



Making Part-time Work

Full Report



Government
Equalities Office

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Preface from the Chief Medical Officer for England

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

Section 1: Introduction

1.1 Background and objectives of the research

This research was undertaken by the Medical Women's Federation (MWF) and funded by 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, one for each of the following groups – consultants, staff and associate specialists, trainees and GPs. The total number of doctors in the study was 86.

The participants were selected using purposive sampling, via medical networks. Doctors were either currently part-time (82), or had worked part-time within the past two years (4). The request for participation was widely circulated through informal networks: 20% of the participants were members of MWF, and 80% were not. 90% of participants were women and 10% were men. There was a wide range of grades, specialties and locations. More details of participants can be found in Appendix 1.

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 only 10%, was 'other life interests', including voluntary work and work-life balance. Other reasons for working part-time included semi-retirement, ill-health, elderly care, private practice and medical politics.

1.2 Background to part-time training and working

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 students¹ 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)² and extended to junior doctors who were unable to train full-time for well-founded reasons in 1979 (PM(79)3)³. In 1993 flexible training posts were advertised centrally with national competition to get manpower approval. Posts were supernumerary, 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 were usually funded if they had 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 posts⁴.

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 as a StR in higher specialist training before obtaining a 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: 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 supernumerary placements are now limited due to financial constraints and a 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. While 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^{5,6}. 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 behaviour 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'.

Variations by 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 a huge growth in female GP registrars, who

now make up 61% of that workforce⁷. 47% of women GPs work part-time⁸. 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 (Senior House Officers) and tiny numbers of other training grades and male trainees working part-time⁵. 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 the 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 2006

² Department of Health and Social Security. Re-employment of women doctors. Health memorandum, HM(69)6. London, HMSO 1969

³ Department of Health and Social Security. Opportunities for part-time training in the NHS for doctors and dentists with domestic commitments, disability or ill health, PM(79)3. London, HMSO, 1969

⁴ NHS Employers. Doctors in flexible training. Principles underpinning the new arrangements for flexible training. London, NHS Employers 2005

⁵ Department of Health. The NHS Plan: a plan for investment, a plan for reform. Norwich, HMSO, 2000

⁶ Department of Health. Improving working lives standard. NHS Employers committed to improving the working lives of people who work in the NHS. London, Department of Health, 2000

⁷ <http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-numbers>

⁸ Allen I. Women Doctors and their careers: what now? BMJ 2005; 331: 659-72

1.3 How the report is structured

The findings from the research are divided as follows:

Section 2 looks at the benefits of part-time working for the profession and attitudes to part-time working, particularly issues of professionalism and commitment.

Section 3 is concerned with part-time trainees. Trainees are separated from career grade doctors because of the specific issues around the way that part-time training posts are designed.

Section 4 covers part-time career grade doctors – consultants, staff grade and associate specialists, and GPs, both salaried and principals. This section shows how participants had achieved their part-time post, how teamwork can facilitate part-time working in a service which operates 24 hours a day and the factors affecting feasibility of part-time work.

Section 5 examines career development for part-time doctors, particularly the ways in which the careers of doctors with outside-of-work commitments differ from traditional medical career paths and the challenges for part-time doctors who wish to achieve a senior position in the profession.

Section 6 reports on the solutions suggested by participants in the research to facilitate best practice in part-time working.

Section 7 gives the conclusions of this research.

Section 8 makes recommendations for policy changes to facilitate part-time working in the medical profession.

Section 2: Attitudes to part-time working

Key findings

- **There were many benefits of part-time working.** Participants identified these as utilising the skills and potential of doctors who otherwise would have been lost from the workforce, part-time doctors having empathy with patients and their lives due to leading a balanced life style, patients getting a second clinical opinion, and meeting the changing needs of the workforce.
- **Many part-time doctors felt they were still perceived as part-committed.** Although it was becoming more acceptable to work part-time, nearly two thirds of interviewees felt that they were taken less seriously as a part-time doctor. Part-time doctors themselves saw commitment and professionalism as a function of their mind set, not just the number of hours worked.
- **Part-time doctors felt they had to make an extra effort to demonstrate commitment.** Three quarters of participants were working extra hours and many were also taking calls when they were not at work and not on-call.

2.1 The positive impacts of working part-time

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

Avoiding wasted potential and skills

It was widely accepted in the medical profession that, with increasing numbers of women coming out of medical school, part-time options needed to be made more available if the profession was to avoid wasted potential, skills and expense: ‘A lot of money gets spent on doctors who’ve been chosen on merit and then just because they have kids they’re allowed to fall by the wayside,’ commented a surgical trainee. The provision of part-time opportunities was considered an essential investment by a GP principal: ‘Assuming a thirty year productive working life, if you can keep people through that five years, then you’ve retained a valuable resource.’

Some pointed out that increasing numbers of male doctors were interested in work-life balance: ‘Over the five years that we’ve been doing NHS appraisals...men...are much more able to talk about a balanced life,’ commented a salaried GP.

Empathy with patients’ lives

Many doctors mentioned that having similar life experiences to their patients made them better doctors: ‘Part-timers have better empathy with the patients, how their lives work,

the difficulties they encounter. They know how to communicate with them,' said an associate specialist in community paediatrics, while a staff grade paediatrician felt that 'Because you're not exhausted, you're able to give more time and patience to patients and relatives.' A salaried GP agreed: 'I think the patients do benefit in terms of the deal they get from a part-time GP...because they do have some concept of life outside of general practice.'

Getting a second opinion

There was thought to be a big advantage in sharing care with colleagues, as a consultant gastroenterologist explained: 'When I was job-sharing I'd do a ward round on a Monday and my colleague would do his on a Thursday for the same in-patients and I think the patients got a really good deal because they got two clinicians thinking about their problem.'

The department or practice was said to benefit from 100% of the experience, knowledge and skills of each doctor, whether full-time or part-time, so the more expertise there was in the department the better. If patients were seeing more than one doctor, they also had the opportunity to build a relationship or establish a rapport with different doctors: '[Patients] get more than one head thinking about their cases...And if they don't particularly like me...they might like the other person,' said a consultant in palliative care.

Part-time doctors work harder, and smarter

Most part-time doctors worked longer than they were contracted for (see page 13), and some also believed that they were more focused, getting more done in a shorter time: 'Part-timers work that much harder because you have a deadline by which you have to leave. You don't waste a moment,' commented a consultant cardiologist. Job-sharing often doubled the input at handover time: 'If you have one part-timer in the morning and one in the afternoon, the morning one doesn't leave till 3.00, even though the afternoon one arrives at 12.00. So that's a pretty good deal for the practice,' said a GP principal.

Happier, more enthusiastic, more balanced doctors

Working part-time could sometimes increase doctors' energy and enthusiasm for their work: '[Working part-time] makes me more positive and cheery. It makes a big difference to patients and decreases the possibility of burn-out,' observed a surgical trainee, while a consultant ophthalmologist commented: 'Because I have a life outside of medicine it helps make me a balanced person.'

Maturity and self-awareness

Part-time doctors had often thought carefully about their own workload tolerance, and what made them a good doctor. Having to make hard professional and life choices, and

often to fight the prevailing culture, gave them a high degree of maturity and personal awareness. Many said that they were better doctors on fewer hours, as this GP principal explained: ‘Because I’m part-time and I’m not completely burnt out I’m a nice doctor to see, whereas I know from experience that when there are spells that I’m working more sessions because someone else is away...after two or three weeks I’m a distinctly less cheerful doctor.’

Growing (or downsizing) a department in part-time increments

Sometimes, a single part-time post was all that could be afforded or all that was needed in a department or practice: ‘There’s just me and the consultant...I’m doing the entirety of the job that needs to be done, so nobody needs to fill in the job when I’m not there,’ an associate specialist in gynaecology explained. When workload grew, doctors observed that it might be more sensible to grow in part-time increments rather than more expensive full-time ones: ‘Our area needs more [consultant psychiatrists]. I’ve argued that what they need is 1.6 consultants in the area, not two. Maybe putting a 0.6 in would be a sensible thing to do,’ commented a trainee in psychiatry, while a GP principal had ‘joined a practice that was looking for a half-time partner. They were expanding and looking for an extra half a doctor.’

Going part-time could also be beneficial to both doctor and employer when a department or practice was downsizing: ‘I was keen to do [part-time] and actually the hospital was broke and was keen to lose some consultant PAs...Because I wanted less hours, it made it easier for them,’ said a consultant obstetrician and gynaecologist.

Covering unsociable hours

Sometimes part-time doctors could fill in slots at unsociable hours, allowing hospitals to make better use of facilities, as a staff grade in psychiatry explained: ‘Being able to work weekends, being able to work in the evenings, would help me because my husband can look after the children...It would suit some of the patients too.’ Extending opening hours could also offer an improved service to patients, as an associate specialist in anaesthetics noted: ‘The Trust has extended the operating capacity of theatre into evenings and also opened up theatres at weekends...Those not particularly sociable sessions...suit a part-time person who wants to have a limited contractual obligation.’

More flexibility and better service cover

Part-time doctors whose non-work commitments were flexible were thought to make for much greater flexibility in the department or practice, and having more people on the team (for example four part-timers instead of two or three full-timers) gave more flexibility for holidays and service cover. A GP principal explained: ‘As a part-timer, you can offer to do things for colleagues. A full-timer can’t take on more work to help out when a colleague is sick, but a part-timer can.’

2.2 Commitment and professionalism

It was generally thought to be increasingly acceptable to work part-time, but there was still pressure to prove dedication and there was also a widespread view that part-time was still seen as part-committed. Nearly two thirds of the 60 interviewees felt that they were taken less seriously as a part-time doctor. As a salaried GP pointed out, 'People assume that part-timers aren't as committed or as professional, or as motivated or as ambitious.' Being a true professional still meant being full-time for many doctors: 'There is an assumption that the job is the hours, rather than what you do in those hours, the results you get. It's an attitude of mind,' observed a consultant psychiatrist.

Although negative perceptions of part-time work were often hinted at, rather than openly articulated, there were said to be occasional comments about part-time doctors: 'When you talk to colleagues or go to meetings, they're fairly careful what they say if they know you. If I go with my husband, sometimes they don't remember I'm part-time and they make comments about part-timers,' said an associate specialist in community paediatrics. When applying for consultant posts, a psychiatry trainee had experienced 'very close to direct pressure' from colleagues who intimated that 'Well, you've had your time doing some part-time training, now be one of the boys and do some proper work.' Confronting these attitudes was not easy, but 'You just have to say, a 0.6 job *is* a proper job.'

Some part-time doctors had a different definition of commitment, pointing out how committed women with children have to be just to stay in the medical profession, particularly in those specialties, such as surgery, which have not always developed working practices to enable part-time working. A surgical trainee pointed out the problem: 'Their idea of commitment is that you need to stay extra hours, show huge enthusiasm, you need to want to dump everything else in your life in order to do surgery. If they could see how hard I've had to work to *stay in* surgery, that's a completely different kind of commitment. If someone's prepared to dump their kids in nursery, travel hours to get to a hospital, and learn again [after maternity leave] how to operate, that should be enough of a commitment, without having to do anything else macho.'

Being taken seriously as a doctor also depended on the behaviour and attitudes of the individual: 'I think [being taken seriously] depends on the person. It depends entirely on whether you become mouse-like and slink in and out or whether you hold your head up,' observed a consultant cardiologist.

