (21.6%) claimed to have done so.

Perceived barriers to flexible training

The trainees and consultants were asked to identify barriers to the uptake of flexible training from a list. *Table 2* shows positive/negative responses by grade. A significantly greater proportion of the flexible trainee sample — when compared with the full-time trainee and consultant samples — perceived barriers to stem from 'the attitudes of full-time trainees' (χ^2=6.70, degrees of freedom (df)=2, P<0.05), 'the attitudes of consultants' (χ^2=10.57, df=2, P<0.01) and from 'organizational issues' (χ^2=9.87, df=2, P<0.01). At the same time significantly greater percentages of the full-time trainees considered lack of access to both 'appropriate training' (χ^2=6.45, df=2, P<0.05) and to 'flexible training schemes' (χ^2=9.77, df=2, P<0.01) to be the main obstacles.

TABLE 1.
Specialty by gender and status (*n*)

	Consultants			Full-time trainees			Flexible trainees			Total sample
Specialty	Male	Female	Total	Male	Female	Total	Male	Female	Total	
O&G	22	6	28	15	16	31	0	3	3	62
Paediatrics	16	8	25*	14	11	25	0	5	5	55
Psychiatry	29	6	35	21	24	45	0	11	11	91
Anaesthetics	13	5	19*	24	14	38	1	2	3	60
Total	80	25	107*	74	65	139	1	21	22	268

O&G = obstetrics and gynaecology. *Including counts of individuals withholding gender information

TABLE 2.
Percentages of positive/negative responses to items relating to barriers to flexible training

Barriers to increased take up of flexible training are linked to:	Consultants (*n*=107)		Full-time trainees (*n*=139)		Flexible trainees (*n*=22)	
	Yes	No	Yes	No	Yes	No
Attitudes of flexible trainees to their job and other trainees	27.0%	73.0%	22.3%	77.7%	10.5%	89.5%
Attitudes of full-time trainees to flexible trainees	32.0%	68.0%	36.2%	63.8%	63.2%	36.8%
Attitudes of consultants	40.0%	60.0%	56.9%	43.1%	73.7%	26.3%
Organizational issues	65.0%	35.0%	73.1%	26.9%	100%	0.0%
Access to training	29.0%	71.0%	45.4%	54.6%	36.8%	63.2%
Access to flexible training scheme	40.0%	60.0%	60.8%	39.2%	52.6%	47.4%

Consultants' and trainees' attitudes towards flexible training

Respondents were asked to consider a series of statements derived from the focus group findings relating to perceived disadvantages, equity and benefits of flexible training. They were then asked to indicate the extent to which they agreed or disagreed with each statement on a five-point Likert scale.

Analysis of differences between the responses of consultants, full-time and flexible trainees found that consultants were significantly more likely to be concerned about potential disadvantages than either group of trainee. Consultants were more inclined to agree that flexible trainees create more work for full-time staff (F=7.52, df=2, P<0.01), impede continuity of care for patients (F=4.73, df=2, P<0.05) and have diminished access to restricted clinical activities (F=3.76, df=2, P<0.05). *Table 3* presents the mean scores for each item by grade.

These findings were reflected in some of the responses to the open-ended comments section of the questionnaire.

'Unless it is well structured, the trainee may not be exposed to all the clinical modules effectively and patient continuity of care is hampered' (consultant)

'Flexible is often an incorrect word. By virtue of home arrangements the trainee can be very inflexible' (consultant)

'[Flexible training] interferes with experiences gained by full-time trainees. Flexible trainees' own experience is diluted by nature of working patterns' (consultant)

'Flexible trainees can avoid challenging tasks.' (consultant)

Despite this attitudes were mainly positive, and there was some recognition from respondents that lack of continuity of care was not just an issue in flexible training.

