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A Study of Consultant Attitudes to NCHD Less-Than-Full-Time (LTFT) Training

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Abstract

Aims

Less-than-full-time (LTFT) training is increasing in availability and flexibility. Negative perceptions by consultants is a concern. This study aims to ascertain the attitudes of consultants to LTFT training and determine potential barriers to LTFT training.

Methods

A prospective cohort questionnaire-based study was designed with mixed qualitative and quantitative methodology. It was distributed to consultants in a tertiary paediatric hospital. The main outcome measures were likelihood of negative perceptions of LTFT NCHDs, and perceived advantages and disadvantages of LTFT training.

Results

35.4% had worked LTFT, and 40.5% (*n*=17) of those who hadn't had considered or were currently considering it. Most respondents did not have a negative perception of LTFT NCHDs (84.6%). Work-life balance, reduction of burnout, and being fully committed were perceived advantages of LTFT training to NCHDs. Advantages to the team were energy, staffing, and productivity. Disadvantages to the NCHD were training duration, involvement in clinical activities, and negative perceptions. Disadvantages to the team were continuity, roster planning, and workload distribution.

Conclusion

Consultant perceptions of LTFT trainees are positive. There are common themes in the perceived impact of LTFT training that must be explored to maximise the success of this training pathway.

Introduction

Less-than-full-time (LTFT) training is defined as "any arrangement with reduced working hours for doctors, as arranged with an employer".[1] LTFT training in medicine is increasing in popularity, although this varies with geographic location and medical specialty; a study of trainees and consultants in the UK showed that 42% of women and only 7% of men worked LTFT.[2,3]

Potential advantages to LTFT training include work-life balance and reduced burnout, and the annual National Trainee Survey shows that self-reported training quality is higher in LTFT trainees.[4,5] However negative perceptions by senior colleagues are a barrier.[6] LTFT champions have been proposed to combat negative perceptions and stigma, and may have a positive impact on trainee experience.[5] Impact of LTFT training on career progression is unclear, with studies showing lower academic scores for LTFT trainees, but others showing higher rates of consultant appointment.[4,7]

Research on attitudes to LTFT training in Ireland is sparse. The aim of this study is to ascertain the attitudes of consultants from a range of different specialties in a tertiary paediatric centre to LTFT training, and to determine the potential barriers to LTFT training based on these attitudes.

Methods

This study was a prospective cohort questionnaire-based study. A mixed method qualitative and quantitative approach was used. The study population was all consultants (*n*=128) working in Children's Health Ireland at Temple Street, a tertiary paediatric hospital in Dublin, Ireland. The specialty groups included are shown in figure 1.

A novel 11-item questionnaire survey was developed based on the previously published literature and a recent unpublished survey about attitudes to LTFT training among paediatric trainees.[8-10] A combination of multiple choice questions (*n*=6), Likert 5-point scales (*n*=2), and free text items (*n*=3) were included. The anonymous survey was developed through the Survey Monkey application and distributed by email to all consultants between September and October 2020.