The European Working Time Directive was thought to have contributed to changing attitudes towards part-time working because it had brought the hours worked by full-time doctors closer to those worked by part-time doctors and had stimulated debate about the more negative aspects of the long-hours culture. A consultant rheumatologist explained: 'The European Working Time Directive...has been a real challenge...but it's making people focus on how do you deliver care and how do you train and how do you maintain your skills working far fewer hours. So it's not such a huge step now from being a full-timer...I think the goal-posts are moving and the differences are getting less.'

2.3 How part-time doctors demonstrate commitment

Contrary to what were said to be widely-held perceptions about part-time workers, this research showed that most part-time doctors worked extra hours. In addition, many made themselves contactable when they were not officially working or on-call. It was also pointed out that commitment was not necessarily a function of the hours worked, but of a doctor's mind set.

Many part-time doctors work extra hours

Three quarters of participants said they worked longer hours than they were contracted for. The amount of extra hours varied, but the average (calculated for all participants, including those part-time doctors who said they worked no extra hours) was 16% extra hours for consultants, 14% for both staff and associate specialists and GPs and 10% extra for trainees.

Some part-time doctors were doing extra clinical time, while many did their administration, continuing professional development (CPD), research, reading or audit in their own (unpaid) time, like this consultant ophthalmologist: 'It's the things you don't diarise, the bits of paper you read at home and the journals you read on the hoof, and the phone calls that you take... There are meetings and things that you need to attend that aren't within your part-time timetable.' A common problem was that appropriate proportions of clinical PAs (programmed activities) to SPAs (supporting professional activities) were not maintained for part-time doctors and contracts appeared to vary hugely in this regard.

The principal reason given for working extra hours was workload, but some also mentioned needing to prove their commitment to full-time colleagues: 'Those of us who are working part-time have to do our best to prove... [our] commitment, but I guess that means that you overcompensate, which is why I do all the extra hours,' said a consultant in chemical pathology. Others put in extra hours because they felt lucky and grateful to be able to work part-time, like this salaried GP: 'At the end of the day... particularly at the moment when there's a shortage of jobs, you're just so grateful that you haven't been kicked out of the job market and are de-skilling.'

Some part-time doctors, however, particularly those with young children, had outside-of-work responsibilities which precluded working any extra hours.

Part-time doctors take calls when they are not at work and not on-call

In addition to their working time and on-call commitment, many part-time doctors made themselves contactable during their colleagues' 'normal' working hours, or because they had a patient they wanted to be kept informed about. In effect, these part-timers had invented a third category of work: not at work, not on-call, but still contactable, like this consultant geriatrician: '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".' A clinical pharmacology consultant agreed: 'Although I go home at three o'clock, if there's any in-patients I'm worried about, they're phoning me. I don't want any disasters happening that I don't

know about,' while a consultant cardiologist felt that 'It's about being there for advice to your juniors. I don't mind being rung on my mobile about patients.'

But again, not everyone could be as flexible or accommodating as this. Some of those with fixed caring commitments for young children found it hard to take calls when they were not working.

Commitment was not just a function of hours

Taking responsibility for patients, and commitment to one's profession, were not seen as a function of full-time or part-time hours, but as an attitude of mind: '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. But that's not why I'm in medicine, to make patients suffer,' said a trainee psychiatrist, while a consultant cardiologist commented that 'Women who look after kids are still doctors in their heart.'

2.4 'Acceptable' reasons for working part-time

There are several traditional reasons for being part-time in medicine, such as academic work, medical politics, medical education and private practice. Issues of continuity of care, or maintaining skills, have apparently been easily accommodated when someone works part-time for these reasons, as a consultant cardiologist pointed out: 'If you're part-time because you're in medical politics or an academic, you're still seen as a full-time professional.'

Part-time working has also become more acceptable for women with children: one trainee in general practice declared that childcare was a 'socially legitimate reason' for working part-time. In some specialties, part-time working has become so much the norm for mothers that the expectation was reversed: 'As soon as I said I was pregnant nobody expected me to come back full-time. So they would have been surprised if I had, rather than the other way round,' said a GP principal.

Although a few of the male participants in this study were involved with childcare, this was still a rarity, and perhaps would have been seen by some as an unacceptable reason for a man to work part-time. As one male GP principal put it: 'It's a real macho thing...I've only just swung my credibility...by being seen to do other things: "Oh that's OK because you train and you do this other work, so maybe you've got a full week, you're macho enough".' However, some doctors, like this trainee in emergency medicine, observed that it was becoming more common, and more acceptable, for men to work part-time: 'A colleague of mine...wanted to work part-time to assist with childcare and was initially refused. He pointed out that if he was a woman then there probably wouldn't be a problem...and they changed their mind.'

For trainees, part-time working is still 'granted' on the basis of special needs (see pages 5-6), rather than offered as just another training option. A consultant radiologist argued that this tended to set part-time trainees apart: 'Part-time needs to be normalised – so anyone can go part-time, regardless of reasons. It's intrusive to keep asking people why

they want to be part-time.’ In theory, career grade doctors who wished to work part-time had no need to give reasons, but, as the GP’s comment above shows, some felt there was a cultural pressure, particularly on men, to work full-time.

2.4 Other perceptions of attitudes to part-time working

Jealousy from colleagues

Jealousy was believed to underpin some of the negative attitudes towards part-time working. Doctors who worked long hours and sacrificed family or personal time, whether for financial reasons or in order to develop their careers, were thought to be reluctant to change working practices. A staff grade in community psychiatry believed that the biggest barrier to working part-time was ‘resentment from colleagues. They think, “You lucky so and so. If only I could afford not to work full time”.’

Attitudes of older doctors

Attitudes were seen to be changing among younger doctors, but older doctors were said to cling to a preference for full-time working. ‘I think there is maybe some lingering attitude of, I worked like that and trained like that, so I don’t see why you shouldn’t. So as maybe some of those more old-fashioned views leave the profession...things will change,’ argued a trainee in emergency medicine. A consultant in respiratory medicine agreed: ‘There is definitely more understanding amongst younger male consultants, but...some older male consultants just don’t understand...For them, it’s either work full-time or stay at home.’

Although full-time women were generally held to be more sympathetic than full-time men towards part-time working, some older women were felt to be less than generous to younger women who benefited from ways of working that had not been available to previous generations. A consultant microbiologist commented that ‘I’ve had full-timers, very career-orientated female consultants, when I was a registrar, saying things like: “Oh, why are you going part-time? We’ve raised our children doing full-time”,’ while a consultant pathologist felt that ‘There is still a macho culture even amongst the women...It was worse for me than it is for you.’

Gender attitudes

Some part-time doctors connected attitudes to part-time work with more general attitudes towards women in the workplace. A GP principal commented that ‘[Part-timers] are mostly women so there’s that girly thing: we’re naturally taken less seriously because we’re girls anyway...We’re girls *and* only part-time, well, there you go,’ while a staff grade psychiatrist believed that ‘The perception that [part-time] is a second rate option...is because it’s something that women do.’

Confusion of part-time and poor performance

Sometimes part-timers felt that assumptions were being made about their competence – that they were less academic, or in some way poor performers who could not quite make it in the tough world of medicine. This was particularly true for trainees who felt they were falling behind their cohort: ‘If anyone had seen that I had graduated in 2000 and wasn’t a registrar by 2007, they may well have thought that I was a ‘failure to progress’ type candidate...It was a risk that in my situation was unavoidable, because of my maternity leaves and working part-time,’ said a trainee in general practice. It was also thought that this attitude was held to discriminate against women with children, as a staff grade in psychiatry commented: ‘The supervising consultant that I work with, I think his attitude is...that if you spend time with your children, then you obviously don’t have the commitment, or maybe you don’t have the intellectual ability to do the consultant job.’

Section 3: Part-time training posts

Key findings

- **Slotsharing was preferred over the other two current options for organising part-time training (part-time in a full-time slot and supernumerary).** However, many trainees struggled to find a slotshare partner and then to organise training appropriate for both partners. Only one third of trainees participating in this study were slotsharing.
- **Part-time trainees had difficulty with the organisation of service rotas.** Although acquiring the right to work part-time was regarded as relatively easy, a number of non-slotsharing trainees had difficulties each time they started a new rotation because rotas were designed for ‘normal’ full-time trainees.
- **The quality of training in part-time posts appeared uneven.** Despite the advantages of increased depth and integration of knowledge gained by part-time trainees, training design was not always adapted to their needs: some felt they were missing out on opportunities and many found that study, research and audit had to be conducted in their own (unpaid) time.

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.

3.1 Getting Deanery approval for part-time training

Since 1995, trainee doctors who wish to work part-time have applied through their Deanery: applications are usually funded if the trainee has a disability or ill-health, or caring responsibilities for children or other dependants.

Acquiring the right to work part-time for childcare or ill-health reasons appeared to be relatively easy. Although Associate Deans for flexible training were said to vary in the amount of support they provided, most trainees were happy with this part of the process: ‘In a way it was quite easy, I thought, to become a flexible trainee. I just spoke to the director of our education programme, who directed me to...the flexible training Dean in this area,’ said a trainee in geriatric medicine.

3.2 Three options for organising part-time training

Most trainee doctors will rotate to a training post in a different hospital every 6-12 months. The trainee role encompasses both a learning component and a service element,

providing care for patients: this latter element involves joining the service rota, which has often been designed with a full-time post in mind.

The part-time trainee currently has three options: first, to slotshare with a partner, secondly to work part-time in a full-time slot, and thirdly to become a supernumerary trainee. Supernumerary training has become much less common in recent years because such posts are funded entirely from the flexible training budget, which has remained static while the number of part-time trainees has increased. In contrast, slotshare posts are funded mostly from the full-time budget, with a small amount of additional funding from the flexible training budget, and reduced hours in a full-time slot posts are funded entirely from the full-time budget.

Slotsharing

Slotsharing was perceived to work well, but only if there were a lot of part-time trainees in a particular specialty and geographical area, so that doctors could be paired up, as a surgical trainee pointed out: 'In anaesthetics and paediatrics, they do [slotsharing] really well because they've had more flexible trainees, they've had more women for some time...and it's a very large department.'

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. An anaesthetics trainee observed: '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.' A consultant anaesthetist also made the point that with slotsharing 'It's very easy to demonstrate your training's comparable and it does make it easier to do audits and projects...You're not floating on the edge with a sort of indeterminate role, you're integral to the working of the team.'

Slotshares worked in different ways. Sometimes two trainees were sharing the week's work and on-call, which provided the benefits of continuity and support. This had worked well for a trainee in obstetrics and gynaecology: 'We are a team, which is quite nice. People have learnt to consider us as the part-time team, so they look to find one of us and they accept one of us as readily as the other.' In other cases, the job was shared on a week-to-week basis, as experienced by a general practice trainee: 'Part-time colleagues had quite a rigid system of slotsharing where they'd have to work a full week from Wednesday to Tuesday...then the person they were slotsharing with would take on next Wednesday to Tuesday. So they'd work one week on, one week off.'

In other cases, the slot was split into two separate jobs, with the two trainees nominally sharing a post but able to take responsibility for different areas, and therefore not needing to hand over work to each other: 'When we first started the slotshare...I was doing general paediatrics on the ward and [my slot-share partner] was out in the community,' said a paediatric trainee.

