TALKING POINT

An open letter to the chairman of the working party on part time postgraduate training

SUE ROBERTS

Dear Madam,

Britain has led the way in promoting part time training for women doctors. You are chairing a working party set up to examine the current scheme PM (79) 3 as it approaches its fifth birthday and to outline some recommendations for the future. The committee has met three times, but word is leaking out that it is depressed by its task, confused in its role, and about to miss the opportunity to continue to pioneer in this matter. To see the way forward means examining aims and specific successes and failures. Three groups have had aims in advancing part time training. The Department of Health and Social Security is interested in efficient use of medical manpower. Women have gradually moved from a wish to practise medicine in any capacity in the 1950s and early 1960s to the current demand for equal choice of career outcome with their full time colleagues, and the expectation of being able to combine this with a range of other activities, including parenting, already enjoyed by male colleagues. Anything less will be seen as unacceptable. The medical profession has mixed aims, poorly understood and articulated, but best expressed as a desire to solve the "woman doctor problem."

The DHSS's aims are outlined in the circular PM (79) 3 and its predecessor HM (69) 6.^{1 2} There is a need to make use of expensively trained doctors. Using this standard alone the schemes have been successful. At any one time 91% of women doctors are in work compared with 82% in 1962, although nearly half of them are working less than full time.³ Medical graduates of the 1970s are contributing more at all stages of their careers than those trained in the 1950s, and the increased availability of part time work is one reason for this. Women's work approaches full time in the 10 to 15 years before their retirement. In order to provide a high level of skill during these years it is essential that earlier in their careers, when family commitments are greatest, they should be trained rather than merely employed. They need to prove at the end of their training that they are good candidates for their permanent jobs. Because of the increased length of training it is difficult to evaluate a part time programme even over a 10 to 15 year period. But DHSS figures show that of the 80 doctors who left the senior registrar scheme between 1974 and 1979, two thirds are working as consultants, over half full time.⁴ The DHSS's aims have thus been successfully fulfilled at senior registrar level for a limited number of women.

Lack of data

From the point of view of women themselves the outcome must be seen as much less satisfactory. For individual women

who could not otherwise have worked at all these posts have been invaluable. But looked at overall the position is more gloomy. There are few data on the past 15 years' experience. Of 249 trainees in Oxford, 115 finished their training and were considered to be in career posts.⁵ Only 19% of these, however, are now consultants, with 30% working in other hospital posts and the remainder in general practice or the community. Even acknowledging that this includes several women who had been out of medicine for many years and the difficulties of career progression for all doctors, these figures give a dismal view of the totality of part time training.

For other women who had hoped that part time training would be a particularly important way into the "greedy" specialties with long hours of duty and difficult on call schedules these schemes must be a particular disappointment. The table shows that it is those specialties in which women have the best chance of succeeding full time that are most easily available for part timers. Part time work has not provided an entry for women into the acute specialties, and the review of part time training in the medical specialties took such a gloomy view of junior grade training that the authors doubted whether it was possible at all.⁶

There are also more specific criticisms. There is great regional variation in administration, advice, funding, time to organise posts, and educational standards. It is suggested that women who have failed to obtain full time posts are applying. There are the paradoxes of the supernumerary nature of the posts. Part timers may be welcomed as an extra pair of hands, particularly in peripheral units where career advancement is already difficult. A part timer in a department may help specific problems of an on call rota but at the same time be criticised by full timers in training for diluting the experience available.

Some of these criticisms reflect problems that are intrinsic to the nature of part time work as we see it in Britain. It tends to be concentrated in a certain range of occupations that often lack

*Women doctors in higher training in various specialties**

Specialty	Women as % of all consultants	Women as % of all senior registrars	Part time women as % of all women senior registrars	Total No of part time women senior registrars	% of all part time women senior registrars
Mental illness/ handicap	21	33	34	49	25
Anaesthetics	19	28	40	48	25
Paediatrics	17	31	43	20	10
Pathological specialties	16	40	29	46	24
Medical specialties	12	29	34	19	10
Obstetrics and gynaecology	12	18	8	2	1
Geriatrics	10	17	20	4	2
Ophthalmology	6	22	10	2	1
General medicine	4.5	4	30	3	1.5
Surgical specialties	1	3	8	1	0.5
Total				194	100

* DHSS hospital medical staff—England and Wales, national tables, 1983.

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status and rewards. Britain has an exceptionally large number of women working part time, and part time work thus comes to be seen as women's work and, partly because of this, as less valuable. These general perceptions may be reflected in part time work in medicine, particularly at senior house officer and registrar level, where controls have been less and monitoring scanty. Some posts have clearly been unsatisfactory with low standards. There are twice as many part timers at senior house officer and registrar as at senior registrar level and their problems may lead to the whole scheme falling into disrepute.^{6 7} It is unfortunate that your committee has already set itself terms of reference that exclude the junior grades from consideration.

