

# **Pregnancy, maternity leave and less than full-time training during surgical training**

*A statement from*



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*Written On behalf of the ASiT Executive and Council*

## 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 specialities, 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. Governed by an elected Executive and Council, the association is run by trainees for trainees.*

## **I. Introduction**

- 1.1 This statement discusses the issues surrounding pregnancy, maternity leave and provision of less than full-time training (LTFT) within surgical specialities.
- 1.2 Concerns have been raised by surgical trainees that reliable advice regarding working during pregnancy is difficult to find.
- 1.3 Concerns have been raised by Opportunities in Surgery, RCSEng regarding surgical trainees' access to LTFT and adequacy of training within these LTFT posts in order to achieve competencies and gain adequate experience.
- 1.4 The resulting position statement represents the consensus opinion following discussion and ratification by ASiT Council.
- 1.5 We hope this document will inform with regards to the trainee's position and help guide discussions with respect to pregnancy, maternity leave and the provision of LTFT within surgical specialities.

## **2. Pregnancy issues and Maternity Leave during Surgical Training within the UK**

- 2.1 Although there are no legal requirements for employees to tell their employers that they are pregnant, it should be borne in mind that employers are not required to take any specific action until written notification has been provided. In order to take maternity leave and pay, employees must inform their employer by the 15th week before their due date. [1-2] If employees are unwell during their first trimester and are likely to require some flexibility in attending sessions, it is best to inform seniors earlier. This is not only acting responsibly for the care of your patients; it will also maintain your reputation as a reliable colleague. Inform the most senior clinical line manager first and in person is most appropriate. The remainder of the people you may wish to inform (*Appendix 1*) can be told via email. It is usual to inform other bodies by letter at any stage after your 20 week appointment (*Appendix 2*) with your obstetrician, because your expected date of delivery will be calculated from the information gleaned during the fetal anomaly scan. You may be asked to produce your Mat BI form, which is a certificate confirming

your expected date of delivery that is signed by your general practitioner (GP) or obstetrician.

2.2 Maternity pay and leave entitlements are calculated on the basis of the conditions during the qualifying week, which is the post you are in during the 15th week before your due date [1]. Annual leave, and in some cases statutory leave, will continue to accrue during maternity leave, and most trainees find it easiest to take pro rata leave at the start and end of this period. Study leave entitlements during maternity leave vary between regions and need to be agreed with your educational supervisor and postgraduate LETBs in advance. Employees can work up to 10 days during their maternity, adoption or additional paternity leave. These days are called 'keeping in touch days'. Keeping in touch days are optional, both the employee and employer need to agree to them, but it is usual that the employee is paid for this time, in effect 'extending' maternity leave by a further 10 days. Most surgical trainees have used these to attend teaching, conferences or courses, or they can be used to attend a number of supervised clinical sessions in advance of their return to work date. During such sessions, the trainee would be supernumerary, and this should be utilised to gain confidence and negotiate the logistics of co-ordinating childcare with clinical work. It is also an opportunity to accumulate some work-based assessments. The type of work and pay employees get should be agreed before they come into work. The employee's right to maternity, adoption or additional paternity leave and pay isn't affected by taking keeping in touch days.

2.3 Pay varies quite substantially throughout a period of maternity leave, equating to full pay for the first 8 weeks, half pay plus Statutory Maternity Pay (SMP) for the next 16 weeks, then SMP for the following 12 weeks, then nothing for the last 12 weeks [1]. This means that in total, the trainee is entitled to 52 weeks of maternity leave, and will attract approximately 40% of the salary that they would normally expect in that time period. Student loan repayments and superannuation continue to be taken up until pay drops below the threshold, so financially it can be a stretching time. Also if the qualifying week occurs in a post that is unbanded, since your maternity pay is calculated on this amount, it may be even less than anticipated. It is possible

to ask the Salaries and Wages department of the employing hospital to average payments over a longer time period to help with budgeting, but is often a contributing factor to trainees returning to work after a 6 month period of maternity leave.