Results

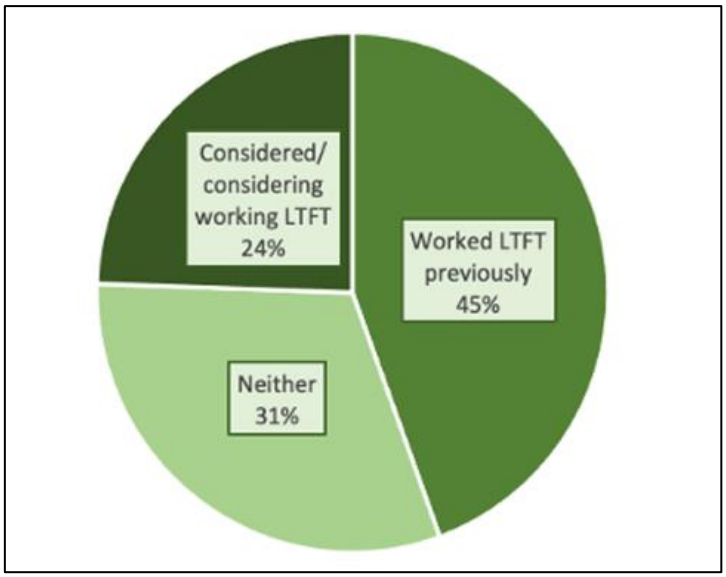
Demographics

65 responses were received, giving a response rate of 50.8%. Most respondents (71%, *n*=46) were female from a population of 56% (*n*=72) female consultants; 3.1% (*n*=2) chose not to specify their gender and 26.2% (*n*=17) were male. The 2 respondents who did not identify their gender were included in all analyses except subgroup analysis by gender. Response rates varied by specialty: General paediatrics (85.7%), paediatric intensive care medicine (83.3%), radiology (75%), laboratory-based specialties (66.7%), paediatric medical subspecialties (57.5%), paediatric emergency medicine (50%), psychiatry (50%), anaesthesiology (38.5%), surgical specialties (19.2%), ophthalmology (0%). Specialties with more female consultants had higher response rates.

Experience with LTFT training

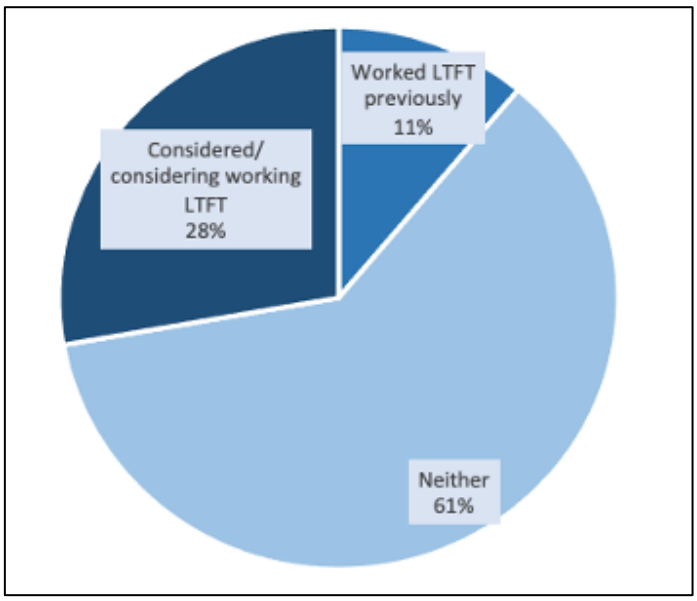
Over half of respondents (52.3%, *n*=34) had worked with a colleague who was working LTFT at some point in their career. 35.4% (*n*=23) had worked LTFT themselves, either as a consultant (30.8%, *n*=20) or as an NCHD (10.8%, *n*=7). A large proportion (40.5%, *n*=17) of those who had never worked LTFT had considered or were currently considering it.

Figure 1: Female consultant experience with working LTFT.



When subgroups were analysed by gender, more female consultants than male consultants had worked LTFT, but a similar percentage of each gender were or are considering it, as shown in figures 1 and 2.

Figure 2: Male consultant experience with working LTFT.



Knowledge about LTFT training in Ireland

Most respondents (72.3%, *n*=47) were aware of job sharing as a LTFT option for trainees in Ireland, and 72.3% were aware of the supernumerary flexible training scheme. 1 respondent was not aware of any options.

