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Editorial

Less Than Full-time Training in surgical specialities: Consensus recommendations for flexible training by the Association of Surgeons in Training



A B S T R A C T

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Changes in lifestyle, career expectations, and working environments, alongside the feminisation of the workforce have resulted in an increased demand for Less Than Full-time Training (LTFT) within surgery. However, provision of and adequacy of flexible training remain variable. It is important that LTFT options are provided to ensure surgery is an attractive and viable career option, and can compete with other specialties to attract and retain the best candidates to maintain high standards of patient care. LTFT options should be readily available to both genders within surgical specialties. Furthermore, improved information for those considering LTFT should be available, locally, regionally and nationally. Training within LTFT posts should be tailored to the training requirements of the individual, in order to achieve the competencies necessary for completion of training. The recommendations set out in this consensus statement should inform the trainee's position and help guide discussions with respect to the provision of LTFT within surgery.

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1. About ASiT

The Association of Surgeons in Training (ASiT) is a professional body and registered charity working to promote excellence in surgical training for the benefit of junior doctors and patients alike. With a membership of over 2700 surgical trainees from all 10 surgical specialties, the Association provides support at both regional and national levels throughout the United Kingdom and Republic of Ireland. Originally founded in 1976, ASiT is independent of the National Health Service (NHS), Surgical Royal Colleges, and specialty associations.

2. Introduction

'Less Than Full-time Training' (LTFT) is medical training undertaken whilst working a reduced number of hours, expressed as a percentage of full time, resulting in a relative lengthening in the

number of years spent training. Concerns have been raised regarding surgical trainees' access to LTFT and the adequacy of training within these LTFT posts in order to achieve competencies and gain adequate experience. Together with changing workforce demographics, including rising numbers of female trainees entering surgery, there is an increasing need to ensure adequate information and provision for flexible training. This consensus statement aims to inform the trainee's position and help guide discussions with postgraduate training organisations in respect to the provision of LTFT within surgical specialties.

3. Background to Less Than Full-time Training

Part-time postgraduate medical training in the United Kingdom was first introduced in the Oxford region in 1966 [1]. Since the Calman reforms and introduction of the specialist registrar grade (residency equivalent), LTFT has been available to doctors in

national training schemes. Since its introduction, there have been increasing numbers of LTFT trainees seen in the UK [2]. LTFT is a gender-neutral concept [3] and LTFT options should be equally accessible to both males and females.

To be eligible for LTFT, current training regulations stipulate that there must be a 'well-founded reason' for not being able to work full-time, either:

- Disability or ill health, or being a carer for children or ill or disabled partner, relative or other dependent, or
- Unique opportunities for personal or professional development (e.g. sporting commitments, academia, quality improvement or leadership roles).

LTFT is usually not less than 50% of full-time training, but can be less (to a minimum of 20% for up to 12 months) if agreed by all interested parties [4,5]. The duration of LTFT is calculated pro rata with full-time training. In the UK, approval for LTFT is organised by the trainee's postgraduate Local Education and Training Boards (LETBs) in agreement with the local Hospital. The funding for a LTFT post is provided by both the postgraduate LETBs (educational component of basic pay) and the local hospital (on-call banding arrangement).

Between 2012 and 2014, there was a rise in the number of LTFT trainees in the UK, from 8.0% (4105/51,316) [6] to 11.3% (6010/53,077) [7]; representing the growing need for LTFT amongst the medical workforce. This trend has also been seen internationally, with evidence to support the increased need for flexible training across Europe [8–10], North America [11–13], Asia [14], Australasia [15–17] and Africa [18].

4. Disparity between increasing number of females in the medical workforce and senior positions

Although relevant to both sexes, flexible training opportunities disproportionately affect female trainees. There are an increasing number of female doctors in the UK, with a rise of 38% since 2001 [19]. In 2012, 43% of GMC registered doctors were female [19], (with 61% under 30 years, 46% 30–50 years, and 28% over 50 years old). However, despite the increasing feminisation of the medical workforce, there is evidence to suggest that female doctors are not taking up senior clinical positions [20–23]. Females account for just under half of registered General Practitioners (GP) [19], yet only one third of Consultant Physicians (Attending equivalent) [24]. Difficulties with flexible working contracts at Consultant level have also been previously reported [25].

Within surgery, 30% of the trainees applying to core surgical training and 16% of those within higher surgical training programmes were female in 2012 [26]. Yet overall only 10% of all consultant surgeons were women [27]; with 11% of consultants in general surgery contrasting with just 5% in trauma and orthopaedics [19]. The picture is similar within the Republic of Ireland, with the lowest proportions of female doctors at the specialist level seen in surgery (10% female) [21].

It is suggested that women choose not to continue with higher surgical training, as this is the peak age for childrearing [26]. However gender discrimination persists within surgical specialties at Consultant level, which may be a contributing factor [28,29], in addition to a shortage of role models [30]. There is evidence to suggest that female medical students feel that a career in general surgery is incompatible with raising children and having a good work-life balance [31]. Furthermore, 12% of newly qualified doctors felt that surgical careers do not welcome women due to difficulty maintaining family life and limited flexible training [32]. As the majority of females in LTFT are women returning to work after having children [33], it would suggest that LTFT is vital for supporting the

growing female surgical workforce.

