Contemporary Themes

Part-time medical training: 15 years' experience in the Oxford region

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Abstract

Part-time training of doctors with domestic commitments has taken place successfully in the Oxford region since 1966; 249 doctors have now passed through such training schemes and a further 120 are currently training part-time. Two training schemes are now offered for doctors at senior house officer and registrar level: one of six to eight sessions a week for those undertaking recognised training aiming for consultant or principal in general practice posts, the other of one to two sessions a week providing ad hoc training for those unable for personal reasons to follow a recognised training programme. For doctors at senior registrar level, part-time training entails five to eight sessions a week. Of the 115 doctors who have left the schemes and are now in career posts in the United Kingdom, 19% are now consultants, 30% in other hospital posts, 27% in general practice, and 18% are clinical medical officers; overall, 71% of those in career posts are working part-time. This experience shows that part-time training can be successful and that there is a continuing need for part-time career posts.

Introduction

Part-time training of doctors has assumed increasing importance in recent years with the rise in the proportion of doctors who are women.¹ Several authors²⁻⁴ have pressed the case for more

part-time training to enable women doctors to develop their potential more fully and to further their careers, and the DHSS⁵ has supported the establishment of part-time posts for doctors with domestic commitments. Nevertheless, the extent of career achieved by those who have undergone part-time training has remained largely unknown. The Oxford region was the first to institute such a scheme⁶ and has remained particularly active in this sphere. The present study reports on the part-time training schemes that have taken place in the Oxford region since 1966 and the subsequent careers of those who have trained in this way.

Method

Data were extracted from the files of the Oxford Part-time Training Schemes about all doctors who have trained on these schemes from 1966, when such training began in the region, to the end of 1980. For those doctors who had left the schemes by the end of 1980, information about their career after leaving was obtained from the files for the schemes, or where necessary by postal questionnaire with two repeat mailings to non-respondents.

Results

SENIOR HOUSE OFFICER AND REGISTRAR TRAINING SCHEME

The number of doctors entering annually at senior house officer and registrar levels, after increasing in the first few years of the scheme, has since 1969 remained at about 20-30 doctors a year. By the end of 1980, 243 doctors had been through the scheme, most having joined it only once, but 26 (11%) had joined it twice or more—for example, taking time off for family commitments. About half had spent under two years on the scheme, one-third two to four years, and the remainder five years or more (table I). A further 113 doctors were currently on the scheme* at the end of 1980, most

*Doctors temporarily off the scheme on 31 December 1980, but on it both before and after this date are counted as still on the scheme.

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(73 (65%)) having as yet been on it for four years or under. Of the total 356 doctors, 189 had contracts for under five notional half days (NHDs)† a week (table II); there was no pronounced secular trend, and no striking difference between specialties, in the number of NHDs contracted. The main specialties in which part-time training was undertaken were psychiatry, "adult medicine"—that is, all medical specialties except paediatrics and geriatrics—paediatrics, geriatrics, obstetrics and gynaecology, and pathology (table III).

TABLE I—Duration of part-time training appointment* (years) of doctors who had left part-time training in Oxford region by the end of 1980

	<1	1	2	3	4	5	6	7	≥8	Total
SHO + registrar	65	61	38	25	18	12	9	5	10	243
Senior registrar	2	4	2	1	2	1	—	—	—	12

*For doctors with more than one spell on the scheme, all appointments at the same grade are cumulated.

TABLE II—Notional half days work a week contracted by part-time doctors in training in Oxford region 1966-80

	1	2	3	4	5	6	7	8	9	Not known	Total
SHO + registrar	12	56	29	92	26	58	49	27	4	3	356
Senior registrar	—	—	—	2	1	5	18	13	—	—	39

TABLE III—Specialties of part-time training and of subsequent career posts occupied by part-time trainees, Oxford region 1966-80

	SHO + registrar scheme doctors		Senior registrar scheme doctors	
	Training specialty	Career specialty	Training specialty	Career specialty
Adult medicine	55	12	5	2
Paediatrics	38	5	4	—
Geriatrics	34	4	1	1
Surgical specialties	22	3	—	—
Obstetrics and gynaecology	27	1	—	—
Pathology	30	5	7	—
Radiology and radiotherapy	8	4	3	1
Psychiatry	82	10	10	1
Anaesthetics	34	5	8	3
Several specialties	17	6	—	—
Dentistry	5	2	—	—
Community medicine	3	—	1	—
planning	—	20	—	—
General practice	—	31	—	—
Other	—	3	—	—
Total	356*	111	39	8

*Includes one doctor whose specialty not known.