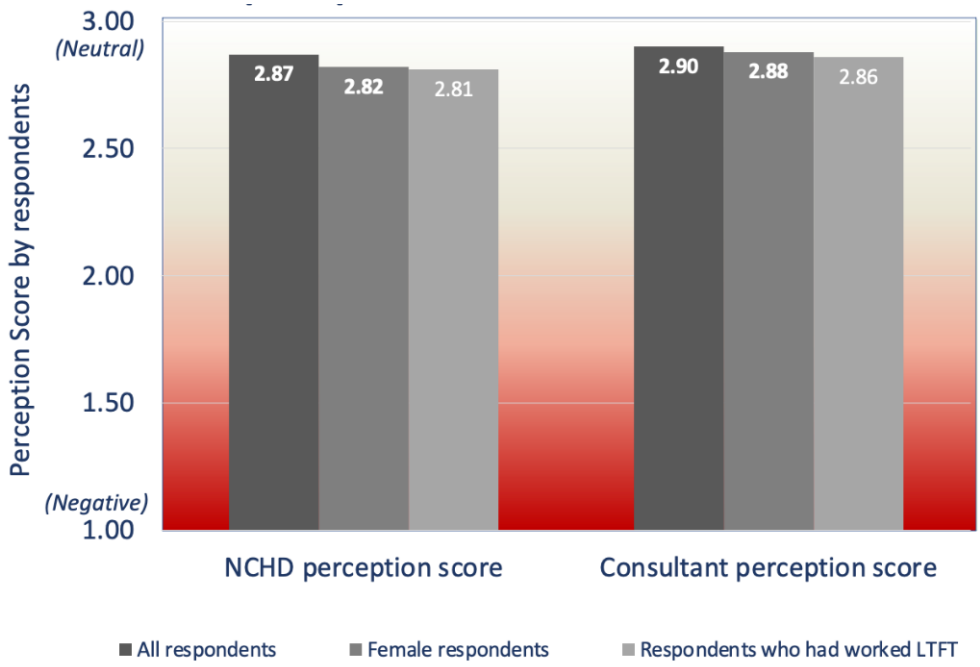
Acceptability of LTFT training to consultants

All respondents felt that being a mother was an acceptable reason for an NCHD to choose LTFT training, and 95.4% (*n*=62) felt that fatherhood was an acceptable reason. Most (98.5%, *n*=64) felt that a physical health issue was an acceptable reason, and 95.4% (*n*=62) for a mental health issue. Most (92.3%, *n*=60) felt working LTFT to accommodate other educational commitments was acceptable. Overall, 81.5% (*n*=53) felt that no justification was required.

Negative perceptions to LTFT trainees

Most respondents stated that an NCHD's or consultant's choice to work LTFT would not negatively influence their perception of that doctor (84.6% and 89.2% respectively). The mean score on attitudes to an NCHD working LTFT was 2.87, with 1 being negative, 2 being neutral, and 3 being positive. The mean score on attitude to a consultant working LTFT was 2.9. Some respondents felt that they may negatively perceive an NCHD or consultant that was working LTFT (9.2% and 7.7% respectively). It was noted that attitude scores from female respondents and respondents who had worked LTFT were lower (i.e. more negative) than for the total cohort, shown in figure 3.

Figure 3: Impact of LTFT training on respondents' perception of NCHDs and Consultants.



Perceived advantages and disadvantages of LTFT training

Thematic analysis of the perceived advantages and disadvantages of LTFT training for the NCHD and for the clinical team revealed a number of key themes. These are demonstrated in figure 4.

Figure 4: Thematic analysis of perceived advantages and disadvantages of LTFT training on NCHDs and the clinical team.

Advantages of LTFT training to the NCHD	
Maintaining work-life balance (38/65 respondents)	"They can pace their career with the rest of their life" "More flexible working patterns to suit their home life needs"
Being rested, with less risk of burnout (26/65 resoindents)	"It gives you mental headspace" "NCHDs would be less stressed and more refreshed"
More well-rounded (10/65 respondents)	"They have the maturity to get out of rat race"
Development of a specific career advantage (10/65 respondents)	"Potential for prolonged placement can allow trainee gain a greater understanding of a specialty" "They have more time to focus on research and papers"
Being fully committed when at work (9/65 respondents)	"They can be more engaged when at work" "They can fully participate in all activities on their work days"

Advantages of LTFT training to the clinical team	
Less fatigue and more enthusiasm (21/65 respondents)	"They would be a safer doctor because they would be less fatigued" "Everyone benefits from a happy enthusiastic trainee"
Extra staff (13/65 respondents)	"They are often supernumerary and have a special interest in the area"
Increased productivity (10/65 resondents)	"LTFT trainees can be more creative and generally more productive" "Part-time workers are more efficient"

Disadvantages of LTFT training to the NCHD	
Prolonged duration of training (31/65 respondents)	"It lengthens an already long road in training"
Less involved in clinical/non-clincial activities (17/65 respondents)	"You miss out on meetings and decision making" "Less time with the team"
Negative impact on clinical accumen (10/65 respondents)	"It can negatively affect skills and confidence in early training years" "Their clinical skills suffer as they do not see the cases through"
Reduced career opportunities (9/65 respondents)	"LTFT may affect their ability to be given the post they want"
Negative perceptions from consultants (7/65 respondents)	"There is still a culture of part-time not being understood or accepted". "Shame and weakness may be perceived by others"

