
National Task Force on Medical Staffing

Flexible Training Strategy

June 2003

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Executive Summary

- 1. The Flexible Training Strategy, while endorsing flexible/part-time options recognises that the preferred option for the majority of doctors-in-training and consultants is most likely to continue to be full-time training and work. This may become increasingly attractive when the forty-eight hour week is implemented. However, given the increasing interest in balancing work/life commitments, the need to retain graduates and the increasing number of female graduates there is a need for better access to flexible/part-time training and work in Ireland. The Task Force considers that this can best be delivered by the commitment of all stakeholders to a Flexible Training Strategy (para 1.1).***
- 2. The aim of the Flexible Training Strategy is the provision of an adequate number of flexible training posts to facilitate doctors-in-training in Ireland who have a requirement for part-time training, where compatible with service needs. There should, in turn, be a number of flexible permanent posts in order to provide career opportunities for doctors with these requirements. By enhancing the work/life environment, more doctors will be encouraged to remain in the health care sector (para 1.2).***
- 3. Prior to the establishment of the Postgraduate Medical and Dental Board (PGMDB) Flexible Hours Scheme, the options for flexible training in Ireland were negligible apart from the Public Health Medicine specialty. The Task Force recommends a major increase in the proportion of training posts that are flexible / part-time and highlights the need for a strategy to drive the change (para 1.1).***

- 4. The Strategy refers to the requirements for flexible training under European law EU Directive EC 93/16/EEC² and defines a flexible trainee as a doctor in training who works less than full time but at least 50% of the full time hours. Flexible training can be one post shared by two people, or one person occupying part of a post (para 1.3).**
- 5. The need for flexible training and work is substantiated in the Strategy by the following**
- **Implications for having a large number of female graduates (56% in the period 1997 – 2001) (para 2.1.1).**
 - **The international trend for the workforce's desire to balance work/life commitments (para 2.1.3).**
 - **Some doctors have special needs (para 2.1.3).**
 - **An anticipated increase in the number of specialists* (para 2.1.4).**
 - **Potential losses of specialists* to other Health Care systems (para 2.2.2)**
- 6. The national and international experience is reviewed. This includes policies and practices in various countries, the criteria for acceptance on flexible training programmes and the barriers experienced (para 2.2). Substantial efforts will need to be made at all levels of specialist training to meet the goal.**

Ireland has a relatively small number of flexible trainees in comparison to countries such as UK, Australia, New Zealand, Sweden and Switzerland (para. 2.2.4, para. 2.6.5). As a direct result of the PGMDB scheme 2.4% of the total number of SpR/SnR are in flexible training in the country as at 1st January, 2003. At present, this scheme only applies to Higher Specialist Training but should be extended to all grades (para 2.6.6).

* The term "specialist" as used throughout this document includes consultants, general practitioners, public health and occupational medical specialists.

7. The Strategy identifies the need for

- **Leadership and commitment to the Flexible Training Strategy at national, regional and local level (para 3.1).**
- **Unified national, regional and local policies where the government, employers and training bodies are committed to the success of the scheme at internship, initial and higher specialist training level^{10,21,22} (para 3.1).**
- **A significant cultural and attitudinal change amongst all stakeholders (para 3.1).**
- **On-going incremental increase in the funding of the Postgraduate Medical and Dental Board flexible training scheme to enable the development of flexible training in line with the strategy (para 3.2).**
- **More detailed tracking and monitoring of graduates who are in specialist training /work so that the benefits of flexible training / working can be quantified.**
- **Specific responsibilities for each of the main stakeholders (para 3.2 - 3.5)**
- **A structure to facilitate specialists who have completed flexible training and awaiting appointment to a flexible specialist* post (para 3.7.1)**
- **Flexible specialist* posts (para 3.7.2)**
- **Retraining facilitated for doctors who wish to re-enter the workforce (para 3.7.2)**

8. The Task Force recommends that, given the rising trend in the percentage of women medical graduates and the anticipated expansion in the specialist* workforce, it is urgent that a flexible training / work strategy is adopted and implemented. This should be phased in, and together with the service implications be closely monitored (para 3.8)

* The term “specialist” as used throughout this document includes consultants, general practitioners, public health and occupational medical specialists.

NATIONAL TASK FORCE ON MEDICAL STAFFING

FLEXIBLE TRAINING STRATEGY

1. Background and Goal of Flexible Training Strategy

1.1 Introduction

The strategy set out in this document for developing further a more flexible medical training and working environment was prepared by the Task Force's Medical Education and Training (MET) Project Group and is endorsed by the National Task Force on Medical Staffing.

In August 2002, the MET Group, in its Interim Report¹ to the Task Force, recommended a major increase in the proportion of training posts that are flexible / part-time and identified some of the central issues which need to be addressed including:

- A need for a strategy for flexible / part-time training including career progression and other family friendly practices
- A change of culture to enable the development of flexible /part-time training and working
- A reduction in the high attrition rate of doctors
- Identifying the policy and plans of the major stakeholders on flexible working and training
- Identifying the extent of flexibility currently evident in the workforce
- The need to establish an understanding of the issues surrounding vocational choice, medical training and current workforce flexibility from the doctors' perspective.

