Summary Report

Government Equalities Office

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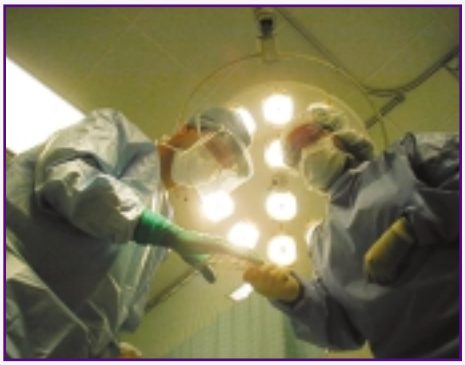
MEDICAL WOMEN'S FEDERATION

Making Part-time Work



Preface

The medical workforce is changing. There are more women, but also more men who want to achieve a better work-life balance, and an ageing population who may want to reduce their hours pre-retirement. Part-time working is not just an issue for mothers, or indeed for women.

This report highlights some of the changes that need to happen to accommodate this changing workforce profile – and how to overcome the barriers to part-time working.

As the Chief Medical Officer for England I urge the medical profession to address the issues raised in this report, and to follow up on the recommendations. It is important that we change not just policies, but attitudes and working practices too.

Sir Liam Donaldson

Introduction to

The growth in the number of female doctors has led to increasing demand for part-time training and working in the medical profession. Around 60% of medical students[1] are female and debate has opened up about the effects on the profession as these women progress into medical careers.

Trainee doctors

Nearly 40 years ago, provision for flexible training was started for women with domestic commitments (HM(69)6) and extended to junior doctors who were unable to train full-time for well-founded reasons in 1979 (PM(79)3). In 1993 flexible training posts were advertised centrally with national competition to get manpower approval. Posts were super-numerary ie extra to the full-time work force. In 1995, the flexible working group of COPMeD (Confederation of Postgraduate Medical Deans) was established and application became Deanery led resulting in an increase in flexible training posts. Male or female trainees of any grade are usually funded if they have a disability or ill health, or caring responsibilities for children or other dependants. In 2005, principles underpinning flexible training were published by NHS Employers and mainstreaming of flexible training was proposed through use of slotshares and permanent part-time posts[2].

Foundation year one is the first year of postgraduate training and leads to full registration with the General Medical Council. A second foundation year is then undertaken. The specialty registrar (StR) grade was introduced in August 2007 and is the next phase of training after the foundation years. Two or three years are spent as a StR undertaking basic specialist training, followed by at least 3 further years

> *Everyone is part-time compared to twenty-four seven, aren't they?*
> Consultant, pathology

part-time training and working

as a StR in higher specialist training before obtaining CCT (Certificate of Completion of Training), after which doctors are eligible for consultant posts.

For doctors in training, the situation is complicated by the different ways of working as a part-time trainee, namely part-time in a full-time slot, slotshare and supernumerary. Supernumerary training has had the disadvantage of being considered as an 'add on trainee' and gaining clinical experience can be suboptimal. The numbers of super-numerary placements are now limited due to financial constraints and slotshare is the option preferred by most Deaneries. The number of part-time trainees tends to closely follow the number of women doctors in that specialty. Whilst great strides forward have been made over the last 40 years, there is still concern that flexible training is complex and not readily available to all who wish to work part-time as a trainee doctor.

Career grade doctors

Flexible working patterns have been arranged on an ad hoc basis with support from the NHS Plan in 2000 and the Improving Working Lives initiative in 2001[3,4]. The Flexible Careers Scheme introduced in 2002 in England made paid provision for doctors to keep up-to-date in a career break by working up to 19 hours per week, return to practice after time out, flexible retirement and setting up of part-time consultant posts. This scheme was highly successful but funding was withdrawn by the Department of Health in December 2005.

Attitudes to part-time working

Little change has occurred in attitudes and behaviours to part-time working. As in other professions, many part-time doctors feel that they are still battling the stereotype that 'part-time is part-committed'.

The ease of working part-time varies with specialty and grade

There is variation from one specialty to another in part-time working. This is dependent on both the nature of the work and the number of part-time doctors, usually women, in the specialty. Overall, 28% of consultants are female. Female doctors account for 43% of paediatric consultants but only 8% of consultant surgeons. 30% of women consultants work part-time.

In general practice, part-time working is generally regarded as much easier, partly because GPs (General Practitioners) can contract out of on-call: 41% of GPs are female, and there has been huge growth in female GP registrars, who now make up 61% of that workforce[5]. 47% of women GPs work part-time[6]. Staff and associate specialists are in non-consultant career grade posts. Some posts are part-time but many are full-time including on-call as part of the working week.

Overall, 8% of female trainees work part-time, with 2006 census figures showing 15% of female registrars, 4% of female SHOs and tiny numbers of other training grades and male trainees working part-time[5]. Only 47% of trainees are women at present, compared with 60% of UK medical school graduates. This is because well over 40% of trainees qualified outside the UK, and these are mainly men.