Advantages of job sharing

It is for reasons like this that job sharing is seen nationally as a more fruitful way for women to work part time at a professional level. Not only are some of the administrative problems lessened, but the supernumerary difficulties are avoided. The trainee has all the advantages of the status and experience of an established post, causes less disruption to the employing department, and attracts less resentment from full time colleagues. It has worked successfully in the Lothian region but even there has not entirely replaced a need for individual part time posts. This may be because of the short term nature of the training contracts, with the major difficulty being finding suitable partners.

The principal reasons for failure of these schemes, however, is the misguided belief that providing satisfactory part time work would solve all women's employment problems. Women need much more than this. They need: (a) to live near their partner (geographical tie); (b) time off to bear children (maternity leave); (c) time off to look after children (part time work, retainer scheme, job sharing, etc); (d) time off, some say, to look after husbands; and (e) above all, flexibility because of the lack of control over all these things and variation in need as circumstances change. Increasingly, (a), (c), and (e) are men's problems too. Unless your committee gives consideration to all these needs even your best attempts to modify the scheme will flounder once again.

I understand that instead of examining these issues your committee has been discussing numbers and trying to determine how many women will want certain sorts of posts. But a woman's "choice" of job is often limited and cannot necessarily be predicted from studying her personal commitments.^{8 9} She will take the best thing that she can get in the circumstances, bearing in mind the pressures on her. Studying numbers may be dangerous in that it leads to setting quotas based on past behaviour that tend to act as a ceiling for minority participation rather than reflect the future fluctuating needs of the group.

Madam, I am aware that if I criticise you and exhort you to do better I must also be constructive. Your first task must be to include the registrar and senior house officer grades in your deliberations. Secondly, you must initiate continuous monitoring of the progress of women trainees and begin to keep detailed records of applicants as well as appointed doctors. Thirdly, you must direct rather than advise regions to devise ways to include part time posts in all established training schemes, interviewing simultaneously with full timers.

Abolishing supernumerary training

I propose a scheme that does away with supernumerary training and incorporates elements of part time work and job sharing that can respond to changing demand; it encourages flexibility in a department and unit without major disruption to manpower planning. Already most junior doctors are appointed by committee to rotations or departments, arrangements that usually have only one or two starting dates each year. Most consultants are thus becoming experienced in appointing more than one candidate at each appointment committee. Outstanding

or clearly unsatisfactory candidates are easily picked out, but choosing the others from a large group of applicants with similar experience and potential is difficult even at interview. A variety of marking schemes are used that eventually result in candidates being placed in an order of preference. I suggest that this practice should be extended to include a mixture of full and part time doctors.

The number of posts available to an appointment committee should be the current establishment based on service need. Applicants should state whether they wish to apply for half time or full time posts without necessarily having to give reasons for doing so, and the appointment committee would then place all applicants in order of preference whether full or part time. If an even number of part time doctors were chosen one or two posts would effectively be shared without the need for the trainees themselves to find their own partners. If an uneven number of part time doctors were chosen funds for an extra five to seven sessions should be available for the duration of the appointment only. This should facilitate the appointment of part time doctors by inducing departments to cooperate. Departments would get used to dividing their work between a slightly larger group of trainees from time to time, and once appointments had been made the hours of any trainee could be adjusted within a total maximum as individual needs arose or as doctors left the scheme. The pool size for each appointment might vary from two or three in a department in a district general hospital to the 40 or 50 in a regional scheme. It might include the option of a national pool for certain small specialties as at present.

Clearly, those in part time supernumerary posts at present should be allowed to complete their contracts, though as many as possible should be incorporated within the establishment where service need can be shown. A percentage of the money released as trainees leave the current scheme should be used to fund the extra five to seven sessions that will be required from time to time under the new proposals.

Your aim must be to avoid earmarking certain posts as part time because this reduces flexibility and quality. At the same time it is essential to set up goals for each region and specialty over a three to five year period, so that no one is required to appoint a poor quality part time doctor just to fulfil an annual quota but a certain average is achieved. If over this period suitable candidates are not forthcoming or not appointed reasons must be sought, explanations provided, and adverse conditions overcome. Suitably qualified women must be actively sought to sit on appointment committees and where possible be concerned in administration and audit. In specialties where women are severely underrepresented at present short term goals should be set above the current number of part time trainees. Where women are progressing reasonably well working full time in a specialty targets might be set a little below the current level. Short term goals should also be set with the aim of correcting regional imbalance.

Geographical immobility

The problem of geographical immobility for women is now of equal or more importance than the need for part time training.¹⁰ At present a woman who fails to obtain a full time post may apply for part time training, giving a variety of domestic reasons to support her claim. Because of her geographical tie she is simply not as free as her male colleague to apply widely where she might be successful in open competition. Indeed, the geographically tied woman with a child may actually find it easier to obtain work than a similar woman with no children, depending on the local interpretation of the "domestic responsibilities" clause. Does a male doctor married to a teacher have similar needs?