Organisation of slotshares varied between Deaneries rather than being a standard process. Sometimes the programme directors organised the slotshare, as in the case of this trainee in general and respiratory medicine: 'Just for the convenience of the hospital

I am a slotshare at the moment... The supervisor for general medicine at the hospital knew there was this girl who was in a different specialty from me, but we're sharing general medicine. That will change again in August and I'll be supernumerary again.'

However, many part-time trainees felt they had to take responsibility for finding a slotshare partner, as a trainee in obstetrics and gynaecology commented: 'My most recent post came about really because the girl who I slotshare with and I engineered it... By having a social network I knew that another girl was going to go off on maternity leave... and I knew she needed to work where I was working at the time and I knew that this other girl was coming back from maternity leave, so we sort of put our heads together and... presented it to the Deanery.' A trainee in general practice had followed the same approach: '[My slot-share partner and I] found each other... We happened to be on the same GP scheme and both happened to be pregnant at the same time, so conveniently it worked out for us.'

A proactive approach to organising slotshares was felt to be important, as stated by a trainee in obstetrics and gynaecology: 'I've had to move Deanery several times because I've followed my husband's career and so each time getting to know quickly who are the right people to talk to and then working with the flexible training bod at the Deanery to try to work out where I was going to work... and keeping my ear to the ground with the local Deanery... and going to my RITAs and talking to them about it.'

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,' observed 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 these data are not collected in the COPMeD flexible training survey.

Sometimes there was a conflict with the slotshare partner's training needs, as was the case for this surgical trainee: '[My slot-share partner] has to do breast and I really need to do colorectal, and we'll have to sort it out some way but it's time consuming and tiring.'

Part-time in a full-time slot

Those trainees who had nobody with whom to slotshare 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.' There were problems for trainees as well, highlighted by this trainee in geriatric medicine: 'I got allocated to [hospital name] who didn't actually know that I was going to be half-time so had given me a full-time slot... I don't feel hugely welcome all the time... I can sense that it's making things difficult for other people.'

Supernumerary

Although supernumerary posts have become much less common in recent years because of funding constraints, some doctors still thought of this as a desirable option because the extra resource was always welcomed by the department they joined, as a trainee in emergency medicine explained: '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, some thought that being regarded as 'an extra pair of hands' was demeaning.

Some supernumerary trainees also found it harder to get exposure to out-of-hours work, and to integrate into the team: 'No one knew when I was going to be there, or cared whether I'd be there...I feel a wee bit superfluous,' said a foundation year 2 trainee. Supernumerary trainees also caused resentment among other trainees because they could 'cherry-pick' their posts and which shifts they worked: 'You can pick what you do as a supernumerary and some people don't like that,' observed a trainee in respiratory medicine.

3.3 Overcoming the inflexibility of part-time training

Negotiating a place on the rota

Although getting approval from the Deanery for part-time training was relatively easy, the organisation of hospital rotations caused a problem for many part-time trainees because of resistance to altering a service rota which had been created for the 'normal' full-time trainees. A consultant in psychiatry observed: 'If the person who's organising rotations isn't very flexible or creative...you can have problems as a flexible trainee.'

In order to overcome the lack of flexibility in the service rotas, part-time trainees commented on their extra administrative work: finding slotshare partners could be a problem, and if they could not find a slotshare partner, they had to negotiate both an adequate place on the service rota (which presented different challenges for supernumerary trainees and those working reduced hours in a full-time slot) and sufficient exposure to appropriate training in each rotation.

Part-time trainees therefore faced a considerable extra burden, as a GP trainee pointed out: 'If you're [full-time] on the VTS (Vocational Training Scheme), everything's laid out for you, you've got your four jobs established, you go on to the registrar year, you don't have to think about anything. If you're part-time you have to a) work out your job, b) get the educational approval, c) get your contract organised.'

The extra burden was particularly heavy for supernumerary trainees whose posts did not incorporate out-of-hours work and who therefore had to negotiate this. A surgical trainee commented: 'To be honest when I came out of flexible training I breathed a small sigh of relief and thought, at least I will just be a normal person for a while. I was looking forward to not having to hassle for educational approval, not having to scout for on-call and out-of-hours.' The same message was reflected by a trainee in general and respiratory medicine, who was switching between slotshare and supernumerary

rotations, depending on whether or not an appropriate partner could be found: ‘In my next job, I’ll be supernumerary, as I have been before, because there’s nobody to slotshare with. I’ll have to go and visit the hospital, work out when they have clinics, try to find rooms, see if I can get a bronchoscopy list, begging people to do their on-call, to be put on the rota...As a full-timer you just walk into a job and your timetable’s there.’

Inflexibility on degree of part-time

Part-time trainees have to work a legal minimum of 50% of a full-time post, a restriction imposed by European law (EEC directive 75/636). Most trainees felt that any less than 50% would be impractical, because of the need to get certain kinds of experience and maintain skills, especially as the individual has little control over where they are sent on each rotation.

However, some trainees wanted to work 70 or 80% of a full-time post – either for financial reasons, or in order to speed up their progress. Deaneries sometimes insisted on 50 or 60% in a slotshare, due to financial constraints, which made part-time training extremely inflexible. A trainee in pathology commented: ‘When you’re working flexibly you can’t up your days to four days a week...It’s either full-time or three days, there’s no in between...At my stage, at the moment, I could give four days and that could speed up my training but I can’t...get funding for a fourth day.’

3.4 Getting exposure to appropriate training

There were felt to be some advantages of training part-time, in terms of the depth and breadth of knowledge acquired over the longer rotations for part-time trainees, as a GP trainee noted: ‘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.’ A consultant rheumatologist agreed: ‘Part-time trainees have many advantages because they’ve seen twice as many cases, have more experience and maturity...So the flexible trainee brings different strengths, in particular more reflection time...The full-timers have the timetable that is given to them but the part-timers...have to negotiate. I’m sure the part-timers have got better managerial skills.’

The haphazard nature of training

Training posts have a service provision element and to some trainees, training sometimes appeared to be fairly haphazard, as noted by a paediatric trainee: ‘[Training] is very opportunistic...You pick up procedures in the cases you see, so if you’re not there then you’re not going to get them...You’ve got to be there a critical period of time really.’ The traditional apprentice model relied on long hours, with the view that if trainees were present in the hospital for long enough, they would pick up what they needed to know. This was felt to have wide-ranging implications in terms of part-time trainees getting sufficient exposure to what they needed to learn, a problem also faced by full-time trainees since the European Working Time Directive has reduced the number of hours for all doctors.

Some part-time trainees felt that their training came a poor second to their service role: 'The priority is service provision rather than training,' said one trainee in obstetrics and gynaecology, while a surgical trainee commented that 'You don't learn much in most clinics...It's a service commitment.'

One pathology trainee had concluded that, with better focus, the training could be much more time-efficient: 'We just get the work that [the consultants] don't want to do... We could get a lot more of an educational mix of cases and have a lot more mentoring... 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 and follow up

Many part-time trainees pointed out the difficulty of finding sufficient training opportunities on the days when they were working or getting exposure to particular procedures or types of clinic, like this trainee: '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.' Others missed exposure to experiences which were on fixed days in the hospital, as a trainee in palliative care explained: 'We have a big multi-disciplinary team meeting... on a Wednesday... with everyone relevant to the patient, going through management plans and discharge plans. I don't work on a Wednesday so I... rely on people passing on that information.'

Swapping days half way through a rotation was sometimes a way around this, as a trainee in palliative care observed: 'There are... certain clinics that you would like to attend but that only happen on certain days... That's the reason why [my slot-share partner and I] decided to swap our days half way through the job, so that we wouldn't miss out on these things.' However, this was difficult if trainees had immovable non-work commitments, as a paediatric trainee commented: 'People... have been expected to suddenly change their days half way through a six month rotation with very little notice... with no understanding that it was going to be really hard to change childcare.'

Another concern was not being present to follow up on patients and see their treatment through to the end: as a trainee in obstetrics and gynaecology pointed out, 'You ideally want to see the people you've operated on for your own learning.' A trainee in respiratory medicine had also concluded that part-time trainees could miss out on follow-up opportunities: 'I leave the patients I've been looking after Monday, Tuesday, Wednesday and come back on Monday when a lot of them have gone... It means me having to learn what happened to them. Was I right in the diagnoses I came up with? So I lose some continuity in my learning there.'

Maintaining competencies

Most trainees felt that it would be difficult to train at less than 50%, because of the need to develop and maintain skills, particularly in practical procedures: 'You couldn't do below 50% as a trainee. If you want to train, to get some breadth, it would be hard to go below five sessions,' argued a psychiatry trainee. A consultant anaesthetist agreed: 'If you're less than 50% it's a real struggle to keep your skills up. Anaesthesia is a very

hands-on, practical thing... particularly as a trainee when you're trying to learn new skills and get up to speed with things.'

Once a trainee had become competent in a certain procedure, they did not always have control over maintaining that competency. A trainee in obstetrics and gynaecology explained: 'I purposefully delayed my accreditation [in colposcopy] to the end of training... I knew that... as soon as I was accredited I'd have to start revalidating and in order to revalidate... you have to do a certain number a year. As a trainee you don't have that control because you might rotate to a unit where, for a whole year, you're told that actually someone else is doing all the colposcopy.'

Getting out-of-hours experience

Getting out-of-hours experience could be 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 held different views on whether or not out-of-hours experience was necessary, and whether it offered training benefits that could not be obtained during the day. This may well be different in different specialties. One surgical trainee felt that out-of-hours was a necessary part of training: '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.' An emergency medicine trainee disagreed: 'In emergency medicine... if you didn't know the time, you could look at the screen of people in the department and you wouldn't be able to say what time of day it was, so in that respect 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 noted by this trainee in emergency medicine: 'One of the reasons why the College were a little reticent [to approve my part-time training] was because if you're a specialist registrar on nights you generally have more responsibility within the department without any direct supervision. Their initial argument was that that was part of training but I think the Deanery pointed out that it isn't actually part of training because there's no one there to train you.' A consultant surgeon agreed: '[Trainees] are supervised more remotely when you're on nights, but otherwise it's probably not that different from the daytime.'

Finding time for study, research and audit

Part-time trainees had difficulty finding enough time for study, research and audit, and were getting around this by using their own unpaid time, like this pathology trainee: 'I try and get the maximum out of my three days that I'm working so that I'm busy all that time... 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.' Sometimes they went further, paying for courses themselves, as did this trainee in geriatric medicine: 'I feel I've had to do more... extra courses, and a lot of them I've paid for myself... The acute medicine course in London costs a fortune, that's all my study budget for the year gone. It's for me, for my own career development that I feel it's necessary to get those extra training days put in. But... you have to fund it yourself.'

There seemed to be widely varying expectations at annual assessment RITAs (Record of In-training Assessment) about how much study, research and audit it was reasonable to expect from a part-time trainee and several trainees pointed out the need to clarify expectations at RITAs. A trainee in rheumatology explained: 'As a registrar, they expected the same from you in a year as they did from the full-timers. I was only doing 60%, so really you couldn't produce as much in your portfolio in terms of all the cases you'd seen and the courses and conferences and training days... Often [the RITA] was with consultants you hadn't worked with... Sometimes they'd expect you to have done as much research as [the full-time trainees].' In some cases, the assessors themselves were not entirely clear about expectations, as a surgical trainee had experienced: 'They give me the same sorts of goals [as full-time trainees]... They don't take into account that I'm part-time, but then when the year comes around, they're not too hard on me if I haven't achieved what they wanted me to achieve.'