Given the increasing emphasis on work-life balance and the rising trend in female medical graduates, it is essential that policies and plans are in place in order to retain medical graduates in the system and optimise their career potential. While acknowledging that full time training/work will remain the choice of the majority of doctors, some will want or need to train and work in a more flexible environment. Full-time trainees/consultants should not be treated less favourably than those who opt for flexible/part-time training and working.

Prior to the introduction of the Postgraduate Medical and Dental Board (PGMDB) Flexible Training Scheme, the options for flexible training in Ireland were practically non-existent, except in Public Health Medicine. The

Report of the National Task Force on Medical Staffing (June 2003) endorses the PGMDB's approach in having identical entry criteria for full-time and flexible training programmes.

The goal of this strategy is to make part-time, flexible training, job-sharing and other family friendly practices a legitimate and accessible option for all doctors. It identifies the key issues which need to be addressed by the stakeholders and highlights the major cultural shift required to implement the strategy.

The Task Force Report recommends that

- The Flexible Training Strategy be adopted and adequately resourced, and be implemented by all stakeholders
- An adequate number of flexible training/working posts should be developed to facilitate doctors in training who have a requirement for part-time training/working, taking account of service needs
- A retraining/re-entry system be developed
- The Flexible Training Strategy should be phased in and, together with the implications for services and the introduction of a 48-hour week, should be closely monitored.

1.2 Aim

The aim of the Flexible Training Strategy is the provision of an adequate number of flexible training posts to facilitate doctors-in-training in Ireland who have a requirement for part-time training, taking account of service needs. There should, in turn, be a number of flexible permanent posts in order to provide career opportunities for doctors with these requirements. By enhancing the work/life environment, more doctors will be encouraged to remain in the health care sector.

All medical graduates who wish to work in Ireland should have the prospect of a career with a quality work/life environment. Flexible training and work are key ingredients.

The objectives are to

- Retain doctors who are unable to train full-time by enabling them to train on a half time basis at minimum
- Maintain a balance between flexible arrangements and service needs.

Fundamental to the achievement of these objectives are the provision of

- Organised training slots to accommodate flexible training
- A structure to facilitate specialists who have completed flexible training and awaiting appointment to a flexible permanent post
- Flexible specialist^{*} posts
- Retraining facilitated for doctors who wish to re-enter the workforce
- Definition of flexible training

1.3 Legislation

European law EU Directive EC 93/16/EEC² does not require member states to provide part-time opportunities, but lays down conditions to which part-time training must comply. It places the obligation on the competent authorities (Medical Council) to ensure that the total duration and quality of part-time training of specialists are not less than those of full-time trainees. It must constitute at least 50% of the weekly programme of trainees in full time training for all specialties. A trainee must demonstrate that they have “well founded reasons” which prevent them from training full time. Doctors working less than 50% full time cannot be accredited for training, but allowances could be made to allow career breaks etc.

1.4 Definition

It is essential that there is a clear working definition of what constitutes flexible training. In all circumstances the duration and quality of training must comply with European Law. A suggested definition is as follows:

A flexible trainee is a doctor in training who works less than full time but at least 50% of the full-time hours. Flexible training can be one post shared by two people or one person occupying part of a post.

^{*} The term “specialist” as used throughout this document includes consultants, general practitioners, public health and occupational medical specialists.

2. Irish and International Perspectives

2.1 Trends in Ireland

2.1.1 Several emerging trends have been identified over the last decade in medical training and practice.

The PGMDB have collated data from various sources, which depicts the current situation and trends ⁴. An extract from the Fourth Report shows that

- 62% of Irish medical undergraduates at 1 January, 2002 were female **[Table 1]** as compared to 57% in 1996, 51% in 1990 and 45% in 1984
- 56% of new Irish medical graduates in the period 1997 – 2001 were female, compared with 51% in 1991/96 and 47% in 1986/90
- 53% of Irish non-consultant hospital doctors on 1 October, 2002 were female. Just 69 female Irish nationals were employed on 1 October, 2002 in the 624.5 posts available as registrars and house officers in the surgical specialties **[Table 2]**
- at 1 January, 2002 23% of Hospital Consultants were female; the percentage varied considerably between the specialties e.g. 48% and 36% of Psychiatrists and Pathologists respectively were female, as were 35% of Paediatricians and 29% of Anaesthetists. The corresponding percentages in the other hospitals specialties were much lower viz. Accident and Emergency 10%, Radiology 18%, Obstetrics and Gynaecology 15%, Medicine 14% and Surgery 4% **[Table 3]**. 59 of the 178 temporary consultants in post as 1 January, 2002 were female
- 28 (29%) of the 97 doctors who commenced consultant practice during 2000 were female; the corresponding percentages for the years 1990-1999 ranged from 18% to 44% with the median being 25% and the mean being 27%
- at least 23% of General Practitioners are female (66% of the persons who commenced General Practice Specialist Training on 1 July, 2001 were female; the percentage female intake in each of the five preceding years ranged from 64 to 74%, with an average of 70%)”.