- 2.4 The GMC, BMA, ISCP and the medical defence societies give a discount for a period of maternity leave, but all need to be contacted in advance.
- 2.5 Although pregnancy is not an illness, there may be instances when you are not able to fulfil your duties, either as a result of pregnancy related ill health or because working conditions exacerbate the expected symptoms of pregnancy. The Health and Safety Executive recommends that a risk assessment should be undertaken by employers when they become aware of a woman's pregnancy [3]. This should take account of individual risks that may be present in the workplace. Employers should take steps to minimise the effect of these risks on the health of mother and baby; if these risks cannot be ameliorated, the employee should be suspended on full pay. If the latter is the case, your GP should issue you with a Med3, a form that documents the nature of the medical problem stopping you from working, which will be required by your employer. This, however, does not universally occur and it becomes the responsibility of the trainee to liaise with their GP, midwife, or obstetrician, and for their employer to modify working conditions as necessary.
- 2.6 There is no guidance on when to stop out of hours work; this is a personal decision that is dependent on the nature of your duties. There is some evidence to suggest that heavy shift working can result in preterm birth, hypertension, and pre-eclampsia, but these studies relate mainly to manual workers and the relevance of their findings to surgical trainees is questionable [4]. The Health and Safety Executive advises that some particular working conditions may influence the ability of a pregnant person to continue to work safely (*Appendix 3*) [3]. The BMA guidance for on-call shifts states that, if the employee or her child would be at risk by continuing and she can do the rest of her normal job, she would not be expected to continue with on-call shifts [2].

- 2.7 For those surgical trainees who experience radiation exposure, effective radiation dose to the fetus is low if you wear a lead gown. Employers must ensure that working conditions do not expose beyond 1mSv for the remainder of the pregnancy, and should be discussed during your risk assessment [5].
- 2.8 Trainees are entitled to time off to attend antenatal appointments, parentcraft or antenatal classes. It is suggested that you plan well in advance and arrange with your rota coordinator to be free (*Appendix 4*).
- 2.9 While the trainee is not under any obligation to inform the employer of their intended date of return to work prior to taking a period of maternity leave, in an environment of open discussion and planning, both the trainee and the Local Education and Training Boards (LETBs) can benefit. If a trainee feels supported with a realistic time frame to return to a manageable post, there are less likely to be difficulties with unplanned extension of maternity leave, career breaks and sick leave. Such absences cause administrative and workforce issues for the LETBs, as well as disrupting the continuity and quality of training.

### **3. Pregnancy issues and Maternity Leave during Surgical Training in the Republic of Ireland**

- 3.1 Many of the issues regarding pregnancy and maternity leave are common to trainees in the UK and ROI, but there are some differences in entitlements due to differences in legislation and health service administration. This section summarises the ROI entitlements and requirements.
- 3.2 In order to take maternity leave, the Health Service Executive guidelines state that the employee must notify their Department Head at least 4 weeks before the maternity leave is due to begin [6].
- 3.3 Similar to the UK, it is best to inform senior colleagues earlier if a trainee is unwell in the first trimester and likely to require some flexibility in attending sessions. This is important for patient care and to be a reliable colleague, although it is not a legislative requirement in Ireland either.
- 3.4 The precise dates when maternity leave is commenced and finished is decided by the trainee. It is best to plan this in advance with your department head

and to give the HR department adequate notice. Under the Maternity Protection (Amendment) Act 2004, the pregnant employee must take a minimum of two weeks leave before the expected week of childbirth, and a minimum of four weeks leave at the end of the expected week of confinement [6,7,8].