Geographically tied doctors do not necessarily need or want part time work and should not be further handicapped by having

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BMA's "major effort" on pay parity for clinical academic staff

The new chairman of the medical academic staff committee, Dr Colin Smith, was able to report on 28 September that it had been agreed in the Clinical Academic Staff Salaries Committee (three months after the doctors' and dentists' review body had announced its award to doctors in the NHS) that similar revised scales would be introduced for clinical academic staff. In 1968 it had been agreed that parity should be maintained between the two groups but for the past few years there had been a delay in implementing the recommendations. This year, Dr Smith said, it had taken a major effort to persuade the Department of Education and Science that parity should be maintained and that the extra money should be found. Since the Department of Education and Science had not made extra funds available the universities, he said, were faced with a substantial sum of money to find; the smallest medical school would have to find the equivalent of a professor's salary. The revised scales were published on 8 September (p 634).

University cuts

University cuts had also exercised the committee during the past year and would continue, Dr Smith warned. The universities faced a 0.6% cut, with regional variations. There was a deficit of £200 000 in one medical school,

which was equivalent to the cost of seven professors' or senior lecturers' jobs. The committee would continue to monitor developments in the current session.

On the instruction of the 1984 conference of representatives of medical academic staff there is to be a small working party with the associate members group committee "to review the impact of potential and actual university cuts on the education of future doctors."

Preclinical staff

The salaries of preclinical staff are negotiated by the Association of University Teachers, and as a result of arbitration they will receive an overall increase of 4.6%. It is BMA policy that preclinical staff salaries should be 90% those of their clinical colleagues.

The reality was, however, more like 50%, Dr David Bowsher told the committee. Clinical staff had been awarded 6.9% (implemented 1 April and 1 November), averaging 4.6% over the year, and preclinical staff 4.6%. A doctor at the top of the lecturer grade received £17 701 and would retire on half that sum. Preclinical staff were a minority group and Dr Bowsher hoped that the committee and the BMA would do all that they could to help them.

Dr W S Monkhouse, a preclinical teacher from Nottingham and a member of the committee for five years, declared that he did not favour differential salaries for non-clinical teachers. If high salaries were introduced tomorrow, he said, there would still be a recruitment problem. The attitude of clinical colleagues had to change. Students were often told when they began their clinical course that they could forget everything that they had learnt in the preclinical course. A differential salary would be divisive, Dr Monkhouse believed. He considered that he was doing the same job as a teacher with a PhD and many of his colleagues in Nottingham agreed with him. But fringe benefits could be improved. He

thought that preclinical staff should pay a smaller General Medical Council retention fee and a smaller defence society subscription. Something had to be done to improve the image of preclinical medicine. There could, for example, be more joint lecturer appointments with clinical staff. Dr Monkhouse welcomed the efforts to consolidate clinical teaching allowances into preclinical staff pay and the fact that preclinical staff paid a reduced BMA subscription, but he would like to know how many other preclinical staff felt the same way as he did.

The chairman pointed out that it was the clinical academic staff who had pushed the idea of clinical teaching allowances for preclinical staff. Furthermore, those preclinical staff who held clinical assistant posts were paid for their clinical sessions. Dr Monkhouse agreed that his views should be circulated to the committee, and the committee authorised a survey on the number of medical and dental qualified preclinical academic staff who undertook hospital sessions and/or had responsibility for patients and teaching in a clinical context.

Dr B C Patterson, under secretary of the British Dental Association, reminded the committee that a 1973 agreement between the BMA, the BDA, and the Association of University Teachers gave the BMA and the BDA the right to negotiate for their members in individual schools, but in many places this agreement had been ignored and the Association of University Teachers had the sole negotiating rights. This was particularly important for the BDA as dental schools had suffered a 10% cut and it was being hindered in fighting redundancies for academic dental staff. The aim during the past year, Professor Payne reported, had been to try to get the BMA accepted as the negotiator for clinical academic staff in the London medical schools as a first step.

The chairman is to write to the Chief Medical Officer expressing the committee's concern about the proposal to build an independent school of medicine in London on the site of Bedford College.

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to train for twice as long and end up considerably older than their competitors at the next hurdle. But the two issues are so clearly linked by their association with women's employment needs and are already muddled in the current administration of these schemes that your committee must be prepared to tackle this difficult area. I suggest that you should continue to allow some part time posts to travel with individuals, especially when they have been appointed in open competition. The receiving department should have the option of incorporating them at its next vacancy or be allowed to increase the establishment by five to seven sessions automatically. The possibility of job swaps at registrar and senior registrar level between various parts of the country should be considered provided both departments agree. But the problem of a tied doctor seeking her first post in a grade is difficult and much more common. When appointing several doctors of similar merit to a scheme it might be acceptable to give geographically tied individuals a small positive weighting. The aim is not to appoint all geographically tied doctors at any cost, but to alter the balance slightly in their favour.

Some of these proposals are based on current practice in many parts of the United Kingdom. Others may be seen as radical. I suggest that to adopt some of them or modifications of them would be an appropriate response by a caring, intelligent, and

innovative profession in the interest of their own colleagues and, I believe, ultimately in the interests of their patients and themselves. I beg you not to miss this opportunity.

I thank Mrs L Gittens and Ms M Burtt for secretarial help.

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