Some aspects to consider in order to end sexism in medicine and support parents during postgraduate training

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Women doctors face sexism at work and in their career progression. The Medical Women's Federation is the largest group of women doctors in the UK and would be pleased to be contribute to future discussions. 56% of doctors in postgraduate training are women [1].

Ending sexism and supporting parenting:
Sexism is a huge issue. Women doctors are exposed to multiple worse experiences. In some specialties 15% of women leave training [2]. The UK cannot afford to lose this talented group of doctors. Where poor behaviours or a negative culture is permitted, bullying escalates, staff leave and patients receive worse care [3]. This is fixable and could change rapidly with changes in culture and processes, training posts and funding.

Sexism in medicine – prevalence
The BMA report '*Sexism in medicine'* found 91% of women doctors had experienced sexism since 2019 [4]. The Kennedy review highlighted sexism within surgery [5]. The Times reported on sexual harassment [6]. Half those training Less Than Full Time (LTFT) report undermining [7]. Sexual harassment and discrimination are more likely where sexism is tolerated and normalised. Liang describes a 'Tower of Blocks' with any additional poor experience making women doctors leave [8].

Sexism - causes:
Causes include: some people holding onto a belief in traditional gender roles; unconscious bias meaning that people have assumptions about a person's role; lack of representation in senior roles reinforcing stereotypes; lack of representation creating an imbalance of power and influence; and the gender pay gap may contribute to lower perceived value of women.
Many people struggle to reconcile the two concepts:

- *For women in general*, there is a far greater likelihood of undertaking childcare duties, so difficulties with this and with parenting predominantly affect women. Organisations should modify the environment to allow for general changes to improve parenting for all.
- *For every individual woman doctor*, opportunities should be given that are not stereotyped.

What are the areas to tackle to improve women doctors' experience:

1. **Culture:** Bad stereotyped career advice, being put off specialties and not being supported within a department.
2. **Progression:** Not being supported into higher roles nor listened to when in them.
3. **Parenthood:** Training structures that do not acknowledge parenthood and other caring responsibilities: workforce gaps, difficulties with arranging flexible working or training, stigma, commuting and childcare costs/burden falling on women.
4. **Sexism:** There are negative assumptions from other staff and from patients. The Kennedy report showed multiple microaggressions. These are worse with intersectionality (eg sexism and racism).

Efforts to reduce sexism and poor behaviours:
When unconscious bias training is optional, the people who most require it are probably the least likely to enrol. Many senior staff do not realise how they are perceived. They can also think they are being kind (benevolent bias) when they confuse general stereotypes with giving individual advice. Some actions require investigation and sanctions. Unfortunately, reporting can result in a lengthy confidential process with no wider learning. Prevention is also needed. The culture needs to change, so that sexism and personal comments are not tolerated and there is equality of opportunity. Staff should undergo 'Active Bystander' training and be encouraged to call out poor behaviour. The Association of Anaesthetists advise 'declare or distract' in the moment, with follow up 'delay or delegate' discussions as needed [9]. Some staff should be trained in 'vanderbilt cup of coffee' discussions, where a respected colleague has a private discussion with the alleged perpetrator, explaining how they were perceived after an episode of poor behaviour. The Royal Australasian College of Surgeons has an app for this [10].

Efforts to eliminate sexual harassment:
Sexual harassment is unacceptable. Prevention should include: challenging a sexist culture with allies and active bystanders; and providing clear guidance about what behaviour, jokes or discussion are not acceptable. Other pro-active actions:

- Establish a clear anti-harassment policy
- Encourage reporting
- Provide training
- Prioritize confidentiality
- Respond promptly
- Conduct thorough investigations
- Enforce appropriate sanctions
- Provide support to the victim
- Monitor the workplace and training reports
- Review and update policies.

