Women in Healthcare Blog

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A few years ago I directed a one day conference at the Royal College of Physicians (London), on behalf of the then Intercollegiate Improving Working Lives Committee, now called the Academy of Royal Colleges' Flexible Training and Working Committee. The conference had as its title and focus, 'Part Time Working: Full Time Professionalism' and emphasised the need for recognition that current social and cultural pressures means that women doctors still carry the major burden of care for their children and elders, and often necessitates periods of working, outside the home, that is less than full time. Their choice to work 'part-time' is not a true choice, but one that is influenced by external pressures, overt and covert.

The small business model of current GP practices allows profit-sharing partners to set their own conditions of work, while demand and shortages have led to the 700% increase in salaried GP posts over the past 10 years, many less than full time. So it is not surprising that women have grasped such opportunities to fulfil all their roles and will in the near future become the majority engaged in this branch of the profession. Salaried GPs sacrifice salary (they are paid much less both in absolute and pro-rata terms), in return for time to meet other obligations. Nevertheless, these are medical professionals, committed to their responsibilities as doctors.

Recent parliamentary pronouncements suggested that part-time women doctors are the source of the current NHS problems in providing sufficient out of hours and emergency care. This is of course nonsensical. Poor long term vision and planning of service needs are the problem, and it is bad propaganda to suggest that the intelligence, diligence and excellence in clinical practice of women should be discounted, if not delivered in a working week of 48hours (the European Working Time Directive). Women doctors not only deliver service, but also recognise their patients' perspectives and priorities which reflect their own.

Another worry at the moment is difficulty in recruiting doctors to work in Emergency and Acute Medicine. The junior trainees see both registrars (more senior trainees) and consultants who seem exhausted and disillusioned by these specialties. It is no wonder that with few vibrant role models, they are shying away from these areas. The nature of such work, with not only triage but also exciting and interesting diagnostic challenges at its heart, means it is tiring to do continuously, week after week, even in shifts. However, that relatively fast patient turnover, means that continuity over more than a week is rarely necessary and so these posts are ripe to be developed as part of a portfolio of contributions. These may see an individual doctor delivering care in a number of hospital and community sectors, e.g. acute care, chronic conditions management, general practice, specialist investigations such as endoscopy, NHS management and even less than full time working. Development of a professional portfolio brings new experiences, at different times, in a lifetime of work, discourages drop out and burn out and will be to the advantage of healthcare providers, patients and doctors. It is time to mainstream portfolio working, and stop referring to part-time.

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