The European Working Time Directive

The European Working Time Directive (EWTD) has added a further complication to workforce planning. The maximum number of working hours is currently 56 per week, reducing to 48 hours by August 2009. Although EWTD has helped to open up debate about the negative effects of long hours on performance, it does not seem to be decreasing the demand for part-time working for junior doctors due to a shift pattern of work spread over the whole working week. Those who work part-time often do so as they wish to work set days and have the rest free for other commitments.

A note on terminology

For reasons of consistency and simplicity, the phrase part-time is used throughout this document. However, less than full-time is now more commonly used for doctors in training, and flexible training is still preferred by some. Confusingly there is variation in the way that the terms are used throughout the medical profession.

1 HEFCE: Annual Medical and Dental Survey
2 NHS Employers. Doctors in flexible training. Principles underpinning the new arrangements for flexible training. NHS Employers, London, 2005
3 Department of Health. The NHS Plan: a plan for investment, a plan for reform. Department of Health, 2000 HMSO Norwich
4 Department of Health. Improving working lives standard. NHS Employers committed to improving the working lives of people who work in the NHS. Department of Health, London 2000
5 http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-numbers
6 Allen I. Women Doctors and their careers: what now? BMJ 2005; 331: 659-72.

> *Your brain doesn't switch off when you go home from your three-day working week – it's processing issues and challenges*
>
> Consultant, rheumatology

How the survey was conducted

This research was undertaken by the Medical Women's Federation (MWF) and funded by a grant from the Government Equalities Office, with the aim of identifying and sharing best practice in part-time working in the medical profession – not just for women, but for all part-time doctors. Between November 2007 and April 2008, the researchers conducted 45-minute telephone interviews with 60 doctors. Four focus groups were held for consultants, staff and associate specialists, trainees and GPs. The total number of doctors in the study was 86[7].

The participants were selected using purposive sampling, via networks including MWF monthly newsletters, BMA (British Medical Association) News, the MWF website, the website of doctors.net, the BMA Staff and Associate Specialists Committee, and both the MWF and Women in Surgery conferences. Doctors were either working part–time (82) or had worked part-time within the previous two years (4).

Participant characteristics

- *Gender:* 90% female, 10% male.
- 20% of the participants were members of MWF and 80% were not.
- *Location:* 72% were based in England (excluding London), 15% were from London, 10% were in Scotland and there was one representative from each of Wales and Northern Ireland.
- *Age:* 6 (7%) were aged under 30 years, 40 (47%) were 31-40, 25 (29%) were 41-50 and 15 (17%) were over 50 years of age.
- *Ethnicity:* 95% were white and 5% from ethnic minorities.
- *Grade:* There were 26 consultants, 15 staff and associate specialists, 27 trainees and 18 GPs (10 GP principals and 8 salaried GPs).
- *Specialty:* 20 were in general practice, with the rest in 22 different specialties.

Reasons for working part-time

As expected, childcare was the most common reason for working part-time, with nearly three quarters of the participants working part-time for childcare reasons. The next largest category, although statistically small at 10%, was 'other life interests', including voluntary work and work-life balance. Other categories included semi-retirement, ill-health, elderly care, private practice and medical politics.

The focus of the study was part-time working, and although specific questions about how part-time doctors arranged their childcare were not included, many participants brought up the problems they encountered in balancing their work and childcare. In addition, it was clear that part-time women doctors often had to handle pressures arising from dual-career families, particularly when their partners were also doctors.

It was not unusual for the need for geographical mobility among doctors, particularly in the early postgraduate years, to have had a limiting effect on the careers of women whose partners' careers took priority.

7 The 26 focus group participants filled out a questionnaire, so we had 86 responses for the demographic and working-pattern questions: this group is referred to as 'participants'. However, although we asked the same questions in the focus groups and interviews, the answers to some questions were only quantified for the 60 interviewees, and this group is referred to throughout this report as 'interviewees'

Attitudes to part

"I work five sessions as a Consultant Psychiatrist in substance misuse, and also chair the board of trustees of the London Buddhist Centre. Working part-time means I can deepen my own Buddhist practice, help others in their practice, and teach meditation and Buddhism." ***Paramabandhu Groves***

> *Assuming a thirty year productive working life, if you can keep people through that five years, then you've retained a valuable resource*
>
> GP principal

> *Part-timers have better empathy with the patients, how their lives work, the difficulties they encounter. They know how to communicate with them*
>
> Associate specialist, paediatrics

> *People assume that part-timers aren't as committed or as professional, or as motivated or as ambitious*
>
> Salaried GP

> *I think it comes down to outlook and personality. I think if you can take responsibility you will take it whether you are part-time or full-time. It's a mind set*
>
> Trainee, general practice

-time training and working

The positive impacts of working part-time

Doctors identified many positive features of part-time working for the profession, for patients and for colleagues.