Specialty training arrangements – Less Than Full Time Training (LTFT)

- Part-time working is possible for those in permanent posts, such as GPs, Consultants, SAS doctors and Locally Employed doctors. Doctors in postgraduate training can apply for Less Than Full Time Training (LTFT) at between 50% and 80% of hours. Pay is reduced. The length of training used to increase pro rata, but now that training is competency-based rather than time served, it may not.
- Women have been in the majority at medical school for 30 years. An immediate increase in training posts is needed to ensure service delivery now and in the future. For example, in Obstetrics and Gynaecology even where there is a full head count, 18% of shifts/hours suffer gaps due to doctors on maternity leave or LTFT [11].
- Most doctors, across genders and specialties, want to work 80% of time in the future [12].
- There is still a stigma to working LTFT – 53% of those in LTFT posts reported undermining [7]. Other staff often blame them for rota gaps, or belittle their working hours. These behaviours should be addressed.
- MWF greatly welcomes recent progress in making LTFT postgraduate medical training more available, especially the availability of Category 3 LTFT training which does not require a reason. We predict this will lead to more men as well as women taking advantage of LTFT. This will help improve attitudes to LTFT training and, in the longer term, may help mitigate some of the gender pay gap. However, there is more to be done.
- It is imperative that more training numbers are made available, to staff rotas properly. We need an increase in training posts so that women can take the maternity leave they need and fathers/partners can participate in taking shared parental leave/paternity leave without affecting shift/rota patterns.

Recommendations for reducing sexism and improving parenthood, especially in surgical training: Surgical training is long and coincides with the years of childrearing for many doctors. We need to design programmes that enable family life, otherwise we lose women specifically and parents from the workforce.

1. Consider how to involve the public, working across organisations. Collate a 'code of conduct' for patients and visitors. The NHS is an anchor institution. This could help to change society. There are parallels with the 'considerate construction' industry or 'Speak up, Interrupt' for sexual misconduct on the railway from the British Transport Police [13].

2. **All trainers/supervisors and permanent senior staff should be required:**
   - to understand how to support parents, eg https://www.boa.ac.uk/careers-in-t-o/parenthood-orthopaedics.html
   - to understand unconscious bias https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/avoiding-unconscious-bias--a-guide-for-surgeons.pdf
   - to understand that some constructive criticism is justified. Some people with other focuses or returning from parental/etc leave lack confidence. This may take more time, more supervision and more support.
   - to understand that everything should be done to assist doctors in postgraduate training to achieve the standards for CCT. They should see supporting those within training as positive and worthwhile. In highly competitive specialties, many perceive a traditional image of presenteeism and perfection as the only option whereas individuals develop on different trajectories.

3. **All NHS Trusts and managers should:**
   - provide mandatory Active Bystander training
   - understand how to deal with disruptive behaviours https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/managing-disruptive-behaviours/
   - have clarity about how they support new parents - expectations should change (for example, just because clinic always overruns does not make it that Registrar's problem). Eg LeadersPlus toolkit for managers and those returning from parental leave: https://www.leadersplus.org.uk/parental-leave-toolkits/
   - consider how to involve other staff – such as demanding a wider focus on 'Respect' within health, more team-working, arranging meetings together across staff groups and explaining the issues and implications.

4. **Training programmes should:**
   - consider how to collect data and ask questions to highlight areas of poor practice.
   - re-evaluate which training opportunities are more important than others. For example, those in Higher training posts in Orthopaedics gain little from undertaking additional fracture clinics.
   - analyse commuting and rotations. There are unnecessary moves to satisfy historical staffing needs. Training aspects should be clear for each post. Placements should be actively managed. An increase in training posts with recruitment would provide some flexibility. A family-friendly approach is needed to training doctors – allowing families to stay together in one place/locally for their training. Structural inequities should change so that women have an equal playing field to progress.

5. **Colleges, Joint Committee on Surgical Training, General Medical Council, regulators and funders should:**
    - use data on historical instances should identify all those who have had repeated, persistent or concerning negative comments about their behaviour as trainers to have targeted re-education of poor behaviour to target training and scrutiny.
    - publicise reporting processes (eg phone number for confidential discussion by College).
    - collate and respond to reports of poor behaviours.
    - demand active bystander training in-person in team groups, especially starting where there have been problems.
    - re-train appraisers and staff doing Annual Performance Reviews.
    - specifically include in GMC appraisals the need to be revalidated as a recognised trainer.

6. **Specific funding issues should be considered:**
    - to acknowledge that each doctor in postgraduate training incurs some fixed cost for the employing organisation, even if training LTFT.
    - to arrange cover for "in between" times, such as ramping up, ramping down or being supernumerary in a local Trust on a phased return to work.
    - to acknowledge that surgery has the longest training and the longest commutes and that childcare may be required to cover commuting time.
    - Craft specialties require many hours of practise.