Disadvantages of LTFT training to the clinical team	
Reduced continuity of care (31/65 respondents)	"Continuity of care can be difficult to achieve" "More time needs to be spent on handover"
Difficulties with roster planning (11/65 respondents)	"The service must be adequately staffed in their absence, but this is not the case in Ireland" "Timetabling needs to fit in with how the team works"
Disruption to team dynamic (7/65 respondents)	"The team do not get to know the person as well" "Resentment from full time colleagues can become an issue"
Uneven workload distribution (6/65 respondents)	"Sometimes there is less ownership of administrative work"

Discussion

The results of this study show that there is demand among consultants across all specialties in paediatrics to consider working LTFT.

While all respondents felt that motherhood was an appropriate reason for an NCHD to work LTFT, there is ongoing evidence of gender-based stereotypes in with regard to the acceptability of fathers working LTFT, as well as those with mental health issues. Research and media publications on promoting mental healthcare equity and addressing mental health issues among medical professionals show there is public interest in this area.[11,12] A focus on addressing mental health inequity in medical schools is welcome and should be adopted across Ireland.[13] A Recent epidemiological study by Lien et al shows an improvement in the understanding and acceptability of mental health issues over time, but that more work is required.[14] This finding may be interpreted as an example of societal discrimination against people with mental health issues, a lack of understanding about mental health issues; indirect discrimination against groups of trainees more likely to choose LTFT training cannot be overlooked, as has been raised in previous research.[15]

Perceived advantages to NCHDs of LTFT training from this study are in keeping with previous research with the exception of career advantages which are not previously described. The themes of work-life balance and reduced burnout in particular have an indirect impact on medical workforce retention. LTFT training has been proposed as a viable method to increase workforce retention by multiple authors based on surveys and NCHD feedback.[16] In the UK's Gold Guide, LTFT training features prominently, with the aim of retaining doctors, promoting work-life balance, and maintaining a balance between training requirements and service provision.[17] To date, Irish medical workforce planning literature has not placed such importance on LTFT training; in the '*Review of Emergency Medicine Medical Workforce in Ireland 2017*', the percentages of doctors in emergency medicine working LTFT was noted (1% of trainee specialists and 8% of general division doctors), but LTFT expansion does not feature prominently in the report.[18]

Potential disadvantages included concerns about leaving the job early/not doing their share of the work, but this may not be supported by the literature. The manner in which clinical competencies and clinical experience are gained and the impact of LTFT training on this can be looked at for answers; Clinical competencies and clinical experience are gained through time, training, simulation, and clinical exposure over time. The role of the trainers and training sites as well as the training bodies in providing for and ensuring acquisition of these competencies must not be understated, and training bodies must address this by developing guidance for trainers regarding the expectations of the training bodies about LTFT trainees. Thus, with an appropriately scheduled roster for LTFT trainees, and with a dedicated trainer overseeing the trainee's learning, there is no objective reason why LTFT trainees cannot gain clinincal competencies on a pro rata basis. For some sites and specialties, the day-to-day clincal exposure may vary, and key learning experiences may be scheduled for certain days of the week only.

One measure to address this potential barrier to gaining clinical competencies and exposure would be to invert the trainee's timetable half way through the rotation, or to make other site-specific changes to ensure that the trainee gains the pro rata amount of clinical competencies and experience as their full time colleagues. The key is that scheduling of LTFT trainee working hours must be approached in a collaborative way with the needs of the trainee and the team both taken into account. Creative approaches to roster planning are required.