Table 1 - Undergraduates in Irish Medical Schools in January, 2002 ⁴

Origin	Female		Male		Totals
	No	%	No	%	No
Republic of Ireland	1,147	62	703	38	1,850
Northern Ireland	56	50.45	55	49.55	111
Elsewhere	815	43.4	1,063	56.6	1,878
Totals	2,018	52.57	1,821	47.43	3,839

Table 2 - Male / Female Ratios ⁴

Grade	Nationals		Non-Nationals		Totals	
	M	F	M	F	M	F
Sen./Sp. Registrars	52	48	85	15	59	41
Registrars	49	51	87	13	76	24
House Officers	44	56	81	19	65	35
Interns	47	53	61	39	51	49
All Grades	47	53	83	17	66	34

Table 3 – Male / Female Distribution of Permanent Consultants at 1st January 2002 ⁶

Specialty	Male No / (%)	Female No / (%)	Total
Accident and Emergency	18 / (90%)	2 / (10%)	20
Anaesthesia	156 / (71%)	63 / (29%)	219
Medicine	218 / (86%)	36 / (14%)	254
Obstetrics and Gynaecology	72 / (85%)	13 / (15%)	85
Paediatrics	51 / (65%)	27 / (35%)	78
Pathology	79 / (64%)	44 / (36%)	123
Psychiatry	105 / (52%)	98 / (48%)	203
Radiology	107 / (82%)	23 / (18%)	130
Surgery	270 / (96%)	12 / (4%)	282
Total	1,076 / (77%)	318 / (23%)	1,394

- 2.1.2 The Comhairle Report on Consultant Staffing 2001⁵ shows that while males traditionally occupied the consultant posts in certain specialities, the percentage of females in all specialities is rising. However the percentage of women in consultant posts is still low relative to their numbers at the more junior levels of the workforce ⁶.
- 2.1.3 Working patterns and family requirements are in many ways incompatible with current training schemes. Internationally there is evidence of a change in young doctors (male and female) attitudes to work.^{7,8} Job sharing and flexible training can provide an ideal solution for men or women who wish to train and work part-time, combining family commitments or other interests with their career.^{6,7,8,9,10,11} Now, with more than half our new graduates being women, the demand for these posts will rise. Some doctors may have other special needs e.g. doctors with a disability and doctors who may have to care for an elderly or disabled relative.^{10,11,16,22}
- 2.1.4 It is likely that there will be a need for substantial increases in the number of specialists* for the provision of a consultant provided service as envisaged by the Forum Report¹², by the National Task Force on Medical Staffing and the anticipated outcome of the Primary Health Care Strategy Group. It is therefore essential that, in so far as possible, graduates are retained in the system and that the potential of all available doctors is optimised.

2.2 International

- 2.2.1 The Annual Survey of Flexible Training in the United Kingdom in 2002 showed that ¹³
- The overall percentage of flexible trainees (all grades) had risen to 5.03%
 - The specialties of Paediatrics, Psychiatry and Anaesthetics had the highest numbers of flexible Specialist Registrars (SpRs)
 - The specialties of General Psychiatry, Obstetrics and Gynaecology and General Practice had the highest number of flexible Senior House Officers (SHO)
 - There were 150 flexible SpRs with their Certificate of Specialist Training (CCST) in the UK. Nine deaneries were finding that they were needing to extend the “period of grace” of flexible trainees, as they were unable to find consultant posts
 - In the majority of deaneries, it was rare for flexible SpRs to convert to full-time training. A relatively large number did so in North and South Thames

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- In September 2001 there were 98 trainees in the UK waiting solely for deanery flexible funding.
- 2.2.2 The recent UK Royal College of Physicians Report highlights that many female doctors cease to practice hospital medicine as the demands of family and home become incompatible with their work. The report highlights the shortage of doctors in the UK to meet the needs of the 10-year plan. They make a number of recommendations, which apply, to men as well as women. These include a recommendation for more flexible working arrangements and for an increase in part-time opportunities and shared consultant appointments, taking full account of the requirements of the post and the need for continuing medical education.¹⁴
- 2.2.3 The British Medical Association recently undertook an international study of the extent and availability of flexible training¹⁵. The results are reproduced here with the kind permission of Ms Sarah Carney of the BMA. The results show that flexible/part-time working is organised in many countries in an *ad hoc* manner with the practicalities being worked out at a hospital or programme director level, even in EU countries, which are all governed by Council Directive 93/16/EEC².
- 2.2.4 The percentage of flexible/part-time trainees in the total junior doctor populations in other countries is variable. Australia, New Zealand, Sweden, and Switzerland and the UK report similar percentages. However many countries either have no data or a negligible number of flexible/part-time trainees. See **Appendix 3**.
- 2.2.5 A Training and Workplace Flexibility Project is currently being undertaken in Australia. Through this it is hoped to draw up an agreed strategy for part-time work with the medical colleges, hospitals, government and health administrations.
- 2.2.6 The reasons for the variations and the identified similarities in the schemes are discussed in **Appendix 3**. The variations relate to the provision of childcare facilities, working hours for full time doctors, supply and demand factors, attitudes and organisation. The similarities relate to demographics, training time and specialty issues.