7. **Recommendations regarding Shared Parental Leave (SPL):**
    - Doctors in postgraduate training can access enhanced pay for shared parental leave. This should be publicised. It should be extended to Consultants and SAS doctors.
    - SPL should have a use-it-or-lose it element available only to the 2nd parent (usually the father), in order to increase take-up. Countries which have introduced this, eg Iceland, have seen far higher take up of SPL.

Workforce issues impacting on all genders and worsening training experience

Many problems are exacerbated by pressures of service provision. There are insufficient doctors, rota gaps and difficulties with many aspects of training. These are worse for a doctor from a minority group, or one who is balancing other issues. There is no spare time to reflect, plan and optimise learning opportunities. The NHS relies upon doctors in postgraduate training to provide a service. From historical lengthy on-call rotas, their hours were limited to 56 in 2004 and 48 hour per week in 2009, with no large increase in training post numbers to compensate for this. It would be possible to increase training posts swiftly and cheaply by converting many Locally Employed (LE) doctor posts to training posts. There are now almost as many doctors not in training posts (61,000 in SAS or LE posts) as in training posts (66,000) [1].

The number of training posts is restricted by training bodies. There are competition ratios of 4 applicants per post for many specialities [14].

Doctors, especially in postgraduate training posts, are rostered to shift work and nights, often reducing daytime training opportunities. The Extended team including Medical Associate Practitioners (MAPs) such as Physician Associates, is being developed and doing excellent work, but far too few are rostered onto out-of-hours cover, to reduce the burden on doctors. Their training makes them risk averse and they cannot replace all the roles and responsibilities held by medical colleagues.

For many doctors, over half their working hours are spent on duties that do not require a doctor's capabilities, for example administration [15]. This worsens quality of training and delivery of patient care. They are stretched, not getting meal breaks, fatigued and many are burnt out.

Workforce suggestions:

8. A large increase in training post numbers across multiple specialties is needed to adjust for the numbers of parents of young children and those training LTFT. This would improve training, improve patient care and reduce rota gaps. This could partly be done by converting Locally Employed (LE) doctor posts to training posts and using the untapped talents of SAS doctors as supervisors (an additional duty which should be appropriately compensated). Shared parental leave should be encouraged. Men should be encouraged to take more paternity leave. 'Over recruitment' is needed, with enough recruitment to account for maternity and paternity leave and part time working when planning numbers of training posts.
9. Consider how to staff rotas with less reliance on doctors in postgraduate training (eg additional out-of-hours skills for MAPs working within a team).
10. Ensure that staff, such as secretaries or Doctors' Assistants [16], are available to undertake administrative and basic clinical tasks.
11. Collate and champion examples of good rotas or IT systems that allow self-rostering or reduce doctors' administrative burden.

Other considerations that may assist the business case for action to retain women doctors

- We are losing thousands of talented doctors, who would otherwise be providing 20-30 years' more service.
- Doctors can handle risk and complexity. 21% of the UK population has a long-term medical condition. 19% are over age 65. At age 65, 50% of the population are multi-morbid (with two of more long-term conditions). We need doctors, especially senior dynamic doctors.
- Litigation, claims and complaints in Obstetrics cost twice as much as running the service [17]. Better staffing, eg doctors, can reduce errors.
- Doctors help improve the population's health. Across the UK, more people than ever are leaving work due to ill-health. We cannot afford to lose their taxes and contribute to care costs.
- Patients are more likely to take advice if personalised by a senior clinician who they trust. This allows patients an opportunity for Shared Decision Making (eg doubts about proceeding with an operation) [18]. This reduces unwarranted investigations and interventions. 10-15% of operations have complications. 15% of patients express regret after surgery. Eg 15% of older patients decide against surgery after a consultation with a geriatric-led service. This saves the NHS huge costs (in resources, staff and complaints). We need to retain doctors to do this.

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Appendix 1

A joint pledge to end sexism in medicine – BMA - 2023

https://www.bma.org.uk/end-sexism

1. Eliminate sexism from career progression opportunities.
2. End sexual harassment in medicine.
3. Ensure that there are multiple channels for reporting sexual harassment and sexism.
4. Promote the benefits of gender diversity in medicine.
5. Guarantee safe and supportive environments for pregnant doctors and medical students.
6. Remove the detrimental impact that having children and other caring responsibilities can have on career progression and work-life balance.
7. Actively challenge gender stereotypes in medicine.
8. Increase the visibility and voices of women.
9. Employees in more senior roles to recognise gender bias in the workplace.
10. Support women's health.