Flexible training under threat

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As the number of women in medicine and the general demand for a better work–life balance rises, flexible training is an increasingly important mechanism for maintaining the medical workforce. The new pay deal, together with entrenched cultural attitudes, are potential threats. Ways forward include more substantive part-time posts, more part-time opportunities at consultant level, and using positive experiences as a way of tackling attitudes in the less accepting specialties.

INTRODUCTION

Part-time or flexible training in medicine was first introduced in the UK in 1979 (Department of Health and Social Security, 1979), a time when women with domestic commitments were leaving medicine at an alarming rate. It was introduced to:

- Retain doctors in training who are unable to work full time, and who would otherwise leave the NHS
- Enable doctors who have commitments outside medicine, or who are suffering from illness or disability, to continue with their training.

The more important of these is the first. Flexible training is not a politically correct gesture for which women should be grateful, but an essential mechanism for retaining a significant proportion of the medical workforce.

As with all preventive programmes, it is difficult to prove that the flexible training scheme continues to retain doctors who would otherwise leave, as few are now denied access to the scheme, and little is known about doctors who are not aware of the scheme, or do not consider it. However, a Royal College of Physicians survey of flexible trainees attempted to address the issue by asking the question 'What would you have done if you had not been able to train flexibly?' While less than a third said they would have worked full time, 10% said they would have changed specialties, and 12% said they would have left medicine altogether. The remainder would have taken career breaks, with the risk that they would have never returned (Nelson-Piercy, 2001).

Many doctors of both sexes are now demanding a better work–life balance, and while the EEC Working Time Directive (1993) could be expected to reduce the demand for flexible training, in practice people's expectations tend to rise with improving conditions. Currently flexible training is predominantly taken up by women with small children, and with increasing numbers of women in medicine (over 50% of medical students are now female, over 70% in some parts of the country; N Redfern, personal communication, 2001), it is now a vital component in maintaining the medical workforce.

The quality of training received by flexible trainees has been shown to be at least as good as that received full-time trainees (Herzberg and Goldberg, 1999; Etchygoyen et al, 2001; Nelson-Piercy, 2001), and the requirement that all flexible trainees be appointed in open competition ensures that they are of at least the same standard as their full-time colleagues. While prejudice against part timers can be found in the workforce (see below), both among consultants and junior doctors, increasing individual experience of working alongside flexible trainees is making this less and less common, part timers being seen as committed, hard-working individuals, who contribute more than one would expect from their hours.

CONFLICTING FORCES

Currently in the UK there are two major conflicting forces in the realm of flexible training in medicine, which have arisen from government itself: in favour, the government's policy for increasing flexibility at work, laid out in *Improving Working Lives* (Department of Health, 2000); and against, problems with funding in the form of the junior doctors' new pay deal. The new pay banding system has resulted in considerable increases in pay to flexible trainees, many of whom are now paid the same as their full-time colleagues, and considerable expense to trusts (who are not obliged to accept flexible trainees). This has made the placing of trainees extremely difficult, and caused a great deal of negativity towards the scheme at a time when so much had been achieved in terms of improved attitudes and perceptions.

Although flexible trainees are very grateful that their working hours have now been properly recognized, a survey carried out by the Northern Deanery (N Redfern, personal communication, 2001) has shown that many are concerned about the removal of the pro-rata element of flexible salaries, and the resentment this may engender from full-time colleagues. There are also concerns that the financial incentive to work full time is now markedly less and may therefore lead to more demand for flexible training. While there is little evidence that this is happening, the idea that junior doctors may try to drop their hours while retaining full pay is producing antipathy to the whole scheme, even among former champions.

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It is clear that a solution to this issue must be found if flexible training is to move forward, preferably a modified pay scheme for flexible trainees which more accurately reflects hours worked.

IMPROVING ATTITUDES TO FLEXIBLE TRAINING

The funding issues in flexible training are stark, but the 'softer' domain of attitudes is just as powerful. While perceptions in many specialties and trusts are very positive, there are still pockets of prejudice and poor understanding of both the nature and the need for, flexible training. Of flexible trainees responding to the Royal College of Physicians survey 44% said they experienced prejudice from colleagues, as illustrated in this reported comment from a consultant to a flexible trainee:

'How is it being a housewife with an interest in cardiology?' (Nelson-Piercy, 2001)

In a profession that traditionally associates long hours with commitment, there are many who genuinely have difficulty with the concept of part-time work. There are still consultants in the workforce who worked 1 in 1 rotas as juniors, so it is little surprise to hear the sorts of comments reported by flexible trainees. However, if recruitment crises are to be avoided in the future, it is essential that male-dominated specialties are supported to make the changes in culture that will be necessary to attract women.

Flexible training is most common in the specialties where there are large numbers of women, and the positive experiences gained in these specialties, both by the trainees and the consultants, leads to a positive attitude to flexible training. This in turn makes it an easier and more acceptable course to follow. Role models are a very important influence here, both from fellow trainees and, increasingly, from consultants who have trained flexibly.

An absence of role models may help to explain why those specialties and regions with few flexible trainees can find it hard to increase their numbers. A low number of flexible trainees will also mean that trainers are unfamiliar with part-time training and may be unconvinced about its value.

Furthermore, the factors that already deter women from joining male-dominated specialties such as surgery will play an even greater role in deterring trainees from working part time. An accusation that is sometimes made is that a part-time doctor cannot give continuity of care, especially in the acute specialties. In surgery, there is also a concern that supernumerary doctors will dilute the available experience. These perceptions would not, however, appear to cause insurmountable problems in paediatrics or anaesthetics, and have been challenged in *Improving Working Lives for Doctors* (Department of Health, 2001).