- It was widely accepted that, with increasing numbers of women coming out of medical school, part-time options needed to be made more readily available if the profession wished to avoid wasted potential, skills and expense.
- Many doctors mentioned that having similar life experiences to their patients made them better doctors. A salaried GP said that patients benefit if GPs 'have some concept of life outside of general practice.'
- Part-time doctors gave a department or general practice flexibility as well as increased expertise. One consultant gastroenterologist commented 'The patients got a really good deal because they got two clinicians thinking about their problem.' Four part-time doctors instead of two working full-time gave more flexibility for holidays and service cover.
- Part-time doctors worked longer than they were contracted for. Some believed that they were more focused than full-time colleagues and got more work done in a shorter time period.
- Many doctors mentioned increased energy and enthusiasm for their work because of working part-time. '[Working part-time] makes me more positive and cheery. It makes a big difference to patients' said one surgical trainee. A consultant psychiatrist mentioned that 'You're less likely to get burnt out and…more enthusiastic for your work.'
- Part-time doctors had often thought quite carefully about their workload tolerance, and what made them a good doctor. Making hard professional and life choices gave them a high degree of maturity and personal awareness.
- Sometimes, a part-time post was all that could be afforded, or all that was needed in a department or practice. It offered a lower-risk financial option than a full-time post.

Commitment and professionalism

Despite these positive views from part-time doctors, there was also a widespread view that part-time was still seen as part-committed. 'You still have to prove that you're just as dedicated,' said a trainee in obstetrics and gynaecology. 63% of the 60 interviewees felt that they were taken less seriously as a part-time doctor. 'Professional' was felt to mean not just full-time but also long hours, and constant availability.

Some pointed out how committed women with children have to be just to stay in the medical profession, particularly in those specialties which have not developed working practices or attitudes which favour part-time working.

How part-time doctors demonstrate commitment

Most part-time doctors worked extra hours. 73% of the 86 participants said they worked longer hours than they were contracted for. The average number of extra hours worked was 16% for consultants, 14% for staff and associate specialists, 14% for GPs and 10% for trainees. Some doctors were doing extra clinical time, while many did their administration, continuing professional development (CPD), research, reading or audit in their own (unpaid) time. For hospital career grade doctors working part-time, a common problem was an appropriate ratio of clinical PAs (programmed activities) to SPAs (supporting programmed activities).

In addition to their working time and on-call time, many part-time doctors made themselves available outside their contracted hours of work. In effect, these doctors have invented a third category of work: not at work, not on-call but 'It's still OK to call me and I'll do my best to help.' A consultant cardiologist said that 'I think it's about being there for advice to your juniors. I don't mind being rung on my mobile about patients', while a consultant in palliative care commented 'Sometimes I know that they're going to run into problems and I do leave my phone number in the notes'.

Commitment to patients was not seen as just a function of hours, but as an attitude of mind. As one psychiatry trainee said, 'If I…worked to the letter of what I'm paid to do and I only did it on days I'm supposed to be there, then yes, [working part-time] would have an impact on patients.' A consultant cardiologist remarked that 'Women who look after kids are still doctors in their heart.'

> *I'd rather they phoned me at home, I'd rather know if there was a problem than somebody saying 'She's not in today'*
>
> Consultant, geriatric medicine

Part-time training posts

"We both work five sessions per week plus on-calls – not the same sessions as we share child care between us." ***Zena (StR Psychiatry)*** *and* ***Chris (SpR General Adult Psychiatry) Schofield***

> *"Every aspect of my work is recorded and assessed in a single electronic portfolio... Irrespective of how long I've trained… I have documentary evidence of what I can do"*
>
> Trainee, respiratory medicine

> *"Getting part-time approval and getting the money was OK, but then when I arrived at the hospital, nobody knew who I was, nobody knew I was coming…I was never part of a team. Week to week, it was 'where can we put you?'"*
>
> Trainee, foundation year 2

Part-time trainees faced some structural barriers not encountered by their full-time counterparts, because the service commitment of the role was usually designed for full-timers. Acquiring the right to work part-time for childcare or ill-health reasons appeared to be relatively easy, although Associate Deans for flexible training varied in the amount of extra help and support they provided. However, every 6-12 months, trainees rotate to another Trust and often encountered resistance to altering rotas which were designed for the 'normal' full-time trainee.

Part-time trainees commented on their extra administrative work. This involved finding posts or slotshare partners, getting educational approval for each rotation, re-organising rotas if they could not find a slotshare partner, sorting out funding and for supernumerary trainees negotiating sufficient exposure to appropriate training in each rotation.

The legal minimum for part time training is 50% of full-time hours (EEC directive 75/636). Most trainees agreed that working less than this would be impractical, because of the need to get particular experience and to develop and maintain skills. A small number of trainees wanted to work at 70 or 80% of full-time, either for financial reasons, or in order to speed up their progress. However, many Deaneries had insisted on 50 or 60% in a slotshare, due to financial constraints. This made part-time training extremely inflexible.

Competency-based training was welcomed as an opportunity to separate out the number of years from the level of expertise, both for those who were capable of moving faster, and those who felt they were perceived as having failed to progress. However, trainees also raised concerns about competency-based training, such as the lack of competent assessors and of agreed standards and definitions of competency.

Three options for organising part-time training

Slotshares were the preferred option for many trainees and for hospitals, because the duties of the full-time post were covered, rotas did not have to be reorganised and training was comparable to full-time. As an anaesthetic trainee pointed out, 'It's just much more appealing to appear as one full-time trainee than a bit of somebody. People don't like a bit of somebody, people like…the old fashioned full-timer basically.'

If slotshares were not possible, part-time trainees worked either reduced hours in a full-time slot or as a supernumerary trainee.