The commonest reason for leaving the scheme was to take up another appointment in the United Kingdom (118 doctors); 42 left because they were moving home within the United Kingdom, 28 were going abroad, 36 for domestic reasons, and 19 for other or unknown reasons.

In December 1980, 29 of the 243 doctors who had left the scheme were known or presumed‡ to be abroad, and two had died. Of the remaining 212 doctors potentially still in the United Kingdom, the subsequent careers of 171 (81%) were known from the Oxford files or from questionnaires, and 18 of the 41 whose careers were not known were no longer in the *Medical Register*. The remainder of the results in this section refer to the 171 doctors with known careers in the United Kingdom.

Since leaving the scheme, most doctors (112 (65%)) had pursued a solely part-time career; 17 worked solely whole-time; 22 worked

†For doctors contracted for UMTs, UMTs were converted to their equivalent in NHDs for this analysis.

‡Known to have gone abroad and not in the 1981 *Medical Register*.

partly whole-time, partly part-time; and three doctors did not state how many sessions they worked; 17 (10%) had not worked since leaving the scheme, in five cases because they had retired. Forty-one of the doctors who had left the scheme were now in training posts, one did not state the level of post she was in, one was a locum consultant, and 111 had reached career posts (table III). Fifty-three (48%) of those in career posts were in hospital medicine (18 consultants, 35 medical assistants (associate specialists) and clinical assistants), 31 (28%) were in general practice, 21 (19%) were clinical medical officers, and six were in other work or mixed sessions in various disciplines; the consultants were working in psychiatry (5), pathology (4), radiology and radiotherapy (3), adult medicine (3), anaesthetics (2), and paediatrics (1).

SENIOR REGISTRAR TRAINING SCHEME

The first part-time senior registrar in the region was appointed in 1972, and the number of new appointments a year has generally increased to 14 in 1980. Altogether, 39 doctors entered such training 1972-80 and, of these, 26 had previously been in part-time registrar training in the region. Most (27) are still part-time senior registrars in the region, while 12 have left the scheme after spending up to five years as part-time senior registrars (table I). Part-time senior registrar contracts have usually been for 6-8 NHDs (table II); the commonest specialties of training have been psychiatry, anaesthetics, pathology, adult medicine, and paediatrics (table III). The further careers of all 12 leavers from part-time senior registrar posts were known; one is a part-time senior registrar in another region, three have gone abroad, and the other eight are now in consultant posts (table III). Four of the eight consultants had been on the regional senior house officer/registrar part-time training scheme as well as on the senior registrar scheme.

Discussion

Opportunities for part-time employment of doctors in hospital and community medicine training grades in the Oxford region consist of the training schemes for doctors at senior house officer, registrar, and senior registrar grades described in this paper, and the DHSS Doctors' Retainer Scheme, a non-training scheme providing a retainer fee for doctors aged under 55 "who wish to remain in touch with medicine" and who work at least one half-day a month and at most one day a week. Hospital training for general practice is covered by the schemes described above; a very few doctors have trained part-time in general practice in the region, this training being organised ad hoc by the family practitioner committees.

The first part-time training scheme in the NHS was started in 1966 in the Oxford region⁶; it allowed doctors with domestic commitments to offer less than full-time service while continuing their training in "part-time medical officer" posts, effectively at senior house officer or registrar level; since 1972 part-time training has also been available at senior registrar level. Since 1977 the part-time medical officer scheme has been split into two parts: (1) the "A scheme," for part-time senior house officers and registrars who can offer at least four and not more than six service sessions a week, in addition to two paid sessions for training or clinical experience, or both, not readily available during normal periods of duty; this is intended for those aiming for higher specialist training and ultimately a consultant post or undertaking vocational training for general practice; and (2) the "B scheme," for those able to contribute only one or two sessions a week, and therefore unable to follow a recognised training programme, who are offered minimal employment and ad hoc training on the scheme. Interchange between the two schemes is easily available for doctors whose personal circumstances change, and in particular encouragement is given to doctors wishing to transfer from the B to the A scheme—that is, to enter recognised training.

Doctors on the A scheme are appointed as part-time senior house officers or registrars under the normal junior doctors' contract and progress through the normal career structure at a

rate compatible with the number of sessions worked, responsibility taken, and achievement of a higher qualification; a formal assessment is made at the stage of promotion from senior house officer to registrar, and on attaining the senior registrar grade personal senior registrar posts and training programmes are submitted for educational and manpower approval on an individual basis in accordance with national requirements. For doctors on the A scheme completing the equivalent of two whole-time years at the registrar grade and not wishing to continue with higher specialist training in the specialty, personal medical assistant (associate specialist) posts are normally available; some doctors on the B scheme, especially older doctors, who do not wish to continue their training transfer to permanent personal clinical assistant posts.

