

# Our profession in today's NHS

Dr Rose Penfold

Not so long ago, I left the stimulating learning environment of medical school to become a doctor in the National Health Service (NHS). Stepping onto the wards on that first day, my sense of purpose legitimised by a shiny new “Foundation Doctor” badge, I was nervous, excited and proud. Yet just a few months later, I found myself and my colleagues embroiled in a bitter contract dispute, with an overwhelming majority vote to take industrial action unprecedented in the history of the NHS. Low morale and high stress levels amongst trainee doctors have triggered recognition and reactive responses from medicine's professional bodies but key issues remain unaddressed.

Is it something different about today's doctors? Or is it something different about the work of doctors in today's NHS? Here, I consider how a well-validated model of occupational strain may apply to our context and help to identify strategies which can empower the current generation of our profession to remain engaged and committed to tomorrow's NHS.

## A current crisis of morale

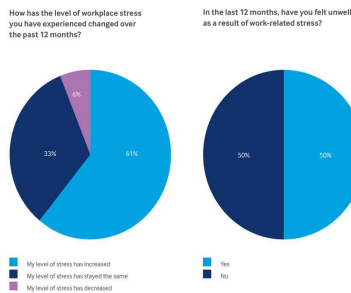
Discontentment is growing amongst junior doctors.

In a national British Medical Association (BMA) survey conducted in 2017, 61% of respondents reported that their stress levels had increased over the past year [1]. In the same study, 44% of respondents described their morale as low or very low, compared to only 19% reporting high or very high morale (Figure 1).

### Stress levels among respondents

The responses to this quarter's survey indicate a significant and increasing issue of workplace stress, with 61% of respondents reporting that their stress levels have increased over the past year, compared to only 6% who said that they have had a reduction in workplace stress levels.

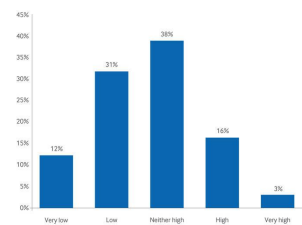
Half of respondents to this quarter's survey reported feeling unwell as a result of workplace stress, over the past 12 months.



### Current level of morale

This quarter, 44% of respondents described their morale as being low or very low, compared to only 19% of respondents who described morale as being high or very high. Over the past 12 months, the proportion of respondents reporting low or very low morale has fluctuated around 50%. This quarter there was a slight reduction (1 percentage point) in those describing their morale as very low or low, but a concurrent reduction of 2 percentage points of those describing their morale as high or very high.

The significant difference between the morale of those who are retired and the average of those working prompted the exclusion of retirees from this slide, in order to gain a more accurate picture of the morale of those currently working.



Question: Taking everything into account, how would you describe your current level of morale?

Figure 1. Levels of stress (left) and morale (right) amongst junior doctors responding to a national BMA survey. Source: BMA Quarterly survey Q2 2017.

The previous year had witnessed unprecedented industrial action by junior doctors, with nationwide withdrawal of routine and emergency care following a breakdown in negotiations over terms of the new junior doctor contract. 98% of doctors balloted by the BMA voted that they would

take industrial action. Media coverage of the issues focused on pay, with areas of dispute including abolition of pay progression and introduction of a seven-day NHS, necessitating longer working hours for similar or lower financial reimbursement. However, it appears that a key opportunity was missed to address the issues really at the heart of junior doctors' discontentment. Johann Malawana, former chair of the BMA's Junior Doctors Committee, contemporaneously wrote:

*"I, and the JDC, have absolutely no intention of standing by whilst the government pushes current and future generations of doctors out of the NHS ...It simply is unacceptable to devalue and denigrate doctors and the medical profession..."*

This unprecedented protest was not just about hours and pay. It reflected deeper-rooted dissatisfaction amongst a group of professionals who felt "devalued and denigrated", with no apparent way to communicate this other than through industrial action.

The crisis in morale is creating a crisis in retention and recruitment. Concerns have been raised regarding high numbers of medical and nursing post vacancies across NHS hospital and mental health trusts [2]. The ripple effect is being seen at all stages of training. The number of doctors progressing straight to specialty training is declining, applications to the Foundation training programme are decreasing and fewer people are applying to medical school [3]. There is recognition amongst professional bodies that the need to act is pressing. For example, safeguards to protect working hours have been incorporated into the negotiated junior doctor contract. New medical schools have been created in geographical regions with high post vacancies. However, many of these proposed strategies targeting recruitment, working hours or financial reimbursement will not address morale or stem the outflow of doctors from the profession if the underlying issues have not been correctly identified.

Perhaps, instead, we need to consider whether doctors are able to perform the job they trained to do in working environments which are conducive to engagement, learning and development.