Slotsharing

Slotshares worked in different ways. Sometimes two trainees were sharing the week's work and on-call or the job was shared on a week-to-week basis. For others, the slot was split into two separate jobs, with the trainees nominally sharing a post but able to take responsibility for different areas, and therefore not needing to hand over work to each other.

Slotsharing worked well but only if there was a large number of part-time trainees in a particular specialty and geographical area, so that doctors could be paired up. The biggest difficulty with slotsharing was finding an appropriate partner: 'I'm struggling to find [slotshares] because there are so few of us…I know of three in

my specialty in my region,' said one surgical trainee. It is hard to know how widespread this problem is. In this study, only about a third of the part-time trainees were in a slotshare, but the proportion may vary at different times, and this data is not collected in the COPMeD flexible training survey. There was inconsistency between Deaneries about who paired up the slotsharers: sometimes it was the programme director, but more often, part-time trainees felt they had responsibility for finding a partner.

Part-time in a full-time slot

Those trainees who had nobody to slotshare with, and who were part-time in a full-time slot, had the advantages of increased flexibility of working hours, being able to work at an increased percentage and more choice in training options. However, as a consultant gastroenterologist commented, this option 'causes difficulties because the post is created to train and provide service and yet that person isn't able to do either the same as everybody else, so the Trust has to cover on-calls, and we've got to think about clinics that aren't done.'

Supernumerary

Supernumerary training has become much less common in recent years due to such posts being funded entirely from the flexible training budget which has remained static whilst the number of flexible trainees has increased. Trainees who are part-time in a full-time slot are funded from the full-time budget, as are slotshares with a small amount of additional funding from the flexible training budget. Some doctors, like this emergency medicine trainee, still thought of it as a desirable option because the extra resource was always welcome: 'I think knowing that there is an extra person available is always really good when you're working on a shift. That creates greater flexibility within the rota for swapping shifts…and everyone likes to have an extra pair of hands.' However, it was still thought by some to be rather demeaning to be regarded simply as an 'extra pair of hands'.

Some supernumerary trainees also found it harder to integrate: 'No one knew when I was going to be there, or cared whether I'd be there…I feel a wee bit superfluous' said one foundation year 2 trainee. Supernumerary trainees also caused resentment because they were thought to be able to 'cherry-pick' what was in their timetable and which shifts they worked.

Getting exposure to appropriate training

Part-time trainees pointed out some advantages of training part-time, in terms of the depth and breadth of their knowledge, and their experience and maturity as doctors: 'My knowledge…is of far greater depth than my equivalent [full-time] colleagues…the learning that has happened and my ability to integrate it has been that much greater,' said one GP trainee. They also gained more experience and maturity, as a consultant rheumatologist pointed out: 'The full-timers have the timetable that is given to them but the part-timers…have to negotiate…It's a good skill…I'm sure the part-timers have got better managerial skills.'

However, getting exposure to sufficient training was sometimes a problem. The traditional apprentice model has relied on long hours: if trainees are present in the hospital for long enough, they will pick up what they need to know. This has wide-ranging implications in terms of part-time trainees getting sufficient exposure to what they need to learn, particularly since the European Working Time Directive has reduced the number of hours for all doctors.

For some part-time trainees, their training needs sometimes appeared to be a fairly haphazard extra to the service provision element of the post. One pathology trainee concluded: 'We just get the work that [the consultants] don't want to do… a lot of the time you can walk out of that room…and think, What did I learn? Absolutely nothing. So I think there is a lot of wasted opportunity in our training.'

Missing out on training opportunities

Getting exposure to particular procedures, or particular types of clinic, was sometimes a problem: 'The bronchoscopy lists are on a Tuesday, and I'm not there on Tuesdays, so it's quite difficult for me to get the experience I need,' said one trainee in general and respiratory medicine. Swapping days half way through a rotation could be a solution to this concern, but this was felt to be difficult, particularly for those with childcare commitments.

Learning by following up patients could also be limited: 'You ideally want to see the people you've operated on for your own learning,' said an obstetrics and gynaecology trainee, while a paediatric trainee pointed out that '[Part-time trainees] have to go seeking out patients and finding out what happened, as opposed to it just kind of falling in your lap because you happen to be around.'

> *There are certain clinics that only happen on certain days…That's the reason why [my slotshare partner and I] decided to swap our days half way through the job, so that we wouldn't miss out on these things*
>
> Trainee, palliative care

> *You don't learn much in most clinics…It's a service commitment…You waste a lot of time*
>
> Trainee, surgery

> *The priority is service provision rather than training I would say*
>
> Trainee, obstetrics and gynaecology

> *Regarding part-time as a separate thing is not a good idea. It needs to be an extension of what everybody does…The person who is going to advise you about your career should know about full-time and part-time*
>
> Consultant, gastroenterology

Finding time for study, research and audit

Part-time trainees often had difficulty finding enough time for study, research and audit, and were getting around this by using their own unpaid time, and sometimes paying for courses themselves: 'My audit, my research, my studying is done at home…Unpaid yes, but that's what I see as a trade off for working part-time,' said one pathology trainee, while a trainee in geriatric medicine said that 'I feel I've had to do more…extra courses, and a lot of them I've paid for myself… I feel it's necessary to get those extra training days put in, because I'm missing out on so many other training days.'