2.3 Criteria for Acceptance on Flexible Training

The main criteria for acceptance for flexible training in countries where such exist are:

- Child care commitments
- Other family commitments
- Health reasons

- Other major commitments

2.4 Barriers

Experience in other countries shows that there are many barriers to the smooth operation of flexible training schemes.^{8,16} From discussions to date it is unlikely that the experience in Ireland is any different. The barriers experienced include

- Attitudes amongst some employers, training bodies and trainers. This may be reflected in the composition and decisions of interview panels
- The resulting lack of policies, strategies and plans
- The length of time it takes to complete training
- Complex procedures
- Uncertain funding
- The lack of accurate mentoring and advice
- The perception that flexible trainees may lack commitment
- Uncertainty surrounding job contracts and job descriptions
- Uncertainty regarding career prospects
- Variations in the commitment between the specialties e.g. internationally the specialties of public health medicine, psychiatry, paediatrics and general practice have most commonly introduced part-time/flexible training, while other specialities are less inclined to do so
- Flexible posts not integrated in the teams and seen as an “add on”.¹⁷

2.5 Current Irish position

Various recommendations and commitments to flexible / part-time training have been made over the years but there has been little tangible success.²⁰ In 2002 the Medical Manpower Forum acknowledged that women are significantly under represented at consultant level in Irish hospitals and that there are obstacles to career progression in the paths of women doctors.¹²

2.6 The PGMDB Scheme

2.6.1 In 2002, the Postgraduate Medical and Dental Board (PGMDB) launched a pilot scheme to facilitate Senior/Specialist Registrars who wish to train flexibly⁴. A guide to flexible training is available on the PGMDB's web site (www.pgmdb.ie). The PGMDB has laid down the

procedures regarding the application process. Entry is through competition and is judged on merit alone.

- 2.6.2 The equivalent of ten full time salaries was made available for flexible posts. If the demand is sufficient and the training posts are educationally approved, the PGMDB intend to seek funding to expand the scheme. The process of appointment to accredited higher training programmes is the same for both full time and flexible trainees. The scheme is designed to include supernumerary posts/job sharing and or partnerships in existing posts.
- 2.6.3 All training bodies have nominated a mentor to liaise with trainees who wish to train flexibly. The scheme is explained in full detail in **Appendix 4**.
- 2.6.4 The PGMDB provided the following overview of the scheme to date¹⁸.

2.6.4.1 Structure of the scheme

This scheme is intended for those doctors who would otherwise be lost to the system because of commitments outside work, the care of an elderly relative, for example. There has been much interest in the scheme and to-date ten appointments have been made, with an additional three to take up post in January 2003.

2.6.4.2 Implementation of the scheme

From the start, the pilot scheme has been a cross specialty initiative. Two posts were allocated each to Anaesthetics, Obstetrics and Gynaecology, Medicine, Paediatrics, Pathology, Psychiatry, Public Health Medicine, Radiology and Surgery. Two posts were held in reserve. There are a total of twenty part-time posts. These twenty posts may be additional to complement. A trainee can only move into a part-time post once it has been established that his/her current full-time post will not be left vacant. The PGMDB is the fund holder for this scheme. The PGMDB on a monthly basis pays hospitals that employ a flexible trainee under the auspices of this scheme. A part-time post will only be funded if the relevant training body educationally approves it. One year in a flexible post has the same educational recognition as six months in a full-time post.

2.6.4.3 Experience to date

Flexible trainees have been appointed in Paediatrics, Obstetrics and Gynaecology, Anaesthesia, Medicine, Pathology, Psychiatry and Occupational Medicine. Paediatrics and Obstetrics and Gynaecology are over subscribed.

- 2.6.5 Before the introduction of the flexible scheme by the Postgraduate Medical and Dental Board there were only 7 doctors in flexible

training posts, five of which were in Public Health Medicine, one in Anaesthesia and one in Occupational Medicine (see MET Survey of the Training Bodies)²⁰

- 2.6.6 In 2002, the PGMDB appointed a part-time Director of Flexible Training (Dr. William P. Blunnie). Dr. Blunnie in his presentation to the MET Group and subsequent discussions recommends that particular emphasis is required on the following in the Strategy¹⁹:

Flexible training

- Should extend to all grades – internship, senior house officer, registrar, specialist/senior registrar
- Should be better supported by all specialities, particularly within surgical disciplines
- Training bodies should align their current approved posts and then fill a portion of them on a job sharing basis
- In the current culture he advises applicants not to declare their desire to train flexibly until after interview and formal appointment to a SpR/SnR training programme.