3.5 Financial and contractual issues

Although the new pay deal for less than full-time training was introduced in 2005, with clearly set out guidance from NHS Employers, there was still misunderstanding of how a part-time trainee was paid: 'I've had so many e-mails and tried to arrange so many jobs that have fallen through because they can't afford us if there's no one to share with,' commented one surgical trainee.

Many supernumerary trainees had difficulty getting out-of-hours work because of funding constraints: 'The Trust weren't keen to give me the on-calls... They didn't want to fund my on-calls,' said a respiratory trainee, while a surgical trainee commented that 'I couldn't get the Trust to fund any out-of-hours because I was supernumerary so they didn't need me on the rota... I was quite creative... and e-mailed to the managers saying, If you need locums... please ask me.'

One trainee in pathology working reduced hours (80%) in a full-time slot had lost all of the out-of-hours banding on switching to this working pattern: 'I don't get pro rata of banding, they have refused... Do you say, Right, I'm going to fight this? It's very hard because then you face the possibility of becoming hugely unpopular with the people you work with.'

After finding a post, some trainees had problems with contracts and payments. A trainee in palliative care said: 'The hospice were very happy to have us, the Deanery were very happy to have us... but it was just the practicalities. Human Resources... just don't seem to be very used to it... and didn't have that much experience of slotshares. Hence why we don't have a contract yet I think.' A pathology trainee commented on the difficulty of getting paid: 'Wherever I've started, I've never ever been paid in my first month... [They say,] You're part-time and... I didn't know that the Trust ought to pay you and then we get paid by the Deanery. Every place I go to I have to... go and see the staffing department and say, Are you aware of this, this, this and this.'

3.6 The benefits of competency-based training for part-time trainees

Competency-based training was welcomed as an opportunity to separate out the number of years of training from the level of expertise, both for those part-time trainees who were capable of moving faster, and those who felt they were perceived as having failed to progress. A trainee in respiratory medicine pointed out the benefits: ‘Every aspect of my work is recorded and assessed in a single electronic portfolio...Someone senior has signed to say I’m competent in x y and z...Irrespective of how long I’ve trained...I have documentary evidence of what...I can do...That’s hugely beneficial for people who train flexibly or who take time out for kids.’

Some trainees felt that their part-time status had affected the kind of training they received, and that competency-based training could help to correct this problem. A trainee in obstetrics and gynaecology commented: ‘As a 60% trainee, I’m definitely over-trained in out-patients and under-trained in other opportunities, so I think for us, competency-based training has to be a good idea.’

However, trainees also raised concerns about competency-based training, particularly the perceived lack of competent assessors. One surgical trainee asked, ‘Being competency assessed by whom? There are lots of consultants out there who could do with being competency assessed. It’s such a political minefield. It’s going to have to be assessing them as they come through and waiting for the old ones to drop off the end.’ A pathology trainee had the same concern: ‘It would need a lot more involvement and commitment from our consultants to get [competency-based training] going. I think pathology’s got a lot of work to do.’

Others commented on the fact that much of their experience was gained when the consultant who would have to sign for their competence wasn’t there. A trainee in respiratory medicine commented: ‘It’s difficult to get [the e-portfolio] filled in...I do lots of procedures – putting in chest drains, performing lumbar punctures – things that are often done to patients when they’re seen acutely when I’m out-of-hours. There aren’t any consultants around to see me do that and tick off that they’ve seen me do it competently.’

Another issue was the lack of agreed standards and definitions of competency, and some felt that competencies had been defined too narrowly: ‘We’ve assumed that jobs can be reduced to a number of skills. That doesn’t necessarily make you a good doctor. You need to look at capability, a more holistic approach,’ said one consultant surgeon, while a foundation year 2 trainee made a similar point: ‘Competency-based is just a tick-box exercise...I’m not saying case-based discussions with your consultant aren’t useful...but you could get everything ticked off in six weeks if you wanted to...In the foundation years, you could do everything within an A and E rotation.’

Section 4: Part-time career grade posts

Key findings

- **Negotiation was the most common means of getting a part-time job.** Just over half of the participants had achieved their part-time post through some sort of negotiation, rather than applying for a post advertised as part-time.
- **Teamwork was seen as an appropriate way of ensuring continuity of care.** In a service which operates 168 hours a week, many doctors recognised that nobody was truly full-time. Both full-time and part-time doctors were operating different degrees of team responsibility for patient care: part-time working could be more easily accommodated when team responsibility for patient care was well established.
- **Working practices were determined partly by clinical needs, but also by the needs and wishes of the workforce.** Although different clinical needs in different specialties were an important factor in determining working practices, many part-time doctors felt that the critical mass of part-timers (usually women) in a department, and the degree to which colleagues were willing to share responsibility for patients, were equally important in determining appropriate working practices.
- **Successful part-time doctors conducted ‘fair trade’ with colleagues.** Negotiating who would do what in the department, a mutually-agreed ‘fair trade’ which did not offload work unfairly onto colleagues, was seen to be important to the success of part-time working.
- **The measurement of part-time doctors’ workload was variable, particularly in terms of clinical and non-clinical activities.** The activities which ‘counted’ when assessing workload were not always clearly defined. Continuing professional development and administrative activities were often done in part-time doctors’ own unpaid time, while part-time GPs commented on inequitable allocations of paperwork, repeat prescriptions, laboratory forms or home visits.

4.1 Getting a part-time career grade post

Just over one third of interviewees in part-time career grade posts had answered an advertisement for a part-time post, while just over half had achieved their post through negotiation. The remaining doctors had achieved their part-time posts in a variety of other ways.

Many doctors described getting their part-time job as a process of negotiation over a considerable period of time. The process of negotiation was not just reducing hours, but also selecting which parts of the job were of interest to them. A consultant in obstetrics and gynaecology explained: ‘I would say when you get into a consultant job it takes you

three or four years to get it the way you want it. You just have to wait till someone retires or you can shift things around a little...I think that happens a lot more than people realise.’ An associate specialist in anaesthetics observed that the job had completely changed over the period of doing it: ‘My job [has] evolved over time because the workload has changed within the hospital...Consultant surgeons have retired, new specialties have evolved and so my job doesn’t bear any relationship to what it started off being.’

Negotiating a part-time post

Just over half of the career grade interviewees in this study had negotiated their way to a part-time post in one of three ways: 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.

It was thought relatively easy to change an existing full-time post to part-time, as an associate specialist in gynaecology observed: ‘If you’ve been full-time...people know you and they know your record and they’re prepared to negotiate something different because they want to keep you...but if you’re an unknown entity when you’re starting out they’re not going to be interested in moving things around to accommodate you.’

Many doctors believed that doing the job full-time first was the surest way to achieve a part-time job. A salaried GP commented that ‘When I went part-time, my practice...wanted me there every morning...We reached a compromise and I’m doing four days...Six sessions over three days would be much better for me but I figured I had to get my feet in the door first of all before I could start pushing.’ Some agreed to start the job full-time, but with the (unspoken) intention of negotiating down to part-time once they had established their position. A consultant in obstetrics and gynaecology explained: ‘To get the consultant post I had to go full-time, because that was the way it was offered...It was my dream job really...and because I didn’t do any private practice I still actually had a little time off within the working week. I did that full-time for about three years and then I went part-time.’

Some had applied for a new job advertised as full-time, and then negotiated it down before starting work, like a staff grade psychiatrist: ‘This current post was advertised as a full-time post...When I applied, I made it clear that I was actually only looking for four or five sessions per week and they were happy to do that.’ Some doctors had more work to do in order to convince their prospective employer that the job was possible part-time, like this consultant in public health: ‘What I had to do...was to say, I will come to you on secondment for six months to prove that I can do it in four days a week. That’s what I did...and I was eventually made substantive six months later.’

Where there was a shortage of candidates, a proactive approach worked for some, including a consultant in palliative care: ‘When we came to the end of our rotation [another trainee and I] knew which post we wanted, so we rang them up and said, We’re coming to see you, show us round...We were interviewed as two part-timers together...and since the post had been empty for some years they had to say yes really.’ A staff grade in geriatric medicine also found that a shortage of candidates increased the

part-time applicant's bargaining power: 'They decided to create a new post, but...because they didn't get many candidates...I could dictate my own terms...I said I'd do it for four days.'

Some interviewees said that their part-time job was created specifically for them, like this associate specialist in anaesthetics: 'The job was an amalgamation of various sessions which GPs and clinical assistants had done previously...They wanted to create one proper...substantive post...out of these various sessions.'

Applying for an advertised part-time post

Among the one third of interviewees who had applied for an advertised part-time post, there were several cases of the post being set up with a particular person in mind, even if a formal procedure was also carried out, like this consultant cardiologist: 'I went there to do a week of management shadowing, as part of my management training as an SpR. So in a sense when it was advertised it was advertised with me in mind and I'd laid the ground work ahead of time.' Sometimes the whole process was initiated by the applicant, as a consultant psychiatrist confirmed: 'I approached somebody who I'd worked for when I was a junior, ten years before, and said I was looking for a part-time post...and really he set up a post that was five sessions. There was a formal procedure...but happily I obtained the post.'

Salaries GPs and principals working part-time

In general practice, several doctors mentioned that it was getting harder for partners to negotiate part-time with the other partners in the practice, because changes in the GP contract had created a financial incentive for the practice to employ salaried doctors instead. A GP principal said: 'I think it's relatively easy to be part-time as a salaried GP, but hard for a partner...because of this business that you can't change your profit share and your arrangements without being in unanimous agreement with the other partners.'

This also meant that a GP principal who wanted to move was at a financial disadvantage: 'By far the biggest barrier [to part-time working] at the moment is the difference between partners and salaried GPs...If you're a partner then the only way you can go part-time is if either your partners let you, or if you leave, but if you leave you're almost certain not to get another partnership. I was looking at a 75% cut in income if I left the practice to become a salaried GP.'

4.2 Ensuring continuity of care

Even a so-called full-time job is only ever possible for part of the 168 hours in every week. The 48-hour maximum allowed by the European Working Time Directive from 2009 onwards amounts to 29% of the week. Even before that date, working practices have already shifted to redefine what full-time means, as observed by this GP principal: 'Actually we're not full-timers any more: we don't do nights, we don't do weekends, we have a day off...so what is full-time?'

Discontinuity of care is the norm for patients

Historically the medical profession has relied on trainees to cover for the hours when consultants were not working, including weekends and nights, or were doing private practice, teaching, meetings, or continuing professional development. This discontinuity for patients has become normalised: consultants are expected to be away from their patients and constant presence is not expected or required, as this surgical trainee pointed out: ‘My consultant, she’s only doing Monday, Wednesday, Friday and one in four Tuesdays – but that’s a full-time post.’ Some part-time consultants, like this cardiologist, thought that reasons for absence were not important: ‘[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.’

However, part-time consultants often felt guilty about adding to this discontinuity 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 job-share partner during the week, but at weekends ‘The whole department offloads to whoever’s on call so we’re all in the same boat...The weekends are awful to be a patient...I think everybody accepts that weekends aren’t ideal and they really shouldn’t exist in medicine.’ A consultant microbiologist took up this theme, pointing out that weekend handovers were ‘normal’ and therefore induced no guilt, but ‘[Part-timers] are an extension of the weekend, we’re making the problem worse really, so...you feel guilty.’