Insufficient LTFT training opportunities and flexible working arrangement across medicine have been a longstanding problem [34]. The General Medical Council (GMC), in its role as the regulator for doctors' training in the UK, has recommended improved access to flexible training, in agreement with the National Working Group on Women in Medicine [35]. This is to encompass greater support for carers, and those with young children. Similarly, In the Republic of Ireland the Health and Safety Executive (HSE) national flexible training scheme for Higher Specialist Trainees has been launched and is funded and managed by the HSE National Doctors Training and Planning Unit [36]. Increasing emphasis on supporting female doctors, reducing gender differences and promoting a family-friendly working environment is also required [37].

5. Current concerns with Less Than Full-time Training in surgical specialties

5.1. Numbers and availability of posts

Currently, funding for LTFT posts is limited [5]. There are a low number of LTFT posts available within the UK and Republic of Ireland; in 2011, there were only 151 LTFT surgical trainees in the UK [38]. In Ireland, the HSE National Flexible Training Scheme for higher specialist trainees and GP registrars provides supernumerary posts to facilitate LTFT, with a maximum of 24 trainees, across all specialties, in the scheme at any one time [36]. This issue is not unique to the UK and ROI [39–41]. These numbers are likely to become inadequate once the number of female surgical trainees increases, or as a larger number of males seek to pursue LTFT. It has also been reported that surgical trainees find it more difficult to obtain suitable LTFT posts compared to trainees from non-surgical specialties [2]. In addition, posts should be available with a flexible range of % of full-time, based on the individual requirement.

5.2. Lack of information and education on LTFT

Concerns have been raised over a lack of information surrounding access to LTFT posts for surgical trainees, as well as a significant difference between individual LETBs and Royal Colleges. It is also apparent that medical students and junior trainees do not feel that a career in surgery can be combined with family life [31,32,42–44], and there is a lack of awareness that LTFT can be undertaken within surgery.

5.3. Adequacy of training within LTFT posts

There has been concern over the support given to trainees during LTFT surgical posts, in providing and maintaining a balanced timetable to meet the necessary competencies of their training. This has been exacerbated by an overall decrease in training time following the introduction of the European Working Time Directive, which has disproportionately impacted surgical training [45]. The current system supports three ways that LTFT can be incorporated into the system:

- LTFT in a full time training post
- Supernumerary
- Sharing of training post with another Higher Surgical Trainee (slot-sharing).

Slot-sharing is logistically easier for local hospitals to manage but requires that two surgical trainees combine to work the hours of one full time trainee. From a surgical training perspective, slot

sharing has a number of problems:

- There may be no other trainees eligible for LTFT within the same LETBs and specialty making slot-sharing impossible.
- There may be eligible trainees but they have different specialty or operative needs making slot-sharing unsuitable.
- Surgical rotations (particularly for smaller surgical specialties) often cover larger geographical areas making slot-sharing unpractical.

ASiT considers it unacceptable that higher surgical trainees in LTFT should have to share operative training sessions with another higher surgical trainee, as this has an adverse impact on the training experience of both individuals and the competencies gained during that training post.

In terms of duration of training rotations, six-month job placements may be inappropriate for LTFT trainees, as this does not allow the same continuity of supervision and training exposure as their full time colleagues. Related to this, the reduction in continuous contact time may make on-going educational supervision more fragmented for LTFT trainees. The importance of mentoring in surgery and lack of support for this has been previously highlighted by ASiT [46], together with recommendations to address this [47]. Identifying a suitable mentor for LTFT trainees is particularly important given this potential for more fragmented supervision, and other additional difficulties likely to be encountered during LTFT training.

At the time of publication, there is no mechanism for LTFT trainees to record the required number of workplace based assessments (WBAs) on a pro-rata basis within the Intercollegiate Surgical Curriculum Programme (ISCP). Without this, difficulties remain for those LTFT trainees at their Annual Review of Competency Progression (ARCP) meetings, in calculating the minimum number of WBAs required for their progression.

5.4. Undermining and bullying

Concerns have been raised that trainees in LTFT posts may experience undermining or bullying behaviour amongst their colleagues or seniors. There is also evidence to suggest that trainees' choose not to pursue LTFT due to fear of discrimination [21]. ASiT feels strongly that any form of undermining, bullying or harassment has no place within modern surgical training and is unacceptable.

6. Recommendations

Based on the results of ASiT's previous trainee survey [48], ASiT have worked to make the following recommendations for LTFT training in surgical specialties. The resulting statements represent a consensus opinion following extensive discussion and ratification by the ASiT Council. This action list details factors that would facilitate, support and encourage high quality LTFT training in surgery. LTFT opportunities must be equally accessible for both men and women.

1. Clearer visible leadership on, and promotion of, LTFT should be provided by bodies responsible for overseeing surgical training in order to drive a positive culture change in surgery on this issue. These include the Royal Surgical Colleges, specialty associations and training bodies such as the Joint Committee on Surgical Training (JCST) and Specialist Advisory Committee's. This should involve clearer national guidance, and actively promoting those who have successfully navigated LTFT in order to provide clear and visible role models, share experience, and create greater openness.

