TALKING POINTS

Part-time training

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Introduction

Several schemes are available for the part-time training of doctors who have domestic or other ties which make it difficult for them to accept employment in the service under the usual arrangements.[1-3] Dr N Sterling examined part-time senior registrar posts in the Wessex Region.[1] I have been looking at some aspects of part-time training in the North-western Regional Health Authority (under the arrangements in HM(69)6 and its predecessor the Manchester Regional Hospital Board from 1970 to 1977.

After the initial build-up of the scheme the numbers fluctuated considerably (table I).

TABLE I—*Part-time posts established under HM(69)6 in the North-western RHA*

Year	Grade			
	Senior house officer	Registrar	Senior registrar	Total
1970			1	1
1971			1	1
1972	1	5	3	9
1973	1	8	3	12
1974	1	1	2	4
1975	4	3	11	18
1976	2	1	1	4
1977	4	6	1	11
Total ..	13	24	23	60

There have been no particular problems, such as shortage of money, to account for this, though in the year of NHS reorganisation—1974—only four posts were created. One-fifth of the posts have been established in the SHO grade and the others equally divided between registrars and senior registrars. Table II shows in which specialties the grades have been established. There have been none in surgery.

Some 58% of the doctors remain in the same posts, 5% have moved to a whole-time post in the same grade, 15% have moved to posts in a higher grade, and 22% have left the scheme without having a definite future post. Only nine have moved to a higher grade, though five of these have obtained consultant posts. Three doctors moved from part-time posts to similar posts in a higher training grade. None of those still in post have been there for longer than would generally be considered appropriate, given the specialty, the grade, and the length of their basic working week.

The previous training of those appointed to senior registrar posts was varied. Five had been whole-time senior registrars and another two had held whole-time university or research posts with this grading. Seven had been whole-time registrars and three had been in whole-time posts of roughly this grade. Two had held part-time registrar posts established under HM(69)6 and the remaining four had had sessional work as clinical assistants.

TABLE II—*Part-time posts by grade and specialty, 1970-77*

Specialty	Grade			
	Senior house officer	Registrar	Senior registrar	Total
General medicine ..	7	4	2	13
Paediatrics	2	1	–	3
Geriatric medicine	2	2	–	4
Rheumatism and rehabilitation ..	–	–	1	1
Nuclear medicine ..	–	–	1	1
Gynaecology and obstetrics ..	–	1	–	1
Mental illness (adult)	1	8	3	12
Mental illness (children) ..	–	–	5	5
Mental handicap ..	–	–	1	1
Pathology	–	1	–	1
Histopathology ..	–	1	4	5
Haematology ..	–	–	1	1
Chemical pathology	–	1	1	2
Anaesthetics ..	1	5	3	9
Radiology	–	–	1	1
Total ..	13	24	23	60

Discussion

Only 60 doctors have taken advantage of the scheme, but suitable arrangements can be made to enable doctors to undertake training part time. During the eight years, five senior registrars obtained consultant posts and in the first two months of 1978 they have been joined by two more. The progress in more junior grades is less obvious. The senior registrars had had diverse previous experience, but only a few had been in part-time registrar posts. This may be because the arrangements were not so well developed in their early careers, their domestic responsibilities were less, or only the most persevering can complete their whole training in part-time posts. The comparatively large number of resignations from registrar posts supports the last possibility.

In future, when there will be a higher proportion of women graduating from medical schools, the lack of part-time training in certain specialties, such as surgery, will affect the number of women who become consultants in these specialties. The proportion of female consultants is just below 10%—ranging from 17% in anaesthetics to 2% in surgical specialties as a whole.

This analysis shows the possibilities of this scheme for providing training. It is perhaps most important for senior registrars but the scheme is also needed in the more junior grades. In practical terms part-time training is not provided in some specialties which are currently male dominated and the increasing numbers of young women doctors will require wise career counselling. In a region in which few, if any, proposed posts have been turned down except for educational reasons, the indications are that the demand is low.

References

1 Department of Health and Social Security, *Re-employment of Women Doctors*, HM(69)6, 1969.
2 Rue, E R, *Lancet*, 1967, **1**, 1267.
3 Essex-Lopresti, M, *Lancet*, 1970, **2**, 204.
4 Sterling, N, *Lancet*, 1976, **1**, 1285.

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Future of British anaesthetics

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During the past 25 years British non-teaching hospitals have created a wide-based career pyramid in almost every specialty. This is unique in the world. The increasing output of British medical schools will almost certainly transform the career structure within the next 15 years, and, unless there is a miraculous expansion of the NHS, British graduates will flood the training grades. Few will be able to emigrate to the traditional English-speaking countries of North America, Australasia, and southern Africa when they have completed their postgraduate training. These countries either are closing their doors or, as in the last case, have become less desirable. The Empire has vanished and I doubt whether the well-doctored non-English-speaking countries of the EEC will provide a substitute. In any case, many wives will feel lonely and isolated, and few factors discourage permanent emigration quite as convincingly as the sympathetic ear of a mother-in-law. So the demand for permanent rather than training posts will increase, and the part played by junior doctors in non-teaching hospitals will decline.

The effect of change will vary according to specialty and location. Of all the hospital career pyramids, the most vulnerable is anaesthetics. The specialty is unpopular among medical students,[1] yet it needs to recruit a larger percentage of medical graduates than any other specialty outside general practice.[2] Furthermore, shortages of anaesthetists have an unusually dramatic and disruptive effect on curative medicine. On the other hand, there is the long-term threat of redundancy among doctors. This complicates matters immeasurably. A future staffing crisis in anaesthetics would mean much more than a simple shortage of suitably qualified and willing candidates. Bottlenecks in the career pyramid will soon become intolerable and may lead to crippling