2.7 The Challenge

Ireland has a relatively small number of flexible trainees in comparison to countries such as UK, Australia, New Zealand, Sweden and Switzerland. However, as a direct result of the PGMDB scheme on 1st January, 2003, there were 14 SpR/SnR training flexibly, which is 2.4% of the total number of SpR/SnR in the country. Given the rising trend in the percentage of women medical graduates, and the anticipated expansion in the specialist* workforce it is urgent that a flexible training / work strategy, building on the PGMDB pilot scheme, is adopted and implemented.

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3. Key Issues - Stakeholders

The following are the key issues that need to be considered with and addressed by the stakeholders:

3.1 Framework

Leadership and commitment to flexible training is required at national, regional and local level. Constant flux militates against the scheme and leads to uncertainty about viability of the training programme amongst the trainees and trainers and other stakeholders. There is need for unified national, regional and local policies where the government, employers and training bodies are committed to the success of the scheme at internship, initial and higher specialist training level.^{10,21,22} Significant cultural and attitudinal changes amongst all stakeholders is required. Flexible training must take cognisance of the EU Directive². The following are suggested responsibilities which each of the main stakeholders should consider.

3.2 Department of Health and Children

- The Minister for Health and Children to formally adopt the training strategy and promote the development of targets for all training grades
- The 10-year target should be that all who have a requirement for flexible training should be able to avail of flexible training posts, taking into account service needs. This to be phased in gradually and systematically evaluated. (Experience in the UK suggests that a critical mass of at least 6-7% is required)
- There needs to be on going incremental increase in the funding of the Postgraduate Medical and Dental Board flexible training scheme to enable the development of the strategy.

The current scheme is costing €716,000 and would cost an additional €45,000 for each extra SpR added to it. However, once the scheme has overcome the constraints and the Strategy adopted future posts would not be supernumerary but would be subsumed into the allotted training posts with a slight adjustment in the cost, depending on the type of flexible training available, e.g. 2 doctors-in-training attending for 3 days a week each will cost proportionately more than 2 doctors-in-training attending for 2.5 days a week each. These costs will need to be closely monitored as the scheme expands.

3.3 The Postgraduate Medical and Dental Board/Central Training Authority

Should ensure that:

- The targets are set for all grades and specialties and agreed with the training bodies
- Central funding is applied to all posts whether in the community, hospital or voluntary sectors
- The posts are funded in “perpetuity” so that there is no uncertainty
- Guidance and detailed policies on flexible training schemes to ensure fairness and universality of access are disseminated widely
- Flexible posts are accurately defined and recorded on a routine basis, targets met and continuous improvements are introduced based on findings
- An information system is introduced to enable careful monitoring. This should include:
 - (a) The numbers of flexible training posts by grade, speciality, gender
 - (b) The number who achieve a specialist* post, whether part-time or full-time and the number who do not. In the latter group the reasons should be ascertained
 - (c) The number of flexible to full time conversions (and vice versa) and the year of training in which the conversion was undertaken
 - (d) Satisfaction of the relevant parties.

3.4 The Health Service Employing Authority and Employers

Should ensure that:

- There is an explicit commitment to the policy / strategy of flexible training and work
- Doctors in full time and flexible training posts have equitable contracts (relative to the % of contract held e.g. 50%, 60%), job descriptions, including issues such as study leave, maternity leave, holidays, pensions
- Interview panels should be advised against discrimination and there should be guidelines on the composition of panels

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- Flexible training is available for all those who wish to train less than full time
- Flexible posts are accurately defined and recorded on a routine basis
- Flexible posts are an integral part of all training schemes and not supernumerary posts
- Flexible trainees are not forced into formal job shares i.e. one job shared between two people
- A flexible training /work plan is submitted to the Department of Health and Children and the Central Training Authority
- Innovative flexible arrangements in place at local level to meet the needs of trainees are included in the plan (e.g. rotation flexibility)
- The implementation of the plan is reported on in the annual service/business plan to the Department of Health and Children
- Childcare facilities are appropriate to the needs of flexible trainees and include hospital crèches with extended opening times and children vouchers for out-of hours work
- There is an increase in the number of specialist* posts available to doctors who wish to work less than full time for well founded reasons
- Care is taken that so that pay issues do not compromise the employment of flexible trainees
- The application and recruitment process is transparent. The flexible trainee should undergo the same competitive process as all other trainees.

3.5 The Training Bodies

Should ensure that:

- The implications of the EU Directive on Flexible education and training considered and addressed where necessary²
- Consideration is given to competency based accreditation rather than duration of training
- Flexible training posts rather than fixed job shares are offered to the trainees

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- Flexible trainees have the right to equivalent opportunities to full-time trainees
- Clear policies and guidelines are provided to the trainees and trainers on the training requirements for flexible trainees, application procedures, availability of posts, funding, entry criteria, study leave rules etc
- The trainers ensure that the flexible trainee is treated equally to the full time trainee
- The application and recruitment process is transparent. The flexible trainee should undergo the same competitive process as all other trainees
- The recommendation of the PGMDB that these posts should not be seen as an “easy entry” to the higher specialists training schemes is implemented.