- 3.5 Employees are entitled to 26 weeks of paid maternity leave. Employees can take up to 16 additional weeks of unpaid maternity leave [6]. If a stillbirth occurs after the 24th week of pregnancy, the trainee is entitled to 26 weeks of paid maternity leave [6].
- 3.6 Maternity pay involves full basic pay plus normal fixed allowances. This does not include allowances for overtime pay, working unsociable hours, nightwork, shiftwork or call [6].
- 3.7 During maternity leave the trainee is regarded as if she is in work for the purposes of annual leave entitlement, incremental credit etc. During additional maternity leave the same applies except the right to remuneration and superannuation.
- 3.8 Payment for maternity leave is dependent on the employee firstly applying for maternity benefit within the required time limits (a minimum of 4 weeks prior to commencing maternity leave) and signing the relevant form [6].
- 3.9 Application for additional unpaid maternity leave must be made at the time of the initial application for maternity leave, or at least 4 weeks before the scheduled end of maternity leave [6]. Although not a requirement to inform your department head earlier than this, it is always best to inform your department head as soon as possible to facilitate the department finding suitable cover.
- 3.10 The temporary contracts of Non Consultant Hospital Doctors (NCHD's) mean that a trainee may not be due to return to the same job following maternity leave. However, NCHD's are entitled to have their maternity leave paid in full by the employer that they were employed by at the time of commencement of maternity leave, even if their contract expires prior to the end of their maternity leave [6].
- 3.11 Under the Health and Safety Regulations, 2007, Employers are required to assess the safety of the workplace for trainees who are pregnant, post

childbirth or breastfeeding and take measures to avoid risk where a risk is identified. This may involve assigning employees to alternative duties, or placing them on health and safety leave [6,9].

- 3.12 With regard to hours and night duty, there are no requirements not to roster pregnant trainees on night unless a doctor has certified that night duty poses a risk to the employee. If a doctor has certified that night duty poses a risk to the employee, they must be removed from night duty during pregnancy and the first 14 weeks following childbirth, and transferred to daytime duties or given leave [6,9]. Night work is defined as between 11pm and 6am [9].
- 3.13 In general, time taken as maternity leave does not count towards training and must be added on to total training time. However, according to the JCST, SAC's have the discretion to allow up to 3 months of exceptional leave which does not need to be paid back to a trainee during higher surgical training, which may include 3 months of maternity leave [10].

## 4. Less than Full-time Training

- 4.1 LTFT is training undertaken whilst working a reduced number of hours, expressed as a percentage of full time; thus resulting in a relative lengthening in the number of years spent training.
- 4.2 LTFT is usually no 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 [11].
- 4.3 To be eligible for LTFT 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.
- 4.4 LTFT is a gender neutral concept and LTFT options should be equally accessible to both males and females.
- 4.5 Approval for LTFT is given by the Trainee's Postgraduate LETBs in agreement with the Local Hospital Trust.
- 4.6 Funding for LTFT posts is provided by the Postgraduate LETBs (educational component of basic pay) and the local hospital Trust (on-call banding

arrangement).

4.7 Funding for LTFT posts is limited [12].

## 5. Current Issues Regarding Less Than Full-time Training

5.1 In 2011 there were 151 LTFT surgical trainees in the UK [13].

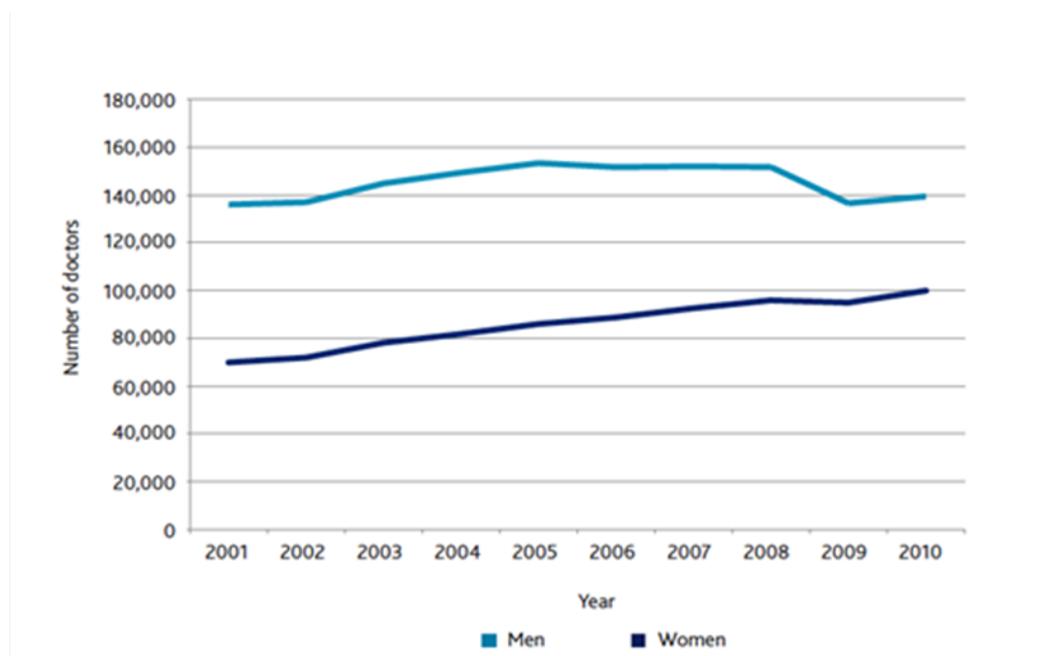
**Figure 1. Numbers of LTFT trainees in surgical specialties (DOH, 2011)**