2. There should be increased facilitated provision and funding for LTFT posts in surgery, across all specialties, in all post-graduate LETBs. This is essential to accommodate the changing workforce and help support trainees with other commitments such as young children or outstanding achievement roles. This is important to prevent loss of high-calibre graduates from surgery who are highly skilled but for various reasons cannot undertake a full-time commitment.
3. Options for undertaking LTFT should be readily accessible to trainees within each LETB, and Training Program Directors (TPDs) should be transparent with trainees if there have been significant difficulties in approving LTFT slots in the past so that modifications and alternatives can be considered. Historic difficulties with arranging LTFT, however, should not preclude continued attempts to make such opportunities available.
4. Trainees considering LTFT following maternity leave should ideally inform their Training Programme Director by the 25th week of pregnancy. This would facilitate an adequate period of consultation regarding options on behalf of both parties.
5. Given wide variation in the length of time required to approve a LTFT post, trainees should be made aware of this in order to inform their extracurricular activities e.g. sporting commitments or childcare.
6. Information should be readily available locally, regionally and nationally for all surgical trainees wishing to or considering applying for LTFT. Individual LETBs and Schools of Surgery should outline basic information including eligibility criteria and the application process as well as offering a point of contact for advice on their websites. Royal Surgical Colleges should provide detailed information and guidance for both trainees and training programmes on their websites.
7. On a practical basis, appointing a LTFT adviser within each School of Surgery could assist with on-going challenges and acting as an advocate for this and LTFT trainees. This person would act as a point of contact for all parties and build a body of knowledge. With such small numbers of LTFT trainees in surgery currently, accumulating experiences and resources will help support future trainees and trainers facing common difficulties regarding applications and logistics.
8. Proactive education and encouragement should be provided via both undergraduate and postgraduate training schemes to medical students, junior trainees and senior clinicians to make them aware that LTFT can be compatible with surgical training. This is particularly important for the wider surgical profession in light of falling application ratios for surgical training.
9. The ARCP Panel should support surgical trainees' in LTFT posts and help them meet their individual learning needs by developing a suitable training timetable.
10. At least annually, and 3 months prior to moving up a career grade, LETBs should arrange an ARCP, regardless of whether this is out of synchronisation with other surgical trainees, to ensure learning objectives are being met.
11. Higher surgical trainees in LTFT should not share operative training sessions with another higher surgical trainee.
12. LTFT trainees should remain in a rotation for at least the equivalent of six months based on the percentage of full time worked in order to ensure equivalent continuity in training experiences.
13. Whilst ASiT recognises the need for job placements to be determined based on the skills, knowledge and competencies required for that individual, considerations should be made by TPDs for those choosing LTFT for health or carer reasons when allocating job rotations.

14. The number of required WBAs should be completed pro-rata according to the percentage of LTFT worked. It is desirable that ISCP should display the required criteria according to the percentage of full-time worked.
15. Time limits in place for completion of the intercollegiate MRCS and FRCS examination or application for national selection for specialist training appointment should remain on a pro-rata basis for LTFT trainees. These should be clearly communicated to trainees.
16. As professionals, surgical trainees have the right to feel valued and safe in the workplace, and are encouraged to raise concerns to either their educational supervisor, surgical college tutor, or training programme director if undermining or bullying behaviour exists.
17. LTFT trainees should be offered a suitable mentor with knowledge or experience of LTFT training in order to help advise them and provide ongoing support. This individual should be supported and resourced by their hospital and training region in order to provide impartial advice for those considering, or currently undertaking, LTFT. This might additionally facilitate the development of regional networks of peers and senior surgeons with experience in this area.
18. Logistical support from hospital human resource departments should be improved, with greater knowledge and awareness of LTFT. This includes improved administration of this and appropriate and timely salary adjustments.

7. Conclusions

Despite an increasing demand for LTFT within surgical specialities, provision of and adequacy of training within LTFT remains variable. LTFT should be readily available to both men and women within surgery, and improved information for those considering LTFT should be available, both regionally and nationally. Training within LTFT posts should be tailored to the training requirements of the individual, in order to achieve their competencies for CCT. The recommendations set out in this consensus statement should inform the trainee's position and help guide discussions with respect to the provision of LTFT within surgical specialities.

Conflict of interest

The authors are current surgical trainees and current elected members of the Council of the Association of Surgeons in Training. The authors have no other relevant financial or personal conflicts of interest to declare in relation to this paper.

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Glossary

ARCP: Annual Review of Competency Progression
 ASiT: Association of Surgeons in Training
 CCT: Certificate of Completion of Training
 DOH: Department of Health
 FRCS: Fellowship of the Royal College of Surgeons
 GMC: General Medical Council
 HSE: Health and Safety Executive
 ISCP: Intercollegiate Surgical Curriculum Programme
 LETBs: Local Education and Training Boards
 LTFT: Less than full-time training
 NHS: National Health Service
 TPD: Training Programme Director
 WBAs: Work-Based Assessments

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