Several doctors pointed out that the old ‘firm’ structure, in which a single full-time consultant had responsibility for a group of patients, with out-of-hours cover from trainees, had already been disrupted by the European Working Time Directive and by initiatives such as waiting list reduction. The traditional concept of continuity of care has in most cases already been dismantled, as an obstetrics and gynaecology trainee observed: ‘Even as a consultant nowadays...with waiting list initiatives etc, it is not unusual at all for consultants to be met with an operating list full of people they haven’t met themselves.’

One associate specialist in paediatrics pointed out that the ‘firm’ structure which used to operate in acute specialties was never ideal for patients: in effect, patients had to ‘make do’ with juniors to cover the hours when the consultant was not available. However, other specialties provided ‘real’ continuity of care with teams of qualified doctors: ‘Community paediatrics has never relied on junior doctors in the same way as acute specialties – it’s always relied on qualified doctors.’

Team responsibility for care

Many doctors pointed out that teamwork was another way of dealing with the 24 hours a day responsibility for patient care: ‘Everybody covers for everyone else out-of-hours – the emergency work is shared out. So why not cover for all the other work too?’ said a consultant psychiatrist. This form of work organisation made part-time jobs much easier to design: ‘On the day when we change, the in-patients change from mine to somebody else’s. We very rarely insist that we do our own patients and clinics, although we will

follow up our own patients... That is a thing that will help part-timers, if you work closely as a team,' commented a consultant gastroenterologist.

A consultant cardiologist felt that 'Patients are happy with a *small* team of consultant cardiologists – they don't want a big team... Continuity of care should be the responsibility of the team, not the individual.' A consultant rheumatologist was also convinced that this worked well for patients because 'We share patients on the ward round and we share patients in clinic... All the patients know that they might see any one of three consultants... So it works very well for the patients,' and suggested that team responsibility might be preferable for patients because it makes for 'better, safer care.'

Sharing responsibility for care among consultants was more common in some specialties than in others. There was a widespread assumption among doctors in non-acute specialties that part-time working would be harder in acute and surgical specialties, but part-time doctors actually working in acute specialties often felt differently: 'I would say 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,' commented a consultant in orthopaedic surgery, while a consultant obstetrician pointed out that 'Everybody realises that it's completely impossible to expect one person to be on-call 100% of the time for a particular patient.' Another consultant surgeon commented that team responsibility was possible in acute specialties, but the culture and working practices had not yet evolved: 'It's not that it's not possible, but... the leaders in teamworking haven't emerged in surgery.'

4.3 Factors affecting the feasibility of part-time working

Different clinical needs were one key reason for different attitudes towards part-time working in different specialties, but were sometimes hard to disentangle from personal attitudes and the gender debate. Some doctors felt that clinical demands in acute specialties rendered part-time working – or indeed personal commitments of any kind – impractical, but others said that as more part-time or female doctors entered a specialty, or as social attitudes in general changed for both genders, working practices would change to enable more part-time working.

The following section identifies the range of factors which might influence the feasibility of part-time working across all specialties. As one GP principal pointed out: 'You can't really divide conditions into acute and non-acute. You just have to trust your colleagues to deal with things when you're not there.'

A critical mass of part-time, or female, doctors

It was thought that new working practices would emerge with an increase in either the numbers of women, or the numbers of part-time doctors, as a consultant in respiratory medicine noted: 'You need more [part-time] 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.'

Many 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: '[Part-time working] is much more difficult to do in specialties where there is a significantly lower proportion of women... The culture in psychiatry... is much more tolerant of different working patterns,' said one consultant psychiatrist, while a consultant in obstetrics and gynaecology commented that 'I'm in a unit which is friendly and supportive to part-timers... There are a lot of women in obstetrics... so there's no prejudice against you.'

Others mentioned a critical mass of part-time doctors, without mentioning gender: 'Once you've shown that [part-time] works and it gets up to a certain mass then it does become self-perpetuating in a way, and people become a bit more accepting of it,' said a consultant anaesthetist. In many cases, gender and part-time working were used interchangeably, the assumption being that women would want to go part-time. A consultant in community paediatrics explained: 'If you look at paediatricians, there are more female than there are male even in something like acute medicine or neonatology... I think there are certain specialties that are geared up for people working part-time. There's a longer history and it's more widely practised.'

Acute patients and frequency of consultation

Most doctors drew a distinction between the acute and surgical in-patients, who required frequent monitoring and fast responses, and the less acute specialties in which gaps between consultations could be longer and patient progress was more predictable. 'An in-patient or a patient with an acute problem... needs to be seen on a daily basis,' said a consultant ophthalmologist but for other in-patients, and for out-patients, a once or twice-weekly ward round or interval between consultations was sufficient, as a consultant psychiatrist pointed out: 'Things tend to move a bit more slowly [in psychiatry] than in acute hospital medicine... Acute emergencies in psychiatry are... over hours rather than minutes... whereas in medicine and surgery things change much faster.'

A staff grade dermatologist commented that the interval between consultations in her specialty suited a part-time doctor because 'In dermatology, there aren't many in-patients or on-call. 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.'

The frequency of consultation also affected the pattern of days that would best suit the job, as a consultant in old age psychiatry observed: 'Acute in-patient work, that's the... reason why I don't do my three days all in one chunk at one end of the week, I space it out across the week... You can't have several days when you're not going to be around.'

Building a relationship with patients

Doctors often spoke about the importance of building a relationship with the patient over the long term, particularly those in general practice, community medicine and

psychiatry. A consultant in community paediatrics explained: 'It's not just doing a clinic...It's what happens after the clinic, which is not just writing a letter, 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.'

Whereas surgeons were said to 'parachute' in, and perform a technical procedure, other doctors felt they dealt more with the whole person, and needed to build up a more holistic understanding and relationship over time, as this trainee in psychiatry said: 'In psychiatry, it's an individual...everything's related.'

Some doctors in general practice and community medicine were comfortable shifting on to patients some of the responsibility for deciding whether or not to see their long-term practitioner: 'My secretary will say to them, She doesn't work on Wednesdays, can someone else help you or will it wait till she's back? I suppose it's about giving them choice,' declared a consultant in community paediatrics, while a GP principal believed that 'My core patients, I think, find it quite easy to work out which are my days.' However, GPs also admitted that some patients waited unnecessarily long times to see their top choice of GP: 'I know some patients have become iller than they should have done because they decided they needed to wait just to see me...not a lot, but one or two,' said a GP principal whilst a salaried GP pointed out that attempts to 're-educate' patients about when not to wait for their usual practitioner were not always successful: 'There are certain patients who only see me...and that can cause some difficulties.'

A consultant in palliative care observed that in her specialty, rather than being long-term, the patient-doctor relationship was intense but over a short period of time: 'It's a very sensitive time for people and their families and if they make a rapport with you, they would quite like to see you and not somebody totally new for the other half of the week...It is very intense but over that short time...They may well have died by the time you get to work the next week.'

Knowing a patient's history and personality could make consultations faster and more effective, as a GP principal commented: 'It's really easy when...you've known someone for 20 years. There's a continuity...you don't have to say things, you're understanding each other.' Without good handover notes, understanding a patient's history could be a challenge for doctors who shared responsibility for patients, as a consultant in old age psychiatry observed: 'What happens if somebody calls up with a problem with their medication on a day that you're not there? I think medicine is quite difficult to just fit into a little pocket isn't it?'

Out-of-hours

Out-of-hours presented a particular problem for those part-time doctors with caring responsibilities. Some thought that hospital doctors could opt out of out-of-hours without de-skilling: a consultant surgeon observed that 'I don't think everybody has to work nights. Nights are becoming a different phenomenon...Perceptions of what you do at night are changing.' Others such as this consultant in obstetrics and gynaecology 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.' The phrase 'street cred' is interesting, possibly implying that there was also

an element of status attached to doing out-of-hours. There was also a concern for fairness and a belief that unsociable and unpopular times of day should be equally shared out between consultants.

GPs found it easier to work part-time than hospital doctors partly because, as a GP principal commented, '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 maintain, but de-skilling or getting out of practice was a concern across the board, as an associate specialist in anaesthetics noted: 'It's a skill. Your work becomes automatic if it's regular. It's a process you get in to. Also you lose confidence if you don't do it regularly.'

Some part-time doctors felt that they had to specialise and drop certain procedures from their repertoire, as a consultant in gastroenterology explained: 'I used to do a colonoscopy list one week and an upper gastrointestinal endoscopy the next week. So my total number of colonoscopies in a year wasn't very many, I wasn't progressing...so I don't do that particular procedure.' A salaried GP had a similar experience: 'I don't get the opportunity to do as many coils as I want to because of my time restrictions. I get around that by...doing family planning clinics...But I don't do joint injections, I just feel I do hardly any of them and there has to be a certain level of competence.'

'Fair trade'

Negotiating who would do what in the department, a mutually-agreed 'fair trade' which did not offload work unfairly onto colleagues, was mentioned by several doctors. A staff grade community psychiatrist commented that '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 – write prescriptions, do home visits, take phone calls, do Mental Health Act assessments.' Part-time doctors stressed the need to negotiate a fair deal with colleagues, sharing out perks as well as the unpopular elements and unsociable hours. A GP principal said: 'You have to raise the issues, learn good negotiating skills. If you need to leave at 13.00 on the dot to collect kids, you need to say, how can we arrange things so that everyone gets a rotation of leaving at 13.00 on the dot?'

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, 'fair trade' might not be available, as a consultant in obstetrics and gynaecology pointed out: 'If I was a gynaecological cancer specialist...If you're the only person that's doing that sort of surgery then really you're the only person who can come in if there are any complications, so effectively you're having to be on-call almost 100% of the time for your patients because they're such a sub-specialty group.'

Finding time for continuing professional development (CPD)

Part-time doctors had a dilemma about continuing professional development (CPD). Most had a pro-rata allocation of CPD time in their contract, but had to maintain their knowledge at the same level as a full-timer who had more contracted time for CPD. A consultant rheumatologist explained: 'You have to acquire the same number of CPD points as any full-time consultant. You've got to be just as educated obviously, you can't just know half as much, but...they expect 100% CPD points but they'll only give you 60% pro rata study leave.'

Sometimes part-time doctors' contracts majored on clinical PAs and did not give even the pro-rata amount of continuing professional development time, which left them even further behind their full-time counterparts.

In either case, part-time doctors were getting around this by keeping up-to-date outside their working hours. A consultant cardiologist said: 'That's the bit that gets squeezed out, keeping up with reading medical journals. My time at work is full on dealing with patients. So the time that should be SPA (supporting professional activity) time...that's what also gets brought home, all the extra stuff.' Although many regarded this as a fair trade for being allowed to work part-time, others including a salaried GP disagreed: 'Continuing professional development is work and should be done in work time.'

Finding time for administration and management

'I get just as much paperwork as I would in a full-time post. I get all the same protocols sent to me as everyone else. I don't get 60% of the emails,' said an acting consultant in psychiatry. There was a fixed amount of administration and management tasks and it was felt that this was not reduced pro rata according to the numbers of sessions worked. A consultant in palliative care gave this example: 'Some things have to be done within a certain time frame...palliative care service appraisals...an annual cancer standard report...Unless I fill that out, we won't have a benchmark...If you want to improve your service it's down to you really...Things like that take a lot of time but if you don't do them, you won't get anywhere.'

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. A GP principal said: '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.' But it was thought that this could be career-limiting, given the lack of opportunities to re-train and broaden out again after a period of specialisation, as a salaried GP pointed out: 'If what you want to do is maintenance and seeing a few patients I think your expectations will be different from someone whose long term goal is...to go back into partnership.'