Changing cultures is difficult and slow, but one way to hasten the acceptance of flexible training in medicine is to change it from its current 'exceptional' status and move towards integration into the mainstream. One way this can be done is to replace supernumerary posts with substantive posts. The Thames deaneries established thirty substantive part-time senior house officer posts in a variety of specialties. These posts have now been running for over a year and an evaluation of the project has shown great satisfaction among both trainees and trusts (I Goldberg, unpublished data, 2002).

The trusts report that the quality of candidates has been as good as for full-time posts, and that the continuity afforded by permanent posts has made the provision of training and covering of service much easier. The trainees have the advantage of ready-made, educationally approved posts where there is 'a job to be done', and avoid the difficulties and tensions in setting up ad-hoc posts and obtaining agreement for funding. There are now plans to extend the scheme and to set up flexible rotations for trainees in general practice, and at specialist registrar level in the more female-dominated specialties of anaesthetics and paediatrics.

Another issue that must be addressed for the future is the availability of part-time opportunities at consultant level. The government has committed itself to the appointment of 7500 new consultants by the year 2004 and, if this is to be achieved, the contribution that could be made by doctors wishing to work part time must be harnessed.

The report of the Royal College of Physicians' Working Group on Women in Medicine (2001) highlighted the high percentage of current flexible trainees (>80%) who would like to work part time as consultants and urged the development of more part-time consultant posts. A survey of all trainees in North Thames carried out in 2001 found that a third of female full-time trainees (and 5% of males) would like to work part time after their training is completed (Paice et al, 2000). A national survey of flexible specialist registrars carried out by the Flexible Training Working Party of COPMed (unpublished data, 2001) identified that 91% would prefer to work part time as consultants. This information, broken down by specialty and deanery, will now be circulated to trusts on a regular basis.

In addition we know that the average age of retirement among consultant physicians is around 60 years (Royal College of Physicians, 2000). If consultants considering early retirement could be persuaded to stay on a part-time basis, this would free up sessions for new part-time consultants while retaining very experienced doctors in the NHS for a little longer.

ACTION FOR THE FUTURE

- Resolve the problems of the new pay deal
- Increase numbers of substantive part-time training posts
- Support specialties to change culture and attitudes to part-time work
- Increase the numbers of part-time consultant posts.

COULD THE NHS COPE IF MORE PEOPLE WORKED PART TIME?

A Tory front bench spokesman for health, Mr Philip Hammond, was quoted in *The Guardian* as saying it

was a 'statistical fact' that women are less productive than men over a working lifetime (Wintour et al, 2000). If one looks at the figures and extrapolates over a working life, then this claim is difficult to refute. However, it is a very narrow view. Consider the following:

- The average age of retirement for hospital consultants is 60 or 61years (Royal College of Physicians, 2000)
- Many consultants work part time in order to do private practice
- Many consultants effectively work part time in order to pursue other interests, such as college work, medical politics, medical management
- Full timers now would have been considered part time 10 years ago.

and…

- Part timers spend a greater proportion of their time actually doing clinical work (they tend to cut out 'fringe' activities)
- Many flexible trainees work 40 hours a week, i.e. longer than full timers in other professions
- Part timers report less stress and greater job satisfaction (Firth-Cozens et al, 1999)
- Part-time working leads to less depression, and less drug and alcohol abuse (Dumelow et al, 2000)
- The long-term benefits of a good work–life balance are as yet unknown, but are likely to include a longer, healthier working life
- Part timers bring greater maturity and experience of life to the workplace.

And for the doctors who choose to work full time, the price that some pay in later life was starkly revealed in a study of the work and personal life among 202 consultants in their forties:

'I wouldn't start my medical career again. It's taken too much out of me. You don't have a life outside medicine… There is no pot of gold at the end of the rainbow. There are other ways of living too. (single, female, childless; surgery)' (Dumelow et al, 2000)

CONCLUSION

The UK flexible training scheme appears to be unique (British Medical Association Flexible Training Working Party, unpublished information, 2001). The numbers of doctors wishing to train flexibly have been rising steadily over the last decade and although there are signs of levelling off, it is likely that the trend will continue to rise.

But flexible training is under siege at the moment. Government rhetoric about improving working lives is belied by its refusal to exert pressure on organizations to employ part-time workers. While recent announcements of extra funding for the new pay deal are welcome, the banding system is still an issue. These problems are causing damage to a scheme towards which attitudes have improved in recent years, but still have far to go.

It is time we stopped apologizing for flexible working and started to celebrate it as an integral part of a healthy workforce, not an optional add-on. Then, the advantages of being fully present, and working at the top of one's efficiency, will be seen as better than working all hours at half cock; people whose personal or family lives are suffering will be able to reduce their hours without discouragement or ridicule; and a healthy workforce, at peace with itself, will provide an excellent service to its users. **HM**

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KEY POINTS

- The number of doctors wishing to train flexibly has been rising steadily over the last decade, and the high proportion of women now entering medical school means that this trend is likely to continue.
- Although government policy encourages NHS employers to allow greater flexibility in working arrangements, the employment of flexible trainees is still voluntary and the increased cost arising from the junior doctors' new pay deal has made it difficult to place flexible trainees.
- To ensure the retention of doctors in the future, it is essential that the problems of the new pay deal are resolved, that specialties are supported in changing attitudes to part-time working and that more part-time opportunities are created at consultant level.