'There should be more acceptance of flexible training as a valid choice, making one no less able or dedicated as a doctor than full-time trainees' (full-time trainee)

'It gives the option of combining a career with children while maintaining a good general training' (full-time trainee)

TABLE 3.
Mean Likert responses to items by grade*

	Consultants (*n*=107)		Full-time trainees (*n*=139)		Flexible trainees (*n*=22)		Total sample	
	Mean	(SD)	Mean	(SD)	Mean	(SD)	Mean	(SD)
Perceived disadvantages								
Having a flexible trainee in the team creates more work for full-time staff	2.55	(1.12)	2.21	(1.01)	1.43	(0.60)	2.28	(1.07)
Continuity of care for patients is impeded by flexible trainees	2.75	(1.07)	2.43	(1.05)	2.23	(1.23)	2.55	(1.08)
Flexible trainees have less access to restricted clinical activity	3.17	(1.01)	2.93	(0.90)	2.50	(1.00)	2.99	(0.97)
Perceived equality of status								
Flexible training is generally accepted as having equal value to full-time training	3.19	(1.10)	3.14	(0.99)	2.73	(1.08)	3.13	(1.05)
Flexible trainees do not find it difficult to be accepted as a fully contributing team member	3.19	(1.02)	3.05	(0.93)	2.95	(1.33)	3.10	(1.00)
Perceived benefits								
The extended length of training allows for those people to have a wider perspective	3.59	(1.02)	3.58	(0.86)	4.09	(0.81)	3.63	(0.93)
Being a supernumerary member of staff allows maximum flexibility for training	3.58	(1.18)	3.49	(1.00)	3.81	(1.36)	3.55	(1.11)

*1=strongly disagree, 2=disagree, 3=unsure, 4=agree, 5=strongly agree. SD = standard deviation

'Flexible training benefits the organisation by minimising loss of valuable talent because of incompatible demands' (consultant)

'Perhaps lack of continuity of care for patients is a disadvantage of flexible training, although this also occurs for patients of full-timers.' (consultant)

Attitudes in different specialities

The responses of consultants and trainees in each specialty were compared in order to establish whether 'pro' or 'anti' attitudes towards flexible training were prevalent in any one area.

The responses of those in obstetrics and gynaecology when compared with the responses of the anaesthetics sample were more inclined towards the beliefs about disadvantages and lack of equality: that flexible training impedes continuity of care ($F=21.91$, df=3, $P<0.01$), is not accepted as equal to full-time training ($F=10.58$, df=3, $P<0.05$) and poses difficulties for trainees to be accepted as fully contributing team members ($F=12.73$, df=3, $P<0.01$). The responses of the psychiatry sample contrasted with the obstetrics and gynaecology responses, indicating greater agreement with statements suggesting advantages: a wider perspective engendered by flexible training ($F=13.65$, df=3, $P<0.01$) and the benefits of supernumerary status ($F=17.06$, df=3, $P<0.01$). There were no statistically significant interactions between specialty and grade in response to any of the items. Mean scores for each item by specialty are shown in *Table 4*.

Again, qualitative comments reflected the quantitative findings.

TABLE 4.
Mean Likert responses to items by specialty*

	O&G (*n*=62)		Paediatrics (*n*=55)		Psychiatry (*n*=91)		Anaesthetics (*n*=60)	
	Mean	(SD)	Mean	(SD)	Mean	(SD)	Mean	(SD)
Perceived disadvantages								
Having a flexible trainee in the team creates more work for full-time staff	2.66	(1.12)	2.58	(1.13)	2.10	(0.99)	1.90	(0.89)
Continuity of care for patients is impeded by flexible trainees	3.05	(1.06)	2.75	(1.13)	2.44	(1.06)	1.98	(1.98)
Flexible trainees have less access to restricted clinical activity	3.15	(1.01)	3.04	(0.88)	2.86	(0.91)	2.97	(1.04)
Perceived equality of status								
Flexible training is generally accepted as having equal value to full-time training	2.93	(0.96)	3.08	(1.02)	3.08	(1.02)	3.48	(1.07)
Flexible trainees do not find it difficult to be accepted as a fully contributing team member	2.87	(0.96)	3.18	(1.07)	3.08	(1.01)	3.30	(0.94)
Perceived benefits								
The extended length of training allows for those people to have a wider perspective	3.33	(0.96)	3.58	(0.96)	3.98	(0.76)	3.43	(0.97)
Being a supernumerary member of staff allows maximum flexibility for training	3.25	(1.15)	3.45	(1.14)	3.73	(1.08)	3.67	(1.00)