3.6 Mentoring System

A mentoring system has been recommended in the Interim Report for all trainees.¹ This should begin in medical school, followed throughout a doctor’s career (particularly in the early stages) to provide much better career guidance. This system should take account of the special needs that the flexible trainees may have e.g. the duration of training, how to move back to the full time posts, how to be competitive for consultant posts. The mentor should also be able to assist in resolving any difficulties that the trainee encounters with the flexible training scheme.

3.7 Workforce Planning

3.7.1 Those who have undertaken flexible training may also wish to have a flexible / part-time job. Currently there are 24 job sharing / permanent part-time posts. Planning the future medical workforce should take account of the output of the flexible training scheme and the career aspirations of those doctors. There is the danger that those undertaking flexible training and want flexible working condition may be trapped in “career posts”. To counteract this pitfall, mechanisms need to be put in place for the continued employment of these doctors while they wait for an available flexible/part-time post if that is their wish. This issue needs to be addressed urgently by the Department of Health and Children, Comhairle na nOspidéal and Employing Authorities. A review of the operation of flexible/part-time specialists should be considered.

3.7.2 The Task Force recommends the following:¹⁴

- The number of part-time posts and job shares should be increased – at present the number is limited, partly by funding and partly by organisation
- There should also be a facility to work a reduced number of sessions – this would encourage doctors who have left to return if flexible working arrangements allowed them to look after their family and other commitments
- A re-entry /retraining scheme should be introduced
- A retainer system, similar to that in the U.K. should be explored
- Pension rights for part-time workers and those who have career breaks should be reviewed
- More part-time academic posts (lecturer and senior lecturer) should be created, and research grants should be available for doctors working either part-time or without a fixed-term contract, although some contracts may not be suitable for part-time
- There should be a process to return to full-time work after flexible working.

3.8 Conclusion

The Strategy sets out the need for a flexible training strategy and considers the barriers which may exist at present. It also identifies the key issues, which need to be addressed by the major stakeholders i.e. the Department of Health and Children, the Postgraduate Medical and Dental Board/the Central Training Authority, the Health Service Employing Authority and Employers and the Training bodies.

The Task Force recommends that the Flexible Training Strategy is urgently implemented and funded accordingly. It also recommends that the Strategy should be phased in, and, together with the service implications, be closely monitored.

Appendix 1

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11. Oxford PGMDE – Flexible Training <http://www.oxford-pgmde.co.uk/fttraining.html>
12. Report of the Forum on Medical Manpower – January 2001
13. COPMeD Flexible Training Sub-group – Annual Survey – September 2001
14. Women in Hospital: Career Choices and Opportunities – RCPI Publications 2001 <http://www.rcplondon.ac.uk/news.news.asp>
15. The British Medical Association – International Study of the Extent and Availability of Flexible Training
16. Royal College of Paediatrics and Child Health – Flexible Training Paediatrics-Report of a Working Party – December 1999
http://www.rcphc.ac.uk/publications/education_and_training_documents/flxweb.pdf
17. Meeting in Birmingham

18. Personal Communication with Mr. John Gloster Chief Officer PGMDB re Flexible Training
19. Personal Communication with Dr. Bill Blunnie of the PGMDB
20. The Updating of ref 1 – Survey of Training Numbers
21. eMJA Job-sharing in Paediatric Training in Australia: Availability and Trainee Perceptions
http://www.mja.com.au/public/issues/174_08_160401/whitelaw/whitelaw.html
22. Flexible Training (FT) in the North Western Deanery
<http://www.pgmd.man.ac.uk/flextraining.htm>

Appendix 2

COPMeD Birmingham Meeting

Conference of Postgraduate Medical Deans of the United Kingdom (COPMeD)

Flexible Training Sub-group

Annual Survey – September 2001

Summary

- The overall % of flexible trainees (all grades) had risen to 5.03%
- The SW Deanery had the highest numbers of flexible SpRs (13%)
- The specialties of paediatrics, psychiatry and anaesthetics had the highest numbers of flexible SpRs
- The old Thames deaneries (now London and KSS) had the highest % of flexible SHOs
- The specialties of general psychiatry, obstetrics and gynaecology and general practice had the highest number of flexible SHOs.
- 5% of flexible trainees were male
- There were 150 flexible SpRs with their CCST in the UK. 9 deaneries were finding that they were needing to extend the “period of grace” of flexible trainees, as they were unable to find consultant posts
- In the majority of deaneries, it was rare for flexible SpRs to convert to full-time training. A relatively large number did so in N and S Thames
- In September 2001 there were 98 trainees in the UK waiting solely for deanery flexible funding

Appendix 3

BMA International Survey on Flexible Training

Numbers of part-time trainees

The percentage of flexible/part-time trainees in the total junior doctor populations in other countries is variable. Australia, New Zealand, Sweden, and Switzerland report similar percentages to the UK. However many countries have no data or an estimated negligible percentage of flexible/part-time trainees.