Some departments have split some jobs between acute/in-patient and community medicine, which again reduced the breadth of the jobs. A consultant gastroenterologist thought that ‘lots of specialties are going to have community-ologists and acute-ologists,’ while a consultant psychiatrist had noticed a similar trend: ‘We’ve been based on a political ward...Whoever lives in that address pocket comes to you...But there are places now where...they divide it differently, and there are some doing in-patient and some doing community.’

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.’ Some GPs had found this experience unsettling as a GP principal explained: ‘As a doctor you actually do like being valued by patients and then when they can’t get hold of you, and they walk away, it is a devaluing sort of experience to an extent. I found that quite hard.’

Feeling part of the team

Reducing hours beyond a certain point also reduced involvement in the team, and for some doctors, decreased job satisfaction, as a consultant orthopaedic surgeon pointed out: ‘I wouldn’t want to go below six [PAs a week]...If you are away from the hospital too much you feel out of the loop of what’s going on.’ For many consultants, a 60% contract felt like the acceptable minimum, while 40% was too little. A consultant in obstetrics and gynaecology said, ‘I think once you drop to two days a week it’s almost like you’re not part of it any more.’

Colleagues’ willingness to innovate

In many departments and GP surgeries, working practices have been redesigned to enable team responsibility for patient care, and flexibility for doctors, but this was thought to require lateral thinking: ‘At times departments aren’t imaginative in the way they plan the work...We do perhaps need to think sideways, away from the traditional model a bit,’ commented an associate specialist in anaesthetics, while a trainee in emergency medicine pointed out that a job could be done in several different ways and still be successful: ‘I think quite often we can, in the medical profession, get an idea that you have to work in a certain way for your job to be valid.’

There was also recognition that working hours could be adapted to suit the needs of doctors, as this trainee in respiratory medicine explained: ‘The structure of existing jobs needs to be altered...There’s no reason why a clinic should be 9 till 1. Why not 10 till 2 and empower picking up children? More flexibility on evening clinics – it’s desirable for doctors and patients.’

Colleagues' willingness to embrace shared care

One GP principal described a working culture in which shared responsibility for patients was well established: 'Here, if you pick up a patient you don't usually see from a colleague, you pick up and go with it, you deal with whatever needs doing, rather than leaving things for the colleague who might not be in till the day after.' It was also recognised that if working practices were not clearly established, problems could ensue for colleagues, as a consultant in community paediatrics explained: 'When I started off working part-time...the team that were doing full-time...landed up dealing with more phone calls and being in the clinics more...but that was just not very good planning...If I was to do it again now with the knowledge that I've gained, I would have prepared for it differently.'

Part-time working could expose different expectations around working practices, particularly at the point of transition to more shared care. Problems could arise when two practitioners had different expectations about shared care, as in this case, where one GP was expecting to share care, and another was expecting to take sole responsibility for a patient: 'Maybe I see a newly diagnosed cancer patient. Then [my colleague] sees them, it's an active situation. He feels...as if he has ongoing responsibility for that patient. In fact he needs to give that patient back to me...I feel he's unnecessarily taking them on. He feels he's put upon, or he gets hurt when I come back in to the active situation... Part-time has revealed that dilemma – split responsibility.'

Some doctors described working in an environment in which swapping and negotiating shifts or on-calls on an ad-hoc basis was the norm. This degree of flexibility was an advantage for part-time doctors with variable out-of-work commitments. A consultant obstetrician and gynaecologist described an environment in which '[My colleagues] are brilliant, they're very good at swapping on-call nights. So it's not that I do less nights on-call but they're...very amenable to swapping or covering... We all realise that if we are flexible and cover the odd hour here and there it makes it easier for everybody...the men as well.' This theme was taken up by a GP principal: 'We all facilitate each other... It's accepted as obvious that you might want to swap a surgery for your child's first piano lesson. We cover for each other...it's very evenly spread.'

Personality preferences and different working practices

'Working practices, the way we organise things, are more to do with personalities than the nature of the work,' said a consultant cardiologist. Some doctors thought that acute specialties attracted competitive, individualistic, driven personalities who were unlikely to prioritise work-life balance and were uncomfortable with the principle of team working: '40 hours is part-time for a surgeon. Most surgeons are the kind of people who will want to work at least 40 hours a week,' said one consultant surgeon, while another added that 'Surgeons are the worst for team working, we're all very competitive individuals.'

Community medicine, psychiatry and general practice were thought to attract a different type of personality: 'Why does part-time work better in general practice? Well, we're better communicators aren't we, sweepingly? Good communication, better autonomy,

better able to sort out for ourselves the workload issues within a practice,’ said one GP principal, while a psychiatry trainee linked gender and personality traits: ‘Surgeons believe that part-time is not full commitment...Surgery’s like that because men do it...Psychiatry has appealed more to women doctors...We think holistically...We’re more rounded.’

Communication and handovers

Communication skills and efficient handovers were important skills for all doctors but especially for those working part-time, as a consultant microbiologist explained: ‘If you’re not working the next day you want to make sure that everything is handed over...This is the patient, I’ve done this but this is left, I couldn’t finish this, could you take it from there?’

Colleagues needed to develop skills in communication and handovers to allow part-time workers to be effective. A part-time salaried GP believed that full-time doctors were not always as meticulous as the part-time doctors in her practice: ‘I would like to think that anyone who comes into that surgery can open that file on a patient and know what’s happening, which I have to say isn’t true with GPs who see their patients regularly – you will often get a one line entry...If an emergency happens you want to have it clearly spelled out exactly what the plan is.’ A GP principal felt that more needed to be done to help doctors to make this system work: ‘We need to educate doctors in how to do proper handovers. 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.’

It was sometimes harder to contact colleagues if working hours did not coincide: ‘If I’m chasing up speaking to an educational psychologist or somebody, there’s only so many days that I’m chasing them and...we’re often missing each other on our days,’ said a GP trainee.

Part-time working presented a challenge to colleagues who had not developed alternative means of communication. A salaried GP commented: ‘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.’ A consultant ophthalmologist suggested that other forms of communication needed to be established: ‘There are lines of communication other than picking up the phone and speaking to somebody at that time. There are delayed methods of communication.’ This was seen by some to be a change management issue, which might take time for doctors to get used to.

Finding a good moment for team or departmental meetings required more organisation if there were many different working practices in the team. A GP principal explained: ‘It’s harder for everybody to meet up...Finding dates for meetings and just the day to day meeting for coffee and discussing patients...you have to be more organised about it where you’ve got part-timers.’ Rotating the time of a departmental meeting was one way that teams had overcome this issue as in the case of a consultant in community paediatrics: ‘We often have meetings where people from across the city all meet up. We alternate the time so it’s Monday morning, Monday afternoon, Tuesday morning, Tuesday afternoon...And we do that with CPD.’

Autonomy for GPs

Some GP principals felt that the added autonomy of being your own boss made it easier to negotiate part-time. 'It's the ability to construct your own working life... We're quite innovative in that sense. For example, this morning we had four partners working and they all started at different times and they're all seeing different numbers of patients in the surgery,' said one, while another commented that 'It's easier to be part-time as a GP than in a hospital because you're more in control... You tell the manager what to do, not the other way round.'

Workload planning and measurement

Traditionally, most jobs have been designed for a full-time doctor: when a doctor wishes to switch to part-time, trusts or practices had to assess what was a reasonable workload. Some doctors felt that more help was needed with this issue, as in the case of this consultant in community paediatrics: 'I think it's helpful to have some guidance about what is a sensible workload to have in a working day, by each specialty, as every specialty is different... I know they tried to do that but it's very crude and if you apply it across every single job it's not going to fit, is it?'

The appropriate proportion of SPAs was a particular challenge when measuring the workload of part-time hospital consultants, and there were very different reports of allowances of time for administrative activities and continuing professional development. However, this was felt not to be the case in Scotland, as a consultant psychiatrist observed: 'The consultant contract in Scotland... has stipulated very clearly in it, "Here's the number of SPAs that are required for a specific number of total programmed activities". That's very helpful for part-timers.'

For GPs, working a half day brought up particular issues around workload measurement: some practices reported a qualitative difference between morning and afternoon surgeries, which unbalanced the workload. The types of activities that were counted when measuring workload therefore needed to be considered: 'If you've got four doctors and one of them is there for half a day... in our surgery, all the post that comes in, all the prescriptions that come in, would be divided four ways and the visits would be divided four ways.'

Different challenges at senior and junior levels

Just over half of interviewees said that working part-time was easier at senior levels. Trainees were particularly likely to believe that part-time working would get easier as they moved to more senior levels.

The reasons cited for increased ability to work part-time at senior levels were:

- Increased confidence. A consultant in clinical pharmacology explained: 'As you get more experienced you get more confident, you're more comfortable in your own skin I think. You don't feel this constant need to prove yourself all the time.'

- Less service cover. ‘There can be greater flexibility the more senior you are because there’s less of a burden of the service provision side of the job,’ said a trainee in emergency medicine.
- The acceptance of consultants being absent from the department or practice: ‘The full-time consultants have sessions when they’re not expected to be in the hospital and they’re not available, they’re just blank on the rota...so I’m just an extension of that. I’m just a bit less available than them but actually not a great deal less, to be honest,’ said a consultant anaesthetist. A GP principal made a similar point: ‘The perception is that senior doctors need time away from patient care to do administration, so it’s more accepted.’
- Increased autonomy was noted by a consultant orthopaedic surgeon: ‘As a consultant I now have more control over the hours I do...On Tuesdays I finish my clinic in the afternoon at four o’clock...As a registrar...that’s being dictated to you by the consultant you work for.’
- Different expectations around on-call rotas: ‘The rota is done in a different way to the trainees’ rota. It’s just put out and then you swap the ones you can’t do. So I definitely think it’s easier at a senior level,’ said a consultant anaesthetist.

However, some consultants made the point that more senior doctors faced different issues when working part-time:

- Greater responsibility: ‘If you’re responsible at consultant level for patients then you can’t stop being responsible for them [when you finish work],’ explained a consultant gastroenterologist.
- Increased workload: ‘As a consultant actually you’re an awful lot busier than as a trainee so there is an awful lot more that can come your way,’ said a consultant rheumatologist.
- Lack of cover for specialist expertise, particularly in a single-handed post: ‘I think it’s probably more easy as a junior...There were more of you, so if you weren’t there, there was someone who was more or less equivalent...whereas now, in a single-hander post, there’s just me. If I’m not there, nobody is,’ commented a consultant in chemical pathology.
- More administration and management: ‘In some ways it’s probably harder [at senior levels] because you’ve got all this management stuff that they don’t train you for that you’ve got to sort out,’ said a consultant in palliative care.

Section 5: Career development for part-time doctors

Key findings

- **Traditional medical career paths were out of step with women doctors' lives.** The pressure to achieve a consultant post within a certain time frame, and the lack of opportunities for re-training, were out of step with the career paths of doctors who had taken maternity leave or periods of part-time working. There was anecdotal evidence of unmet demand for part-time training, women dropping out of training and into staff grade posts, and the choice of specialty being affected by family considerations.
- **Part-time doctors struggled to find time for career-building activities.** Although part-time doctors could capably fulfil the clinical requirements of their jobs, those with busy outside-of-work commitments found that career-building activities often suffered, particularly continuing professional development, research and clinical excellence awards.
- **Part-time doctors were not achieving senior positions in the profession.** Networking, politics and committee work were a further casualty of part-time doctors' outside-of-work commitments: many part-time doctors felt that committee posts in senior bodies in the profession – Royal Colleges, Deaneries, the GMC, the BMA or editorial boards – were out of reach.