<b>Specialty</b>	<b>Trainees</b>
Core Surgical Training	4
General Surgery	65
Neurosurgery	14
Oral & Maxillo-facial Surgery	1
Orthopaedic & Trauma Surgery	14
Otolaryngology (ENT)	17
Paediatric Surgery	10
Plastic Surgery	11
Urology	15
<b>TOTAL</b>	<b>151</b>

5.2 The majority of those currently in LTFT (95%) in the UK are female trainees [14].

5.3 There are an increasing number of female doctors in the UK, with a rise of 37% since 2001. In 2010, 42% of GMC registered doctors were female [15].

**Figure 2. Number of Doctors on the GMC Register by gender 2001-2010**



- 5.4 It has been shown that female doctors are not taking up senior clinical positions despite increasing numbers [16]. Within surgery in 2012, 30% of the trainees applying to core surgical training were female. For higher surgical training, 16% of the trainees were female [17]. In 2010 only 10% of consultant surgeons were women [18].
- 5.5 It is suggested that women choose not to continue with higher surgical training as this is the peak age for childrearing [17].
- 5.6 As the majority of females in LTFT are women returning to work after having children [14], it would suggest that LTFT is vital to maintaining the inevitably increasing female surgical workforce.
- 5.7 12% of newly qualified doctors felt that surgical careers do not welcome women due to difficulty maintaining family life and limited flexible training [19].
- 5.8 The GMC has recommended improved access to flexible training, in agreement with the National Working Group on Women in Medicine [15]. This is to encompass greater support for carers, and those with young children.
- 5.9 In Ireland, the HSE national flexible training scheme for Higher Specialist Trainees has been launched and is funded and managed by the HSE Medical

Education and Training (MET) unit. A detailed guide can be found via a link on the RCSI website [20].

## 6. Current Concerns with Less than Full-time Training

- 6.1 There are currently a low number of LTFT posts available in the UK and Ireland [13]. These numbers may become inadequate once the number of female surgical trainees inevitably increase, or as a larger number of males seek to pursue LTFT.
- 6.2 Concerns have been raised by Opportunities in Surgery, RCSEng over lack of information surrounding access to LTFT posts for surgical trainees, as well as a significant difference between LETBs.
- 6.3 It has also been reported that surgical trainees have a harder time in securing suitable LTFT posts compared to trainees from non-surgical specialities.
- 6.4 There is also 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. The current system supports three ways that LTFT can be incorporated into the system:
  - LTFT in full time slot,
  - Supernumerary,
  - Slot sharing.
- 6.5 Slot-sharing is logistically easier for local hospital Trusts to manage but requires that two surgical trainees to work the hours of one full time trainee.
- 6.6 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.
- 6.7 It is considered unacceptable that higher surgical trainees in LTFT should have to share operative training sessions with another higher surgical trainee, as this has an impact on their training experience and competencies gained.