Country	Do any doctors in training in your country train part time?	How is this arranged?	No of flexible or part-time trainees as percentage of total junior doctors
Austria	Yes	Governed by Council Directive 93/16/EEC. Part-time working is only granted in the case of pregnancy-maternity.	negligible
Australia	Yes	Part-time work normally takes place after the intern year, but it is often difficult to arrange. Job-sharing for RMOs does exist in public hospitals, but is unusual and has to be arranged by the doctors themselves. When it comes to vocational training with a medical college, the availability of part-time training differs a lot according to the discipline or college. Colleges do not offer part-time training places: each trainee must negotiate his/her own part-time arrangements with the college and with the hospital or supervising practice.	6.3 %
Belgium	Yes	Governed by Council Directive 93/16/EEC. In specialist training, it is not permitted other than in very exceptional circumstances. In general practice doctors in training can set up their own practice in order to complete their training.	No data ' <i>part-time training is avoided</i> '
Canada	Yes	There is a six month maternity and paternity leave, leave to look after an aging parent, but the time off must be made up. Any other cases would be on an individual basis and worked out between the resident and program director i.e. it might be feasible for a family medicine or psychiatric resident but doubtful whether a surgical resident would be permitted to train part time.	No data
Finland	Yes	Governed by Council Directive 93/16/EEC. The training period is increased proportionately to number of basic hours worked.	No data

Country	Do any doctors in training in your country train part time?	How is this arranged?	No of flexible or part-time trainees as percentage of total junior doctors
Germany	Yes	Governed by Council Directive 93/16/EEC. Consent to train part time must be obtained from the medical board. When he/she applies they must indicate the duration of part-time training and the reasons why he/she wants to do part-time training.	No data
Netherlands	Yes	Governed by Council Directive 93/16/EEC. In addition junior doctors have to be full time in the first and last year of his/her training.	No data
New Zealand	Yes	The majority of part time RMOs job share, working one week on and one week off (or longer) rather than day or part days. Training time is increased by the proportion of the work performed. For other part-time working arrangements specific jobs must be created.	5-10%
Switzerland	Yes	Dependent on the hospital and the senior consultant.	<9%
Sweden	Yes	Governed by Council Directive 93/16/EEC. Training time is increased by the proportion of the work performed.	2-4%
UK	Yes	Governed by Council Directive 93/16/EEC.	5%

Arrangements for part-time training

Where it is available, flexible/part-time working is organised in many countries in an ad hoc manner with the practicalities of it being worked out at a hospital or programme director level, even in European countries which are all governed by Council Directive 93/16/EEC

Reasons for the variation

The following possible influences were highlighted from the information obtained:

- *Childcare facilities* – for example, the Scandinavian countries are well known for being ahead in their thinking and facilitation of childcare provision
- *Working hours for full-time junior doctors* – for example, in Finland and Germany full-timers work approximately 38 hours a week
- *Over or undersupply of junior doctors* – for example, in Germany there is an excess of doctors competing for posts; whereas in New Zealand it is

suggested that a scheme is not needed as all junior doctors are treated well due to them being in such demand

- *Attitudes* – for example, the Netherlands reports that ‘trainers are not very pleased if the junior doctor wants to have his/her training part time’; Belgium reports that ‘It is avoided’ and ‘In specialist training, it is not permitted other than in very exceptional circumstances’
- *Organisation* – there are many factors that make direct comparison between different countries’ provision of part-time working invalid. For example, the way that junior doctors are trained and managed are very different between countries, and many of the reasons cited for training flexibly in the UK are not issues for doctors in other countries.

Similarities

The following similarities were discovered:

- *Demographic reasons* – Australia and Germany mirrored the UK in having a future population of 50 per cent female doctors
- *Training time* – of note is that the UK’s response to training time is mirrored by other countries i.e. where a reduction in hours is permitted, training time is increased by the proportion of the work performed (Finland, New Zealand, Sweden). So if the junior doctor is working half time, the training time will be doubled
- *Specialty issues* – other common issues lie in part time opportunities within specialities. Both Canada and Australia reported that part-time working was easier to organise in psychiatry and general practice, than in surgery!

Specific examples

Australia was the most interested in the issues with current work being carried out on flexible working options with the Training and Workplace Flexibility Project. The project explores the different work patterns of men and women in the medical profession; changing attitudes to work; and policy and practice relating to flexible working. The hope, ultimately, is to draw up an agreed strategy with the medical colleges, hospitals and the respective governments and health administrations on addressing part-time working issues.

New Zealand reported that they found job-share was preferable to part-time working i.e. two junior doctors perform the duties of one. They found that handover/communication was better with consistent people involved. It also allowed run (team/firm) allocations to continue uninterrupted through the training period. The job-share partners tended to work week on week off (or longer) rather than days or part days.