5.1 Medical career paths

Time-pressured 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, plus (mostly short) maternity leaves or career breaks. The pattern of women's non-work lives was out of step with achieving a consultant post by a certain age, and there was a lack of opportunities for re-training or re-entering the medical profession after a career break or a period of specialisation. A staff grade in psychiatry explained: 'I think the whole process from medical school onwards is that you are under a certain amount of pressure to fulfil these goals...to sit your postgraduate medical exams, to become a consultant, and to do that in quite a rapid time frame.'

Two thirds of consultant and trainee interviewees felt that, as part-time doctors, they had had to do something extra or different to develop their careers, to 'compensate' for being part-time. However, two thirds of staff grade and associate specialist doctors said they had not had to do this, perhaps because the career expectations for this grade of doctor were felt to be different. GPs were divided more or less equally between those

who said they had had to do something extra or different to develop their careers, and those who had not.

Lack of careers advice for part-time doctors

Although half of interviewees said that more should be done specifically to help *women* doctors to develop their careers, others said that, rather than helping only women, more should be done to help all part-time doctors develop their careers, or to help doctors in general: 'I think it's more *doctors* developing their careers, rather than women doctors, because careers advice for all is sadly lacking,' said a trainee in obstetrics and gynaecology.

Women doctors' non-work lives

This research focused on part-time working, and questions about how part-time doctors with children arranged their childcare did not form part of its scope. However, childcare concerns formed the backdrop to the discussions about women's career development. The fixed hours of nurseries did not work well for doctors whose work was not predictable as experienced by a consultant microbiologist: 'The nursery shuts at six o'clock... There was a notice that says if you're late by five minutes or so, we're throwing your child out.'

Many of the women in the study were unwilling to delegate their family or home life to the degree necessary for a traditional male medical career: 'I have a colleague who says, Well you really need to have a woman who runs your whole life outside of work, and I said, No, I want to have my life outside of work, that's my life thank you and I don't want it handed over to someone else,' commented a consultant in respiratory medicine.

Another common theme for female part-time doctors was the difficulty of juggling dual-career households, with many women doctors saying that their partners' careers (medical or otherwise) took priority: 'I'm less focused, have more priorities. My husband's career takes a front seat,' said a respiratory trainee, while an orthopaedic surgery consultant commented that 'I've got to juggle my husband's career as well... If part-time hadn't been available... for me to juggle a full-time job with the on-call and his work would have been impossible.'

The need for geographical mobility among trainee doctors was a further problem for those whose husbands' careers took priority, as was managing and arranging childcare with each training rotation: 'NHS nurseries... are not conducive to doctors... I'm in a region that's from Truro to Cheltenham... It's not nice to have to move [children] around from hospital to hospital,' said a surgical trainee.

Degree of part-time

There was wide variation in the degree of part-time among career grade doctors, with around a quarter working 80 or 90% of full-time. Most consultants worked 60% or more: 'People are often surprised at how much you can work even though you're part-

time. People say, Four days a week? That's part-time? and I know they're quite surprised,' explained a consultant in community paediatrics.

There was much less variability in the degree of part-time worked by trainees, whose working pattern was constrained by both European legislation (EEC directive 75/636) which sets 50% as the minimum allowable for doctors in training, and funding constraints, which meant that all those who were slotsharing had to work 50 or 60% contracts.

Career breaks

Three quarters of participants had taken maternity leave or a career break for childcare reasons, but the majority had taken just 6-8 months maternity leave per child, and no further breaks. 80% had taken a total absence from work (ie including several maternity leaves) of two years or less.

Many doctors mentioned the importance of retainer schemes and return-to-work schemes to encourage re-training after a break or a period of specialisation, as this consultant ophthalmologist commented: 'There need to be opportunities for women that have taken a career break and maybe don't have anywhere to go. They haven't taken maternity leave so they've got no post to go back to. There needs to be support for them to go back.' A surgical trainee believed that this should be the highest priority: 'If your project only does one thing, you should bring back the hospital retainer scheme...[especially] for high-intensity specialties.'

Unmet demand for part-time training?

The evidence of unmet demand for part-time training was anecdotal but widespread. Many trainees felt that there was a pressure to postpone part-time working until reaching consultant level. Leaving aside the different problem of those who had experienced delays in getting approval for part-time training, there were reports that doctors did not apply for part-time training because they felt that full-time training was the only option, either financially or because of the way that training was structured. Some had children while training, but remained unhappily full-time, while others delayed starting a family: a foundation year 2 trainee believed that '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,' while a consultant ophthalmologist maintained that 'People are tending to put off childbearing until they're in their consultant posts because then they feel...it will be easier to get the flexible working.'

Dropping out of training

There was anecdotal evidence of trainees dropping out of training, or considering dropping out. Many doctors mentioned staff grade and associate specialist posts as a kind of career siding for women who did not want to delay having a family. Some trainees seemed ill-informed about part-time training opportunities, like this trainee in

geriatric medicine: ‘In the past it’s been accepted that if you didn’t want to work full-time you don’t get to train in the job and you have to work in a staff grade or service provision job.’

This option had been unfairly seen by some to indicate a lack of potential rather than a lack of time, as a staff grade in psychiatry explained: ‘There is a certain, 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.’

Choice of specialty

It has often been claimed that women choose specialties which are more family-friendly, and that the obstacles to part-time training may be one of the major reasons. ‘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,’ said a consultant ophthalmologist.

Almost without exception, participants in this project had chosen 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 one factor in their choice: ‘I was doing surgery but thought this was more family-friendly,’ said a radiology trainee. Others had thought about switching specialty: ‘Last year I was so despondent I contemplated switching to general practice. I was coming up against all these shut doors. Flexible training was just talk,’ commented a psychiatry trainee.

Part-time working could also affect the choice of sub-specialty at consultant level, as a consultant rheumatologist found: ‘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.’

Fear that part-time working would disadvantage promotion

If it was felt that there were more doctors than posts available in a specialty, then both trainees and career grade doctors were reluctant to request part-time hours, feeling that this would adversely affect their subsequent career progress. This was true of both hospital doctors and GPs: ‘I didn’t go part-time...because I knew there was a stigma attached, and I was afraid the consultant posts were about to dry up,’ said a consultant surgeon. A salaried GP explained: ‘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.’

5.2 Finding time for career-building activities

As mentioned in previous sections (see pages 23 for trainees, and 34 for career grade doctors), part-time doctors had less contracted time and money for study or continuing professional development (CPD) and frequently made up for this by using their own (unpaid) time. Two other areas of concern for part-time doctors were research and clinical excellence awards.

Research

Finding time for research was difficult for part-time doctors with out-of-work commitments: 'I don't get asked to do any research any more because everyone assumes I'm too busy... They probably are right but I never get the opportunity to even try,' said a pathology trainee. Part-time doctors knew that lack of research experience would be career-limiting, but simply did not have time to do it. '[Working part-time] has possibly affected my career development in that I would have done research if I wasn't working part-time, and didn't have children. And that might reflect on the jobs I can get at consultant level. I chose not to do research because of having children,' said one trainee in general and respiratory medicine, while a surgical trainee made a similar comment: 'I'd have done research if I wasn't part-time. The BMJ talks about women not being involved in other aspects of medicine, in politics. I'd have tried to be more textbook successful if I wasn't part-time.'

Clinical excellence awards

Clinical excellence awards were also felt to be harder for part-time doctors: '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,' commented a consultant psychiatrist. A consultant in public health agreed: 'The things that get you clinical excellence awards are the things that go, because you haven't got the time.' 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: 'I think there has to be a very above board recognition process when part-timers go for clinical excellence awards... Presumably there should be some sort of algorithm where you multiply things up,' said a consultant in clinical pharmacology.

5.3 Part-time doctors in senior positions in the profession

Part-time doctors with busy out-of-work commitments found it hard to achieve senior positions in the profession, such as Royal College or Deanery roles, committee work for the General Medical Council (GMC) or the British Medical Association (BMA) or being a member of a medical journal's editorial board. A consultant in clinical pharmacology explained: "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.'

Some doctors felt that this was partly because of attitudes in these professional organisations: ‘The dominant bodies are still very male orientated in their philosophy... The BMA is predominantly men who are on the committees, who are on council, who hold chief executive posts,’ said an associate specialist in anaesthetics, while a respiratory trainee argued that ‘Top jobs go to people who have worked full-time... [As a part-timer,] whether you progress to positions of influence is doubtful.’

Many part-time doctors pointed out that, although they could capably complete their clinical sessions, their out-of-work commitments meant that 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. A public health consultant confirmed that ‘I can do my mainstream job on four days a week by working hard. What it doesn’t allow me to do is any of the add-ons,’ while a staff grade in psychiatry felt that ‘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.’

Section 6: Solutions suggested by participants

6.1 Solutions suggested for changing attitudes to part-time work

Part-time role models

The most common suggestion from participants to encourage and facilitate part-time working was to create and disseminate case studies of role models, as suggested by a consultant in public health: ‘We need some good role models saying “It is possible to do [part-time] and *this is how I’ve done it*”.’ A consultant in orthopaedic surgery provided a graphic illustration of the importance of such role models, particularly for women doctors: ‘Some medical students have said to me, “Oh I didn’t realise women could do orthopaedics”...If they don’t see people doing it they don’t think they can do it.’

For those who did not have the opportunity to observe other part-time doctors at first hand, role models in journals, online or at conferences were seen as the next best thing: ‘We need a positive attitude in articles, encouraging women to write about their experiences in the BMJ, Hospital Doctor, the GP paper – so women know that there are part-time options,’ said an associate specialist in community paediatrics.

There was felt to be a particular need for male role models, in order for part-time working to be taken seriously. ‘There are more men wanting to do part-time...That will be when you start to see a change in opinion, I think,’ commented a consultant rheumatologist.

Raising the profile of part-time working in Royal Colleges and Deaneries

Some participants felt that the best way of changing attitudes was to get part-time doctors, and more women, into senior positions in the profession, in order to raise the profile of part-time working from within Royal Colleges, Deaneries, the BMA and GMC: ‘Women need to be in the places where the agenda’s being set – ie college appointments,’ said a consultant psychiatrist. A staff grade in community psychiatry felt that ‘The medical profession is very slow to change...to catch up with the changing workforce...The profession has to shift...from patriarchal, male-dominated at the top, not recognising that change is happening at the coalface...When I say at the top, I mean the Royal Colleges, the BMA, LMCs, management, clinical directors.’

6.2 Solutions suggested on part-time training posts

More support from programme directors

Part-time trainees needed help with integrating into each hospital and each rota. A trainee in obstetrics and gynaecology was one of several doctors who suggested that the programme director should play a bigger role in this: ‘A dedicated programme director...is definitely what’s made it work for us in obstetrics and gynaecology because

she trained as a flexible trainee and has fought all the way to sort us all out.’ A trainee in general and respiratory medicine thought that ‘You need someone in charge, so that you’re... getting the right experience... [someone] who spoke to the hospitals, to say, “These are her days of work, could you please sort out where we’re going to put her, what she’s going to do”.’