The part-time training schemes have expanded over the years to become an important part of training and of junior hospital doctor service commitment in the region; in 1979,⁷ 36% of women doctors in training in the region were working part-time, and doctors in part-time training posts now contribute about 83 whole-time equivalents of service. Most of this service contribution would simply have been lost had part-time training not been available, which would have been particularly undesirable because part-time trainees have often worked in shortage specialties.

Part-time training in the region also makes a substantial contribution towards future consultant manpower (22 doctors from the schemes are now in consultant posts, many in shortage specialties) and towards general practice, clinical medical officer, and non-consultant hospital career post manpower. The "wastage" from the training schemes—that is, doctors not working again in medicine after leaving the schemes—cannot be assessed exactly because some doctors who have not worked to date since leaving the schemes may in future return to medical work, and because the non-respondents to the questionnaire may well have included a biased proportion of non-working doctors; so far, however, wastage of doctors remaining in the United Kingdom must be in the range 8% (given that no non-respondents ceased working or emigrated) to 26% (given that all non-respondents ceased working but remained in the United Kingdom on leaving the schemes).

The distribution of specialties in which part-time training took place, and the career specialties of these doctors, was largely similar to that for career choices of women doctors in general,⁷ with the familiar lack of women in surgery and obstetrics and gynaecology; only six doctors who have left part-time training in the region are still working in surgery or obstetrics and gynaecology, and none of these has reached senior registrar or consultant level. While the specialties of the part-time doctors may in part reflect women doctors' specialty preferences, they probably also reflect the constraints currently

operating on part-time specialist training: the regulations of the royal colleges and higher training committees for accreditation mainly demand a minimum of five or six sessions a week to be undertaken,⁸ in general practice the training grant is reduced for principals training part-timers, in some specialties there is prejudice against part-time training,⁹ and for many specialties part-time work does not fit easily with the nature of the service. Despite these difficulties, however, the experience in the Oxford region has been that part-time doctors can train successfully.

The Oxford region data show that part-time trainees usually continue in part-time careers. Although many doctors in part-time training state that they would like to work full-time later in their careers,⁷ only 24% of respondents had actually engaged in any whole-time work since leaving the Oxford schemes, and only 12% had worked solely whole-time since leaving. It is, therefore, essential that employing authorities be prepared to offer part-time career posts, otherwise there will be great wastage of doctors with postgraduate training and experience. The current optional provision of part-time posts at training and career levels has not led to many posts appearing throughout the country. Part-time training and career posts have now been extensively tried and found to be satisfactory. The demand exists^{3,7}; there is therefore a strong case for ensuring that these posts are made available.

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Is there any age at which you would advise a symptomless and apparently physically fit individual to give up downhill skiing, and if so why?

As long as someone is physically fit and capable of walking strongly I believe that skiing is a relatively safe sport that can be practised at any age. Accidents tend to occur more often on crowded slopes at weekends to unfit, inexperienced skiers. An intelligent, competent skier of mature age will almost certainly know how to compensate for his reduced physical prowess and should be encouraged to ski as long as he so wishes.—K G DICKINSON, university medical officer, Birmingham.

Can rabies be contracted by physical contact with the body of a human being or a dog who has died of rabies? How should such a corpse be disposed of?

The seriousness of rabies, once contracted, should not be allowed to obscure the fact that its transmission from man to man, even when

the patient is alive, is so extremely rare as to be virtually unknown.¹ A bizarre exception is transmission by corneal graft from donors who died of undiagnosed rabies, reported in 1979 from the United States² and in 1980 from France.³ The body of a dead dog is still a source of danger, if carelessly handled, though clearly less than its live counterpart because it cannot bite. The bodies of animals should be incinerated. It is sensible for those dealing with a human corpse to wear protective clothing and to avoid any more handling of the body than is necessary.⁴ Embalming is contraindicated, and cremation is preferable, though not mandatory. The best antiseptic, if required, is a quaternary ammonium compound such as 0.1% cetrimide solution.—A P WATERSON, professor of virology, London.

¹ Kaplan C. *Rabies, the facts*. Oxford: Oxford University Press, 1977.

² Houff SA, Burton RC, Wilson RW, *et al*. Human to human transmission of rabies virus by corneal transplant. *N Engl J Med* 1979;300:603-4.

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⁴ Department of Health and Social Security. *Memorandum on rabies*. London: HMSO 1977.