Getting out-of-hours experience

Getting out-of-hours experience was sometimes a problem for supernumerary trainees as this component of training is not paid for by the Deanery. Although it is usually needed to fulfil training requirements, trainees in different specialties held different views on whether or not out-of-hours experience was necessary. 'The Royal College of Surgeons say that it's OK for me not to do any out-of-hours and I have educational approval, but I don't think it's OK and need some out-of-hours,' said one surgical trainee, while an emergency medicine trainee held the opposite view: 'In emergency medicine…you could look at the screen of people and you wouldn't be able to say what time of day it was, so…it doesn't really matter whether you work nights or not.' Trainees felt that they got more responsibility, and more exposure to decision-making, at night because consultants were usually not in the hospital, as this consultant surgeon confirmed: '[Trainees] are supervised more remotely when you're on nights, but otherwise it's probably not that different from the daytime.'

> *If the person who's organizing rotations isn't very flexible or creative…you can have problems as a flexible trainee*
>
> Consultant, psychiatry

Part-time career grade posts

"I am a consultant paediatrician working 6.5 PAs a week in the community. I changed to part-time when my daughter was born and I now also care for my mother. I job-share my specialty area and also share the consultant responsibilities in our geographical patch team with a full-time colleague." ***Yin Ng***

> *"I've had to educate people along the way to develop the posts…There is a lot of negotiating"*
>
> Consultant, rheumatology

> *"If you've been full-time…people know your record and they're prepared to negotiate something different because they want to keep you"*
>
> Associate specialist, gynaecology

> *"I asked whether there was any chance of filling [the post] part-time…Once I'd got the job we negotiated the best way of working"*
>
> Consultant, pathology

Getting a part-time post

Of the 40 interviewees in part-time career grade posts, just over one third had answered an advertisement for a part-time post, whilst half of them had achieved their post through one of three types of negotiation: a) some doctors had changed their existing full-time post to a part-time one; b) some had applied for an advertised full-time post and by negotiation had changed it to a part-time post before starting work; c) some said that the post had been developed or created for them. The five remaining doctors had achieved their part-time posts in a variety of ways.

Factors affecting the feasibility of part-time working

A full-time post is only ever possible for part of the 168 hours in every week. Many doctors, such as this surgical trainee, pointed out that a lot of the full-timers are only available to their patients part-time: 'My consultant, she's…only doing Monday, Wednesday, Friday and one in four Tuesdays – but that's a full-time post.' Discontinuity of care for patients was the norm, but part-time consultants often felt guilty about adding to it by handing over to others during the week, and agonised about the completeness of the handover. One respiratory consultant spoke of doing extensive handovers and meetings with her jobshare partner during the week, but at weekends 'The whole department offloads to whoever's on call so we're all in the same boat…I think everybody accepts that weekends aren't ideal and they really shouldn't exist in medicine.'

Many doctors pointed out that teamwork was another way of dealing with the 24 hours a day responsibility for patient care. This option made part-time posts much easier to design, even in acute specialties where, as one consultant obstetrician pointed out, 'Everybody realizes that it's completely impossible to expect one person to be on-call one hundred per cent of the time for a particular patient.' And as a consultant psychiatrist said, 'Everybody covers for everyone else out-of-hours – the emergency work is shared out. So why not cover for all the other work too?'

Doctors mentioned a wide range of factors which affect the creation and design of a part-time post.

A critical mass of women or part-time doctors

Some doctors believed that the differences in attitudes and working practices between specialties were based as much on the dominant gender in the specialty as on clinical needs, even in acute specialties. New working practices would emerge as the number of women or part-time doctors increased: 'You need more people to actually create new working patterns. I think you'd be able to persuade people to organise rotas differently, to do the on-call in a different way. It wouldn't be based on a traditional full-time model because there would be more of you to justify it' (consultant, respiratory medicine).

Acute patients and frequency of consultation

As a consultant ophthalmologist said, 'An in-patient or a patient with an acute problem…needs to be seen on a daily basis,' while a consultant psychiatrist said that, 'Acute emergencies in psychiatry are…over hours rather than minutes…whereas in medicine and surgery things change much faster.' For other in-patients, and for out-patients,

> *[My colleagues] do private outpatients…the fact that I'm going home to my children, I don't think is any different to them going off to their private work*
>
> Consultant, cardiology

a once or twice-weekly ward round or interval between consultations was sufficient: 'In dermatology…even quite bad patients come back a week later, so that works for a part-timer – you can see them next week, not next day' (staff grade, dermatology).

Building a long-term relationship with patients

The patient-doctor relationship was frequently mentioned by doctors in general practice, community medicine and psychiatry: 'In psychiatry, it's an individual…everything's related' (trainee, psychiatry). Or as a consultant community paediatrician said, 'It's not just doing a clinic…it's maybe working with schools or arranging to observe a child in a nursery or going to do a home visit and then getting people together who all know the child.' Knowing a patient's history and personality could make consultations faster and more effective: 'It's really easy when…you've known someone for twenty years, there's continuity…you don't have to say things, you're understanding each other' (GP principal).