De Jong et al found that part time specialists do more hours and more out-of-hour shifts per FTE than their full-time counterparts, with the difference being greatest among surgeons.[19] This also raises issues with the practicality of the role, as the reasons why the specialists were working more hours is unclear. Regarding negative perceptions from senior colleagues, the reasons for this negative perception from a small number of consultants requires further study. Interestingly, consultants who had first-hand experience of working LTFT had a more negative view of LTFT NCHDs and consultants. Reasons for this are unclear, and it is in contrast to other studies.[20] The perception of discrimination in LTFT employment in medicine has previously been found to be weighted against women; Lack of access to part time careers has been described as a form of gender discrimination by Lugtenberg et al. due to the known substantially higher demand for it among female doctors.[21]

The generational pattern of attitudes to LTFT training noted by previous authors was not replicated in this study, although the number of respondents at either end of the spectrum is a limiting factor.[22] Attitude scores for consultants qualified as doctors for <10 years (*n*=1) were 1 for both, for those qualified 11-20 years were 2.97 and 2.93, 21-30 years were 2.8 and 2.92, and for those qualified >31 years (*n*=6) were 3 for both.

The impact of LTFT training on the team are noteworthy, as there is a paucity of evidence about this topic. Continuity of care, roster planning, workload distribution and team dynamic were discussed, but consultants also reported perceived benefits including increased productivity, reduced fatigue and increased enthusiasm, and extra staffing. Previous research has found that part time employment was superior to taking leave of absence in relation to long term career prospects and long term salary growth, and is therefore a key factor to consider in the planning of medical recruitment and retention.[23] Regarding continuity of care, the issue is multifaceted, as it relates both to the workings of the team and to the quality of care provided to the patient. It is unclear which factor is of the most concern to participants in this study, and further research is required to explore this concern and to develop strategies to address this. Clinical handover has the potential to mitigate most team-based continuity of care issues. The issue of the quality of care provided to patients, the learning experience of working with a patient on consecutive days, and the overall impact on education and training is worth considering in the context of LTFT training. More frequent change of trainees on a daily basis has the potential to negatively affect patient and team perceptions of the service provided. However, the longer duration of time that LTFT trainees spend at each training site has the potenital to have a positive impact on patient and staff relationships both in the core medical team and with all involved health and social care professionals.

Regarding the management of LTFT trainees, it must be recognised that training bodies, HR departments, trainers, and hospital management each play a role in the management of LTFT trainees. Clear guidance is needed to inform and educate key stakeholders about the expectations that training bodies place upon them when working with a LTFT trainee. Online logbook requirements should be modified for LTFT trainees to reflect the pro rata requirements expected of them. Incorporation of the LTFT training pathway into the Train-the-Trainer courses run by training bodies may be beneficial and educational. On an individual support level, the model of site-specific 'LTFT champions' may play a role in providing practical support and advocacy for LTFT trainees as individuals and as a group; this model has been used with success in the UK.

Subgroup analysis by specialty was not performed in this study due to small numbers. Previous research has demonstrated significant inter-speciality rates of LTFT training.[2,6,15] Selection bias is likely to be a limiting factor in this study, as is the trend with previous surveys on the topic of LTFT training; in the research by Hoesli et al, female respondents and LTFT respondents were disproportionately more likely to answer the survey.[7] Eysenbach's analysis of the quality of web-based survey data defines the 'volunteer effect', whereby self-selection of participants can lead to sample bias, which can be noted from the disproportionate number of female and medical specialty respondents, and the lack of surgical consultant and older/younger consultant responses. Response rate was comparable to other studies.[7,15,19,20,24,25] Questionnaire-specific bias was limited in this survey-based research through careful preparation of questions, formatting of the questionnaire, and careful interpretation of data.[8]

Overall, it is clear that in this Irish tertiary paediatric hospital, consultants have a moderate amount of experience with LTFT training and have some concerns about the disadvantages of this style of training. Female trainees in paediatrics are increasing, and with this the need to address the gap in LTFT training availability and efficacy must be addressed. Key recommendations of this study are that further research is required to explore the reasons for negative perceptions of NCHDs and consultants working LTFT; Roster guidance should be developed with a creative and easily-modifiable template for roster-makers, HR departments, and LTFT trainees alike; A focus on clinical handover, with specific instruction to LTFT trainees, should be developed; More NCHDs should be encouraged to work LTFT, and more places provided and funded to allow this; A steering group is required to guide this process and to make continuous changes as the process evolves, including further research into the naming of this style of training; and training bodies should produce a guide for trainees and trainers to clarify the rights and responsibilities of both parties during LTFT training.

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Declaration of Conflicts of Interest:
The authors have no conflicts of interest to declare.

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