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Scenes from Postgraduate Life

Women in medicine

The time has come, if I am to salve my conscience, to tackle a topic which I have avoided up to now, mainly for reasons of anger and frustration. With women making up half the intake of medical schools you would have thought by now the profession as a whole, and not just a few enthusiasts,[1] would have responded with positive action. Instead we have cosmetic schemes like PM(79)3 (I shall come to that later) which I suspect have been cobbled together so that they can be trotted out by ministers in answer to awkward questions from those damned feminists. It is a wonder – and a miracle – that women ever achieve anything in medicine, and it is time the profession took action to make amends. The difficulty – and the reason for fighting shy of the subject – is the impossibility of a satisfactory solution.

In fairness it is not all the fault of the men. Some of the most hard-bitten opponents to part-time training are women who have raised usually large families *and* worked on, with short gaps for maternity leave. It is not possible to generalize either about all hospital specialties – some, like anaesthetics, radiology, rheumatology, lend themselves to sessional work, while others – surgery, obstetrics – may demand a greater commitment oftime (surgeons are making a positive effort to appoint more women to career posts). Some specialties require 'at least a year's full time training'. It is worth remembering that during training part-timers must do the same type of work, for example, emergency on-call and weekend rotas, as their full-time colleagues. But part-time work as a junior hospital doctor will usually exceed forty hours a week and in any other walk of life would be considered to be at least full time. Note also that the total duration of full-time training, and the hurdles that have to be surmounted, seem to be continually expanding.

For these and other reasons women who want to continue working and have a family might consider general practice as by far the best option. Training is structured in a way that is as yet unheard of in the hospital specialties and can be completed in three years, after which a partnership will provide the necessary freedom. Some women are naturally tempted by the challenges of specialist and academic medicine, and it would be a poor day for the profession if they were to be put off. But general practice is at present the most popular career choice, and one hopes that this has at least something to do with job satisfaction.

If a woman (or man) wishes to train part-time there are two options. The first is the PM(79)3 scheme for doctors with domestic commitments, under which part-time posts at senior house officer (SHO) and registrar grades can be established by health districts but senior registrar posts have to be given manpower approval by the Department of Health and Social Security (DHSS). Any district health authority can seek manpower approval from region and educational approval from the appropriate college for a part-time post at SHO or registrar level but few seem to be aware that this is possible for senior registrar part-time posts. Applications are invited once a year by the end of October for a limited number of posts nationally (probably not more than three or four depending on the specialty). The applicants are vetted by regional postgraduate deans and by doctors at the DHSS, and those considered to be comparable to their full-time colleagues are assessed by a national committee for shortlisting and interview. Successful applicants are usually informed by the end of the year.

Unfortunately that is not the end of the story. Regions vary in their willingness to fund such posts. My own, for instance, expects hard-pressed districts to find the money, and a great deal of time and effort – not always successful – is spent in trying to set up suitable training schemes which in the case of senior registrars (note) they will have up to eight years to complete. Surely it is cruel and sheer hypocrisy to go through all the motions knowing full well that money is unlikely to be available. If a post is created a formal interview has to be set up, and colleges or faculties have to be contacted with the proposed programme in order to give it their approval. The successful applicant, unlike the successful applicant for a full time post, has to appear before two interviewing committees rather than one, as well as the postgraduate dean, and has to wait, often in a queue of other successful candidates while funding for a part-time post is found. It is hard to explain to applicants that the existence of a scheme carries absolutely no guarantee that it will work and that an outstanding applicant will end up in a post. Every unsuccessful

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candidate has to wait a year before there will be another chance of applying whereas wholetimers can apply every time a post is advertised.

A second possibility, especially in large metropolitan areas like London, is job-sharing, slowly gaining ground largely due to the success of the pioneers who often provided substantially more than two halves.[2,3] I know personally people job-sharing in medicine, paediatrics, general practice and obstetrics and no doubt there are others. And although I am talking about training there does not seem to be any overriding reason why it should not continue in consultant posts. A job share register is maintained by the British Medical Association (BMA) for its members[4] and the Royal College of Pathologists has its own scheme.[5] The difficulties are formidable as the chances of there being another part-timer at the same level of training in the same specialty in the same place are small. To succeed in training through job-sharing demonstrates a rare level of enteprise and determination.

A good deal of feminist heat has been generated by plans in *Achieving a Balance*[6] for an intermediate grade of staff doctor. This is seen of course as yet another cul-de-sac for compliant women who want to keep their expertise but are put off the rat race for consultant jobs. It was interesting to hear, therefore, that 66% of women presently in career posts in obstetrics and gynaecology had no intention of seeking a consultant post. The percentage of men was alarmingly high too and it would be useful to know whether there are other specialties with a similar high proportion of unhappy juniors. Data from other specialties would be valuable. It is a pity that entry to the staff doctor grade has been set so low (SHO and registrar) and that the opportunity has not been seized to bring all non-training posts, including clinical assistants and associate specialists, into the grade. In this way a suitable career could have been constructed, with a salary structure geared to increasing seniority, opportunities for continuing education (not mentioned in *Achieving a Balance*), and even the possibility of switching between the two career ladders – staff doctor and consultant. Many women doctors facing the double strain of a young family and a demanding series of junior hospital posts will be tempted to take the short term view and opt for sessions in the staff grade. There must be arrangements to help them return to the consultant training ladder later in their careers.

My advice to women at the beginning of their careers is to work as long as possible full-time and to get specialist examinations out of the way if possible. If you plan to train part-time in hospital practice choose your specialty carefully; medical specialties are difficult on the whole, mainly because of their popularity and competitiveness, surgical specialties because of the on-call commitment needed for experience; psychiatry and geriatrics are expanding; pathology and radiology together with the so-called 'outpatient' specialties, rheumatology, genitourinary medicine and dermatology (the last three all competitive) suit part-time work; and remember community medicine, which tends to be flexible and accommodating in the interests of attracting high calibre recruits. Try and do some research and/or write papers as early in your career as you can: this will help to keep you competitive for the more senior jobs.

What about the future? We tried to get agreement to advertising all senior registrar posts in the North East Thames region as either full-time or part-time as with consultant appointments. The colleges and faculties were not happy and the move was not implemented. If it had been I doubt if appointments committees would have hesitated for one minute when faced with the choice between a full-time (and probably male) and a part-time (and probably female) applicant. And I'm not being sexist. If ever the country and the health service has enough money I would expect the government to fund part-time training centrally and to provide at least part of the costs of having to employ help for those who wish to work full-time. Not every doctor with a need to train part-time is a woman. Men can be landed with domestic commitments because of divorce or death, or if they are partners in a two career marriage. Other countries seem to manage things better; are there lessons to be learnt?

Postcript. While writing this I read a report in *The Times*[7] that the Confederation of British Industry (CBI) is calling on its members to offer working women breaks of up to seven years without damaging career prospects. DHSS please copy.

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