Out-of-hours

Out-of-hours presented a particular problem for those part-time doctors with children. Some thought that hospital doctors could opt out of out-of-hours work without de-skilling: 'I don't think everybody has to work nights. Perceptions of what you do at night are changing' (consultant, surgery). Others disagreed: 'Once you drop the on-call you…lose the ability to deal with the emergencies and…you don't really have enough street cred to call yourself a consultant' (consultant, obstetrics and gynaecology). GPs found it easier to work part-time partly because, as a GP principal said, 'You can contract out of overnight cover…it's a level playing field in general practice.'

Maintaining competence, especially for practical procedures

Depending on the specialty, there may be more or fewer practical procedures to learn and maintain, but de-skilling or getting out of practice was a concern across the board: 'It's a skill. Your work becomes automatic if it's regular. It's a process you get into' (associate specialist, anaesthetics).

'Fair trade'

Negotiating who will do what in the department, a mutually-agreed 'fair trade' which does not offload work unfairly onto colleagues, was mentioned by several doctors: 'When I'm not there on Friday, another doctor has to deal with my patients. But…the consultants are based at the hospital and I'm here in the community, so in return I do crisis stuff for them, for all 350 patients – write prescriptions, do home visits, take phone calls, do Mental Health Act assessments' (staff grade, community psychiatry). For those covering a geographical area alone, or those in a very small sub-specialty where they were the only one with a particular expertise in the hospital, this option was not available.

Finding time for non-clinical activities

Continuing professional development (CPD) was a challenge for many part-time doctors: 'Sometimes if you're doing part-time, they cut down a bit of the SPAs…as a proportion…[but] you have to get the same amount of CPD points as the full-timers' (consultant, medical micro-biology). Many part-time doctors made up for this in their own time: 'My time at work is full on dealing with patients. So the time that should be SPA time…that's what gets brought home, all the extra stuff' (consultant, cardiology). Other doctors commented that they got no reduction in the amount of administration and management activity compared to their full-time colleagues. Team or departmental meetings also had to be factored in. 'I get just as much paperwork as I would in a full-time post…I get all the same protocols as everyone else. I don't get 60% of the emails' (acting consultant, psychiatry).

Personal career goals

Many doctors commented that it was possible to reduce hours by sticking to a particular sub-specialty, or a limited number of types of procedure. However, this could be career-limiting, given the lack of opportunities to retrain and broaden out again after a period of specialisation. 'Something I might do in the future is…three long surgeries a week where I just do chronic disease management. I would never again see a child who might have meningitis, therefore that would become irrelevant to my repertoire of skills…but that's no good for younger people who would be looking to maintain a full range of competence' (GP principal). Reducing hours might also reduce involvement in the team: a consultant orthopaedic surgeon said, 'If you are away from the hospital too much, you feel out of the loop.' A GP principal pointed out that part-time doctors might unintentionally select out certain kinds of patients: 'Patients will tend not to select you as their doctor. So you may get to see

instead those who have the flexibility to come to your days, or those with acute problems.'

Colleagues' willingness to redesign working practices

In many cases working practices have been redesigned to enable team responsibility for patient care – but this requires lateral thinking, as an associate specialist in anaesthetics pointed out: 'At times departments aren't imaginative in the way they plan the work…We do need perhaps to think sideways, away from the traditional model a bit'. Some thought that acute specialties attracted competitive, individualistic, driven personalities who were unlikely to want work-life balance, and were uncomfortable with the principle of team working. A consultant cardiologist thought that 'Working practices, the way we organize things, are more to do with personalities than the nature of the work' and a consultant surgeon that 'surgeons are the worst for team working, we're all very competitive individuals.'

Communication and handovers

Communication skills and efficient handovers were important skills for all doctors but never more so than for those working part-time. As one GP principal said, 'Handovers are necessary…Not just notes, but making sure the person who's going to be responsible for your patients while you're not there knows what you're anxious about when you're away'. Communication was difficult if the part-time doctor's hours did not coincide with others in the department, or if colleagues were not used to working with part-time doctors: 'The main issue in my partnership…is that they feel they never see me, because I'm working through the lunch hour often, I have very little break and then I'm away' (salaried GP).

Different challenges at senior and junior levels

Just over half (55%) of interviewees said that working part-time was easier at senior levels: three quarters of trainees held this view, but only one fifth of GPs. The reasons cited for increased ability to work part-time at consultant level were increased confidence, less service cover, the acceptance of absence, increased autonomy and different expectations around on-call rotas. However, some consultants pointed to factors which impeded flexibility at consultant level: greater responsibility, higher workload, lack of cover for specialist expertise and more administration and management.