Appendix 4

PGMDB Flexible Training Scheme for Senior/Specialist Registrars

INTRODUCTION

Many doctors (male and female) are seeking different working arrangements, often because of domestic responsibilities. The purpose of flexible (part-time) training is to retain within the health service doctors who might otherwise leave because they are unable to train on a full time basis.

APPLYING TO ENTER THE SENIOR OR SPECIALIST REGISTRAR GRADE

The process for appointment to a training post is the same for both full-time and flexible applicants. Entry is through the same competition and is on merit alone¹. Once candidates are notified that they have been selected for training they may apply to the Postgraduate Medical and Dental Board (PGMDB) to be considered for flexible training. For a trainee to commence training in a part-time capacity funding, educational approval, hours of work and the agreement of a Hospital/ Health Board to accept a flexible trainee have to be organised.

The PGMDB's Director of Flexible Training will ascertain whether an individual's request for flexible training is based on well founded individual reasons. Having established eligibility the PGMDB's Director of Flexible Training will determine the feasibility of acceding to the request. This will depend on:

- The specialty the trainee has chosen
- The stage of training
- The presence of other flexible trainees enhancing the possibility of job-sharing or partnership arrangements
- The availability of resources, where having exhausted other possibilities, the Director decides to establish a supernumerary post
- Suitable educational approval for the supernumerary post

PART- TIME/FLEXIBLE TRAINING PLACEMENTS

The scheme will encompass a variety of part-time training options including job sharing, job partnerships and flexible supernumerary posts.

Job-Shares: A job-share can be created by dividing a training placement between two trainees.

¹ Those candidates who wish to train part-time do not declare this desire to the interview board.

Job-Partnerships: Job partnerships can be arranged by the PGMDB. Using flexible training funds for an additional session, each partner works 60% of full-time. This allows each partner to fulfil the duties of half of a full-time post and for both to attend protected teaching sessions and audit, with time for a formal hand-over of responsibilities. Part of the extra time can be used for additional training sessions or for service needs. Trainees eligible for flexible training may be placed in job partnerships.

Flexible Supernumerary Posts: New training opportunities are created by supernumerary placements additional to the existing complement of trainees. Supernumerary posts are needed when a trainee needs specific specialist training and cannot be paired with a suitable partner in a job-share. These posts are funded by the PGMDB.

FUNDING - GENERAL

The PGMDB has limited funds available for flexible training and priority will be given to those with a definite need for the opportunity to train flexibly.

If funding is identified for a supernumerary flexible training post the PGMDB will fund 100% of the basic salary cost including the employer's PRSI contribution and costs relating to indemnity and training allowances/grants. The payment will be based on 50% of a full-time post calculated at the mid-point of the senior or specialist registrar salary scale.

EDUCATIONAL APPROVAL

All training programmes/placements (whole-time or part-time) require educational approval from the relevant Training Body. Some of these programmes may include flexible training placements which have been approved already. In others, educational approval will need to be obtained for the individual part-time placement/programme.

IMMEDIATE PROPOSALS

Funding has been made available by the Department to the Board to enable 20 additional senior or specialist registrars to be appointed, on a part-time basis. It is the Board's intention that all of these posts should, if possible, be filled as close as possible to 1 July, 2002. It is the Board's wish, subject to demand from trainees, that the posts should be spread over many specialties and for this reason has adopted a draft distribution of two part-time specialist registrar posts in each of the following specialty groups: anaesthetics, obstetrics/gynaecology the medical specialties (excluding public health medicine), paediatrics, pathology, psychiatry, radiology, surgical specialties, public health medicine together with two posts held in reserve. That distribution should be seen as indicative of the Board's intentions, should suitable applicants from all specialty groups present themselves. This proposed distribution is not "set in stone" and if insufficient suitable applicants come forward in the immediate future to

fill the posts in accordance with it the Board's intention would be to transfer very quickly, with the Comhairle's approval, any unfilled posts to specialties in respect of which suitable applications from trainees have been received.

One criticism in the past of efforts to introduce flexible training arrangements has been the absence of agreed schemes and the slowness with which decisions were made or sometimes not made. It is the Board's earnest hope that the pilot scheme will enable decisions to be taken quickly. Obviously it is impossible to be precise at this point as to what the initial demand will be among trainees in the different specialties. The indicative allocation of posts among the different specialties should be seen as an initial desired framework and model but which must be capable of being revised speedily if the demand from trainees in some specialties falls short of the proposed indicative allocation. The Comhairle's approval to the 20 posts on the basis proposed has been sought now so as to obviate a need to make up to 20 individual applications over the coming months.

The training bodies are aware, and have welcomed, the Board's proposals.

Postgraduate Medical and Dental Board
26 April, 2002

P.S.: This scheme is designed to increase the availability of part-time training. It will supplement any existing scheme/facilities.

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