## 7. Recommendations

- 7.1 There should be increased provision and funding for LTFT posts in surgery, in all specialities, in all Postgraduate LETBs. This is essential to accommodate the changing workforce and help support trainees with other commitments such as young children/ill relative/outstanding committee roles etc.
- 7.2 Information should be readily available for all surgical trainees wishing to or considering applying for LTFT. Individual LETBs should outline basic information including eligibility criteria and the application process as well as a point of contact for advice on their websites. On a practical basis, having a LTFT adviser within each School of Surgery, in addition to within each LETBs, who would have closer links with trainees and trainers on a local level, could ease ongoing challenges. 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, without accumulating resources with regards to such issues, each trainee and trainer will continue to face the same difficulties repeatedly.
- 7.3 Education and encouragement should be provided to junior trainees and medical students to make them aware that LTFT can be compatible with surgical training.
- 7.4 The ARCP Panel should support surgical trainees' in LTFT and help them meet their individual learning needs.
- 7.5 Higher surgical trainees in LTFT should not have to share operative training sessions with another higher surgical trainee.
- 7.6 LTFT opportunities must be equally accessible for both men and women.
- 7.7 Options for LTFT should be readily accessible to trainees within each LETBs, and training program directors should be upfront with trainees if there have been significant difficulties in approving LTFT slots in the past so that modifications and alternatives can be considered.
- 7.8 Trainees considering LTFT following maternity leave ideally should 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. The length of time required to approve a LTFT post varies between LETBs and trainees should be made aware of this.

## 6. References

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## 7. Further Reading

- 7.1 The Royal Colleges of Surgery provide advice available at  
<http://www.rcseng.ac.uk/career>  
<http://www.rcsed.ac.uk/training-careers/postgraduate/less-than-full-time-training.aspx>
- 7.2 Medical Women's Federation. Maternity.  
[www.medicalwomensfederation.org.uk/new/maternity.html](http://www.medicalwomensfederation.org.uk/new/maternity.html)
- 7.3 BMA. Working parents- maternity rights  
<http://bma.org.uk/practical-support-at-work/working-parents>
- 7.4 NHS Employers. Maternity issues for doctors in training. December 2010  
[www.nhsemployers.org/Aboutus/Publications/Pages/MaternityIssuesForDoctorsInTraining.aspx](http://www.nhsemployers.org/Aboutus/Publications/Pages/MaternityIssuesForDoctorsInTraining.aspx)
- 7.4 ASiT has published a number of statements that are available at  
<http://www.asit.org/resources/articles>

## **Appendix I: Who needs to be informed about your pregnancy?**

Educational supervisor

Programme director

Head of school of surgery

Postgraduate dean

Clinical director

General Medical Council

Specialty advisory committee for subspecialty

Human resources at employing trust (that is, where you would be employed at the 24th week of your pregnancy)

## **Appendix 2: Details to be included in your informing letter**

Your personal details (including email address, permanent home address, and mobile number)

Current post and level

National training number

Expected date of delivery

Date you intend to start maternity leave

How much maternity leave you intend to take (this can be altered at a later date with four weeks written notice)

When you will return and what stage you will be at in training

## **Appendix 3: Potentially harmful working conditions for a pregnant surgical trainee**

Inadequate facilities (including rest rooms)

Excessive working hours (including night work)

Unusually stressful work

Lone working

High or low temperatures

Travelling

Exposure to violence

## **Appendix 4: Schedule of antenatal appointments for an uncomplicated, single pregnancy, as recommended by the National Institute for Health and Clinical Excellence**

### **Week gestation—purpose**

- 12—Booking appointment
- 14—Appointment if having triple test for Down’s syndrome risk
- 16—Routine appointment
- 20—Anomaly scan
- 25—Routine appointment (first pregnancy only)
- 28—Antibody check
- 31—Routine appointment (first pregnancy only)
- 34—Routine appointment
- 36—Routine appointment
- 38—Routine appointment
- 40—Routine appointment (first pregnancy only)
- 41—Membrane sweep if overdue