*1=strongly disagree, 2=disagree, 3=unsure, 4=agree, 5=strongly agree. SD = standard deviation

'I have yet to be convinced that it is appropriate in main line specialties, particularly surgical' (consultant, obstetrics and gynaecology)
'[Flexible training is] inappropriate for surgical specialties' (consultant, obstetrics and gynaecology)
'Length of training can be an advantage: helps in "maturation" process and increases knowledge of local services' (consultant, psychiatry)
'I think changing attitudes are helping. More women doctors and mothers showing others the advantages of their situation, so that the picture is not always a negative one.' (consultant, anaesthetics)

DISCUSSION

These findings demonstrate a conflicting duality of beliefs. The majority of flexible trainees believe that their training is perceived by their full-time colleagues to be flawed in some way, while the majority of consultants and full-time trainees actually view flexible trainees and their posts positively. Allen (1994) has charted a steady development in acceptance of flexible training, and the findings here suggest that this trend continues apace — at least within the four specialties sureveyed here.

However, negative attitudes were observed. Approximately a third of the consultants surveyed saw disadvantages to flexible training, and although there were no significant differences between consultants, full-time and flexible trainees in their responses to perceived equality or benefits, doubts about the acceptance of flexible training remain.

Of the four specialties chosen for the study, obstetrics and gynaecology would appear to be the least sympathetic to flexible training. Doctors from obstetrics and gynaecology were more likely to have doubts about the capacity for flexible training to be integrated into their specialty. Equality between full and flexible training was most strongly felt by the anaesthetics sample, while the benefits of flexible training were most keenly noted by the psychiatry respondents.

Differences in typical clinical experience and activity between the disciplines are undoubtedly a contributing factor to this variance in climate. The nature of patient care is central to this. Patient contact in anaesthetics is relatively short-term, so integration of training and service is comparatively straightforward. The modular structure of current training schemes in anaesthetics can therefore facilitate individual choice of time and pace of training. In contrast, paediatrics, obstetrics and gynaecology and psychiatry involve contact with patients over a longer period of time, perhaps restricting the potential for tailoring training to individual needs.

This cannot, however, fully explain the relative indifference of those in obstetrics and gynaecology towards flexible training, since the psychiatrists face similar barriers but remain positive.

Despite seeing a move towards more shift working, obstetrics and gynaecology clinicians may see continuity of care over a few days as a priority, whereas psychiatry tends to have prolonged admissions and outpatient contact, so that week-to-week continuity is considered paramount.

Psychiatry has, historically, attracted women in medicine. As a specialty it is perhaps more 'person' than 'procedure' oriented, requiring a clinical approach attuned to needs of the individual within the context of their relationships with family and others. This orientation may be cultivated by the demands of combining work with family, and as such, life experience may be regarded as a benefit and not a symptom of lack of commitment to medicine.

CONCLUSIONS

Time and changes in social mores and lifestyles will demand that flexible posts are accepted and accommodated across the board. Moves towards modular training and shift working will facilitate the development of flexible posts on an equitable basis with full-timers.

Plans to reduce junior doctors hours may in future reduce the need for flexible training; however, there will still be trainees for whom the need to balance training requirements in the face of other demands in their lives will exist for at least part of the training period. It is therefore unlikely that the overall demand for flexible training will decrease. Indeed, as flexible training becomes more established a wider range of trainees across all specialties may wish to access it, with a greater variety of reasons for doing so.

The evidence presented here suggests that the medical establishment is gradually accepting — albeit patchily — the need to offer individual trainees greater control over their training, and recognize the commitment and dedication of those who choose to train flexibly. HM

Conflict of interest: none

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KEY POINTS

- Flexible trainees believe that their training is perceived by their colleagues to be flawed in some way.
- The majority of consultants and full-time trainees actually see flexible training in quite positive terms.
- Full-time trainees may perceive flexible training as difficult to access.
- Different specialties have varying levels of acceptance of flexible training.