More information and careers advice for trainees

Support and information was particularly important for trainees, and many participants suggested that there should be formal sessions during postgraduate training, or even at medical school, on how to make part-time work: ‘I don’t think people consider early enough as to how they could train part-time and I think some more careers advice along the way would be helpful,’ said a consultant rheumatologist. However, others said that many students and younger trainees believed that they would not need part-time training, so the timing of careers advice was crucial. A GP trainee commented: ‘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 careers advice.’

Trainees also suggested that more contact with other part-time trainees in their Deanery would be helpful: ‘There’s no resource which tells me where all the other part-time trainees in my specialty in my region are... which jobs they’ve done, how they did them, who they did them with... I don’t know whether that’s because of some kind of confidentiality issue,’ said a trainee in obstetrics and gynaecology.

Mainstreaming part-time training

In the long term, it was felt that part-time trainees should be funded and managed in the same way as full-time trainees, in order to help integrate part-time doctors and normalise part-time working. ‘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,’ observed a consultant gastroenterologist, while a consultant anaesthetist commented that ‘If the financing was done in the same way as full-time, rather than this separate rather vague pool of money that goes up and down... that would make it more acceptable to the Trusts and make it more explicit to our full-time colleagues.’

However, some were a little more sceptical about whether the medical profession was ready for mainstreaming. A consultant psychiatrist commented: ‘A nominated flexible person is necessary to be a thorn in the side of the Dean and remind him of the importance of flexibility.’

Making rotas more flexible

A few trainees envisaged a more radical change to the way that rotas were designed, and suggested that it was unnecessary to see the rota in terms of full-time slots, or parts thereof. A foundation year 2 trainee said: ‘You only have to slotshare because of the rotas... But it’s a mind set. It is truly a mind set. There is no reason why, in an

organisation this huge, you can't organise it to be truly flexible in every sense of the word... There have to be part-time jobs just as part-time jobs.'

The same trainee suggested that more advance warning was needed to accommodate a part-time trainee into the design of each rota: 'The scheduling of rotas is only done at the last minute because funding is unsecured, so they don't know a part-timer is coming early enough. They only know two weeks ahead.' A psychiatry trainee had found that the answer was to have more input into the design of the rota: 'It's helped since I write the rota now. The rota is written by one nominated full-time and one flexible trainee, and then we submit it to medical staffing... We make it work between us.'

6.3 Solutions suggested on part-time career grade posts

Royal Colleges should lead on new working practices

Doctors looked to Royal Colleges to provide leadership, because working practices varied not only according to clinical needs but also because of different attitudes, and different proportions of part-time doctors (mostly women) in different specialties. 'You need to get to the clinical directors and consultants... and you need to get to them through the Royal Colleges... Each college... should bring together clinical directors, clinical tutors and trainers to discuss the issues in each specialty,' said a consultant radiologist.

Medical directors need a better understanding of part-time work

Senior clinical managers needed a better understanding of part-time working and more creativity in terms of designing and negotiating jobs: 'I think the... head of department needs to have a very good understanding of part-time work... That attitude... needs to be nurtured,' thought a consultant in respiratory medicine. A consultant in palliative care was one of several who suggested training senior clinical managers: 'It wouldn't hurt for the managers to have some training... looking at ways of working and splitting jobs fairly and evenly and trying to get the most out of people... Both the clinical director and the hospital managers.'

A consultant ophthalmologist suggested that jobs could also be advertised more flexibly: 'Everyone thinks of every post as a full-time post – that's the way that posts are constructed and advertised and business plans go forward... If people thought of it more flexibly and said, "Anything between this number of hours and this number of hours would be useful to us..." They could have a minimum amount that they'd want someone to do, and a maximum amount that they could afford to pay and advertise it in that sort of way.'

Part-time doctors need more support and information

Many part-time doctors felt isolated and wanted more opportunities to network with others in the same situation, share information and get advice. 'If you wanted to work part-time you really wouldn't know who to turn to... When [my job] was being set up

nobody knew what it would look like or what the job plan would be,' commented a consultant in respiratory medicine, while a consultant cardiologist was 'immensely helped by the part-time days at the BMA...where all aspects of part-time were discussed right from juniors up to consultants...That was really where I learnt most about how to make part-time work.'

6.4 Solutions suggested on career development

More opportunities for re-training

Just as those coming back from a career break needed re-training, those who had chosen to go part-time and to narrow their focus or specialise in a particular procedure or sub-specialty might also want to broaden their focus again before taking up a full-time or a higher-percentage part-time post. Re-training was therefore needed: 'I think [women] just need to be given the same opportunities...so they don't always get the lower paid, less responsible jobs because...they've had to go into the sidings for a while and can't get back out,' commented a consultant ophthalmologist. 'When you step off the ladder, it's hard to get back on...It's changing now...but you still have to pay to be considered, and get further training, and compete with the young registrars,' said an associate specialist in anaesthetics.

A different approach to re-training was needed, one which did not confuse re-training with incompetence. A surgical trainee explained: 'You've got to take the stigma away from re-training...A lot of the young consultants are doing this themselves. They're saying, OK, so I've had a leak...I'll make sure the next one I do I'll get watched by someone...So they're doing it unofficially...If you make it official, it all gets quite frightening.'

The same trainee suggested that there needed to be dedicated trainers, responsible for ensuring high quality re-training, because 'Certain people are good at training...[They] should be nominated as proper trainers, inspected regularly that the quality of their training is good.'

Mentoring

Many doctors nominated mentoring as the most effective means of helping women to develop their careers and to negotiate an appropriate career path. 'At the early stages of my career, I found people who I could turn to for advice, who became trusted confidantes. Realising that it's OK to do that is important...You don't have to do it alone,' commented a consultant psychiatrist, while a trainee in respiratory medicine suggested that 'We need mentoring...and to stop pretending that women are just like men.'

Some were sceptical about official mentoring initiatives which direct individuals to a particular mentor, because of the importance of finding an appropriate match: 'When you try and officialise mentoring I don't think that really works...because mentoring works by virtue of the fact that you connect with somebody...But you could encourage

both consultants and trainees alike to take the initiative to seek people out...Some people do that naturally much better than others,' commented a surgical trainee.

Part-time doctors in senior positions in the profession

In order to overcome the difficulties which many busy part-time doctors had in finding time for networking, politics and committee work, an associate specialist in anaesthetics suggested that part-time doctors, especially women, needed more encouragement: 'We have to try and engage women because women...are not inclined towards becoming representatives, standing for things...They need a lot of encouragement.' A consultant psychiatrist pointed out that 'Structural and gender issues don't encourage women to put themselves forward for college appointments – it's hard to come to London meetings if you live miles away and have to be back to put kids to bed.' The same consultant suggested that technology might be able to help: 'Teleconferencing can help a bit, but you don't get the quality of networking.'

Others suggested that it was up to individual women to make their way in the world of medical politics: 'We need more women in the Royal Colleges, the GMC...The only way is for people who are brave and impassioned to go and do it,' said a salaried GP, while also admitting that 'personalities that want to be in the political limelight...not many women have that personality.' Some made the point that, at the moment, the women who do get on in the world of medical politics often have to conform to the male career model, being competitive and career-oriented (and sometimes childless): 'We need more normal working women in positions of influence...in the Royal Colleges...people you can identify with, not queen bees,' said a trainee in respiratory medicine.

Section 7: Conclusions

Recognition and acceptance of part-time working as a 'normal' career path to senior posts

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% 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 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.

Section 8: 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 training posts

- Employers and Royal 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
- Junior doctors should be made more aware of sources of information and support for part-time training at undergraduate and postgraduate level

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 in order to encourage 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

Appendix 1: Methodology

Data collection

Data was collected from 60 interviewees and 26 participants in focus groups, bringing the total number of participants to 86.¹

The 60 interviewees were selected using purposive sampling, via networks including Medical Women's Federation (MWF) membership, website and monthly newsletters, the weekly medical newspaper BMA News, the website of doctors.net, the BMA Staff and Associate Specialists Committee, and both the MWF and Women in Surgery conferences. The request for participation was widely circulated through informal networks and the number of volunteers far exceeded the number of interviews originally planned. 20% of the participants were members of MWF, and 80% were not.

We selected consultants, trainees, staff and associate specialists and general practitioners who were either currently part-time (82), or had worked part-time within the past two years (4), across a wide range of geographical areas.

A 45-minute telephone interview was conducted with each interviewee, using a semi-structured questionnaire developed by the principal researcher and the steering group, and piloted with eight doctors. Notes were taken, and the interviews were also recorded and transcribed, so that quotes could be accurately represented in the final report.

Four focus groups were also set up through MWF networks, one with each of the target groups of doctors: consultants, staff and associate specialists, GPs, and trainees. There were 26 participants in the four focus groups. The focus groups were recorded, and participants also filled in a questionnaire with demographic details and questions about their working patterns.

In addition, informal telephone interviews were conducted with four Postgraduate Deans, representatives of four Royal Colleges and two HR directors. These interviewees do not form part of the statistical analysis of the sample below.

All the interviews and focus groups were conducted between November 2007 and April 2008.

¹ Focus group participants filled out a questionnaire, so there were 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 quantifiable for the 60 interviewees, and this group is referred to throughout this report as 'interviewees.'

Participant characteristics

Interviewees and focus group participants by grade			
	Interviewees	Focus group participants	TOTAL
Consultants	19	7	26 (30%)
Staff and Associate Specialists	12	3	15 (17%)
GPs	11	7	18 (21%)
Trainees	18	9	27 (31%)
TOTAL	60	26	86

Gender of participants	
Female	77 (90%)
Male	9 (10%)
TOTAL	86

Location of participants	
England excluding London	62 (72%)
London	13 (15%)
Scotland	9 (10%)
Wales	1
Northern Ireland	1
TOTAL	86

Age of participants	
26-30	6 (7%)
31-35	11 (13%)
36-40	29 (34%)
41-45	11 (13%)
46-50	14 (16%)
Over 50	15 (17%)
TOTAL	86

Ethnicity of participants	
White	82 (95%)
Ethnic minority	4 (5%)
TOTAL	86

Grade of participants	
Consultant	26 (30%)
Associate Specialist	5 (6%)
Staff Grade	7 (8%)
Clinical Assistant	3 (4%)
Registrar or ST3-6	20 (23%)
SHO or ST1-2	5 (6%)
Foundation Year 2	2 (2%)
GP Principal	10 (12%)
Salaried GP	8 (9%)
TOTAL	86

Specialty of participants	
General Practice	20
Psychiatry	9
Paediatrics	7
Obstetrics and Gynaecology	6
Geriatric Medicine	5
Respiratory Medicine	5
Pathology	4
Public Health	4
Anaesthetics	3
Surgery	3
Occupational Health	3
Emergency Medicine	2
Radiology	2
Palliative Medicine	2
Gastroenterology	2
Microbiology	1
Clinical Pharmacology	1
Cardiology	1
Rehabilitation Medicine	1
Rheumatology	1
Ophthalmology	1
General Medicine	1
Dermatology	1
Foundation Year 2 Trainee	1

Abbreviations

BMA	British Medical Association
BMJ	British Medical Journal
COPMeD	Conference of Postgraduate Medical Deans
CCT	Certificate of Completion of Training
CPD	Continuing professional development
EWTD	European Working Time Directive
GMC	General Medical Council
GP	General Practitioner
LMC	Local management committee
PA	Programmed activity
PMETB	Postgraduate Medical Education and Training Board
RITA	Record of In-training Assessment
SPA	Supporting professional activity
SpR	Specialist Registrar
StR	Specialty Registrar
VTS	Vocational Training Scheme