> *"It's the consultant that's on-call in that slot who is responsible, not the consultant whose name happens to be on the patient's notes"*
>
> Consultant, obstetrics and gynaecology

> *"Once you've shown that [part-time] works and gets up to a certain mass then it does become self perpetuating in a way and people become a bit more accepting of it"*
>
> Consultant, anaesthetics

> *"It's not that it's not possible, but…the leaders in team working haven't emerged in surgery"*
>
> Consultant, surgery

> *"Orthopaedics is no different [from other specialties]…Working part-time in any medical specialty, you have to make sure your handovers are water-tight for the days that you're not there"*
>
> Consultant, orthopaedic surgery

Career development for part-time doctors

"I am a partner working 4 sessions a week seeing patients and attending the Primary Care team meeting whilst my youngest is at preschool. I have been working part-time for 12 years and love being a GP." ***Helena McKeown***

> *I chose ophthalmology because I found it interesting … but it probably was in the back of my mind that it would be a job that would be suitable if I did want a family*
>
> Consultant, ophthalmology

> *There's a huge swathe of women not doing flexible till they're consultant …There's just a culture of getting to the top and then having children… It's an extremely competitive world*
>
> Trainee, foundation year 2

Although 58% of interviewees said that more should be done specifically to help women doctors to develop their careers, others said that, instead of helping women, more should be done to help all part-time doctors. More careers advice in general was felt to be needed: 'I think it's more doctors developing their careers, rather than women doctors, because careers advice for all is sadly lacking' (obstetrics and gynaecology trainee).

Medical career paths

Medical definitions of a 'normal' career progression traditionally involved having a great deal of time to give to on-call and night work at exactly the point when many women were contemplating starting a family. Women's careers followed more variable paths than men's, with periods of full-time and periods of varying degrees of part-time with (mostly short) maternity leaves or career breaks. The pattern of women's non-work lives was out of step with the pressure to achieve a consultant post by a certain age, and there was a lack of opportunities for re-training or re-entering the medical profession. Two thirds of consultant and trainee interviewees felt they had had to do something extra or different to develop their careers. However, two thirds of staff grade and associate specialist doctors said they had not done this. The commonest extra was doing continuing professional development in their own time.

Career breaks

Three quarters of participants had taken maternity leave, or a career break for childcare reasons, but the majority had only taken 6-8 months maternity leave per child. 80% had taken a total of two years or less off work.

Pressure to postpone part-time until reaching consultant grade

The evidence of unmet demand for flexible training was anecdotal but widespread. Many women with children felt that full-time training was the only option, either financially or because of the way that training is structured. 'It seems to be easier to become a consultant and then become part-time. That's what a lot of women do – they train full-time even when they have children' (associate specialist, anaesthetics).

Dropping out of training

There were also trainees dropping out of training, or considering dropping out, although again this was anecdotal: 'I've certainly had a little hiatus in the middle where I thought, Oh what's the point, I'll go and be a staff grade. I'm very glad I didn't…but you have to really want to see it all the way through' (consultant, anaesthetics).

Many doctors mentioned staff grade and associate specialist posts as a kind of career siding for those who did not want to delay having a family. This option has been unfairly seen by some to indicate a lack of potential rather than a lack of time. 'I don't know if stigma is the right word, but there's a certain snootiness in consultant circles about staff grade doctors…They seem to think it's an option you take if you can't achieve, not because you don't want to delay having your children when you are in your late thirties' (staff grade, psychiatry).

Choice of specialty

It is often claimed that women choose specialties which are more family-friendly, and the obstacles to part-time training

> *Some medical students have said to me, 'Oh, I didn't realize women could do orthopaedics*
>
> Consultant, orthopaedic surgery

may be one of the major reasons. Almost without exception, interviewees chose their specialty because they liked some aspect of it – the immediacy of obstetrics, the patient-doctor relationship in general practice, the chance to use practical skills in surgery. However, many admitted that family or work-life balance was a factor in their choice.

Part-time working sometimes affected the choice of sub-specialty at consultant level: 'When the two of us were appointed, the full-timer took on all the lupus and connective tissue disease side and I took on the osteoporosis because that was felt to be more manageable part-time' (consultant, rheumatology).

Fear that part-time will disadvantage promotion

If it was felt that there were more doctors than posts available in a specialty, then both training and career grade doctors were reluctant to request part-time hours, feeling that this would adversely affect their subsequent career progress. 'There are too many GPs, and we have realistic prospects of GP unemployment…There's no doubt that the people who need part-time work will be disadvantaged' (salaried GP).

Part-time doctors in senior positions in the profession

Part-time doctors found it hard to achieve senior positions in the profession such as Royal College or Deanery roles, and committee work for the GMC (General Medical Council) and BMA or being a member of a medical journal's editorial board. Many part-time doctors pointed out that, although they could capably fulfil their clinical sessions, they struggled with finding the time for 'add-on' activities to develop their careers after obtaining a career grade post.

Networking, politics and committee work were casualties of part-time doctors' busy out-of-work commitments. 'If I were to try and move [my career] forward from where I'm at just now, I'd have to try and get more involved in some of the committee work, but…there aren't enough days in my week' (staff grade, psychiatry).

Clinical excellence awards were also felt to be harder for part-time career grade doctors. In part this was due to part-time doctors being compared with their full-time counterparts, rather than their application being assessed in the context of the number of contracted sessions. 'Working part-time probably makes it harder to obtain clinical excellence awards…You've only got half the time…that just seems to me that's half the opportunity' (consultant, psychiatry).

"I became a flexible trainee in Paediatric Surgery in 1987 and trained six sessions a week while the children were small. I was appointed as a part-time Consultant Paediatric Urologist at St George's Hospital London in 1991."
Su-Anna Boddy

> *In your twenties people in general are far more ambitious and in their thirties people are looking for a work-life balance …That transition time, then it's time for career advice*
>
> Trainee, general practice

> *You've got to take the stigma away from retraining*
>
> Trainee, surgery

> *College committees… editorial boards, all those key things that make you get on in the world. I wonder how many part-time women are on them? Very few, I'd say*
>
> Consultant, clinical pharmacology

Conclusions

Recognition and acceptance of part-time working

It is clearly essential that part-time working in medicine is recognised and accepted as an important element in future medical workforce planning. Around 60 per cent of those entering the profession are now women and there are no signs that this proportion is likely to decrease. It has long been recognised that women's careers are different from the traditional male pattern of 40 years of full-time work, but that is also changing, with more men seeking flexible working at different points in their careers.

Enabling women to stay in hospital medicine

For many years women doctors' careers have tended to follow an M-shaped curve of full-time working, followed by a period of part-time with a return to full-time working when they have fewer childcare responsibilities. However, in the past women often found it difficult to remain in hospital medicine with its long hours and many years of postgraduate training requirements, even with part-time training schemes first introduced 40 years ago. Over the past few years there has been rapid change in training, with a marked decrease in duration and dramatic reduction in full-time hours. Nevertheless, there is still a demand for part-time training posts – often only for a short period – which can help to retain women doctors in hospital medicine so that they reach consultant level. If women drop out of hospital medicine, simply because of difficulties in achieving part-time training posts, the arithmetic shows starkly that there will not be enough hospital consultants in the future, particularly in some of the acute specialties.

Dedication of part-time doctors

This study has demonstrated many of the positive aspects of part-time working in medicine, both at junior and senior levels. It has long been recognised that part-time workers often work more than their contracted hours. This research shows the extent to which part-time doctors concentrated their time on clinical care, putting in extra unpaid hours on administration and educational activities. There was no evidence that they were any less dedicated or committed than their full-time counterparts. Indeed there were many indications of a more than conscientious approach to ensuring smooth handovers, communication and teamworking.

Challenges of being a part-time doctor

There were different challenges at junior and senior level. Part-time trainees were still facing an uphill battle in arranging posts, ensuring funding, getting educational approval, negotiating appropriate training in each rotation and simply managing the problems of the geographical movement still required every six or twelve months during the training period. In addition, those trying to slotshare, particularly in sub-specialties, were often faced with great problems in finding a partner, often having to hunt about for one themselves. There were many examples of trainees demonstrating great resourcefulness in making sure that they stayed in hospital medicine, and it seems extraordinary that part-time – or less than full-time – training remains such a hazardous path. There has been overwhelming evidence for many years that it should be fully integrated into mainstream workforce planning and it should be recognised that this is a top priority for the NHS and the medical profession.

It was generally agreed that it was easier to work part-time at a senior level – as a GP or consultant – although considerable negotiating skills were often needed by doctors seeking such posts. Once in post, these part-time doctors were often working nearly full-time, and it was pointed out that many of their full-time colleagues were seldom seen every day in the hospital or practice. Part-time doctors were clearly less able than full-time doctors to take part in medical politics, networking or out-of-hours committee meetings, but there was no evidence that they were any less committed to their patients.

The way forward

There is an urgent need for a change in attitude of the medical profession and the NHS towards part-time or less than full-time working in medicine. This study has demonstrated a need for more flexible thinking on the organisation of work and rotas. The traditional model is not suitable for the 21st century and medicine could learn much from the corporate world, in which teamworking, rota design and career development are now intrinsic tools in ensuring the best possible use of resources.

Recommendations

Recommendations on attitudes to part-time working

- The medical profession needs to promote more positive attitudes to part-time working through mentors, role models and case studies
- Royal Colleges, Deaneries, the BMA, and the GMC need to find effective ways to consult with those doctors working part-time on a wide range of issues

Recommendations on part-time career grade posts

- Royal Colleges should issue guidance on part-time career grade posts
- Medical directors should support and promote innovative job design to promote part-time working for consultants and staff and associate specialists

Recommendations on career development for part-time doctors

- Employers, medical directors and Deaneries should adopt a formal approach for the reacquisition of clinical skills after a career break or a period of extended leave
- The MWF should seek to work with key stakeholders to promote successful examples of part-time working in the medical profession
- Deaneries, Royal Colleges and the BMA should work with PMETB to use the national survey of trainees to explore any systematic differences in the quality of training experienced by those in full and part-time posts

Recommendations on part-time training posts

- Employers and colleges should work together to ensure that rota design can routinely incorporate part-time workers
- Medical directors should support and promote innovative job design
- Deaneries should ensure that training programme directors take responsibility for leading integration of part-time trainees into training programmes
- Deaneries and employers should continue to build on the progress of mainstreaming part-time training
- Employers, Deaneries, training programme directors and educational supervisors should ensure a prompt and sympathetic response to those trainees who express a desire to train part-time
- Trainees should be made more aware of sources of information and support for part-time training at undergraduate and postgraduate level

Summary Report

Read the full report at www.medicalwomensfederation.org.uk/makingparttimework

Acknowledgements

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