### **Back to basics: Karasek's demand-control model of job strain**

In 1979, US sociologist Robert Karasek published a model of stress factors in working environments which has since dominated empirical research on the subject (Figure 2) [4]. The premise is that "high-strain" jobs impose high demands, with low individual control. Such work is conducive to ill health, including emotional exhaustion and psychosomatic health complaints. Conversely, "active" jobs involve high demands but also high individual control and give rise to positive outcomes, such as personal challenge and job satisfaction. Thus, control can buffer some of the negative effects of high demands on personal wellbeing and enhance job satisfaction. Of course, this model is a simplified two-factor representation of complex and dynamic working environments and there are many qualifiers. High levels of control may only alleviate stress in individuals with high self-efficacy; furthermore, if task complexity exceeds the employee's knowledge and ability, the employee will suffer [5].

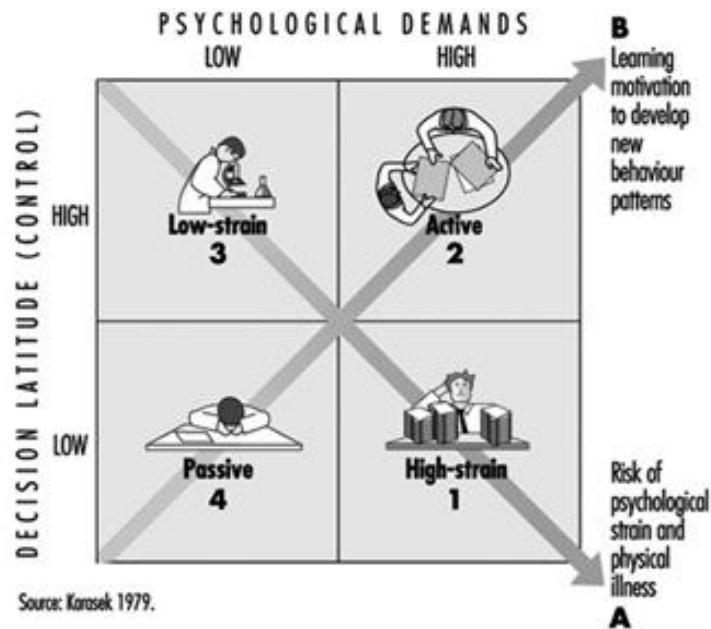


Figure 2. Karasek's job demand-control model. Source: Karasek (1979)

When I first learnt about this model, production and retail work were given as examples of “high strain”, with high demands during busy periods but little control and flexibility working to requirements. Doctors were an example of an “active” job - with high demands but also extensive decision latitude. However, I would argue that the work of many junior doctors today (especially in the earlier stages of training) may in fact be high strain, with high demands but limited control.

### Are excessive demands causing the strain?

Karasek's model as presented above predicts that individuals will suffer if work demands are excessive or task complexity exceeds ability. Medicine is clearly demanding. Each day, doctors perform a multiplicity of tasks for many patients in busy systemic environments. By 2025, the number of people aged 65 and over is predicted to increase by nearly 20% and those with physical and mental health care needs by 25% [6]. Whilst we can try to predict and mitigate against the impact of this to an extent, the NHS workforce will undoubtedly continue to feel the strain.

However, high demand is not a new problem for the medical profession. Many senior clinicians anecdotally report working much longer hours during their training, covering clinical areas with higher numbers of in-patients and greater personal responsibility for out-of-hours care delivery. Furthermore, with junior doctors now spending the significant proportion of their time on administrative and basic clinical tasks, there is limited evidence to support the notion that task complexity exceeds ability in the majority of cases. Despite this, many recent national-level strategies have focused on reducing demand. The new Terms and Conditions for Junior Doctors (2016) enforce that no doctor should be rostered for an average of more than 48 hours per week

or work more than 72 hours in any seven-day consecutive period. Exception reporting procedures aim to ensure that safe working hours are upheld [7]. This is not intended as a call for a return to 24-hour on-calls or 100-hour working weeks. Limits are irrefutably important for the safety of both patients and doctors, as tired doctors make mistakes and extreme fatigue impacts on doctors' health. However, if the NHS is to continue to uphold its fundamental principles to serve everyone, free at the point of clinical need, high demands are inevitable and may be necessary to facilitate adequate training opportunities.

Instead, let's return to Karasek's model. Strategies reducing demands on doctors are only feasible and desirable to an extent and, importantly, tackle one axis. We also need to consider decision latitude for doctors in today's NHS - and how to ensure that medicine returns to Karasek's "active" quadrant.

### **Or a lack of decision latitude...**

At medical school, students are trained to become doctors by conducting systematic histories and examinations, prioritising lists of differential diagnoses and independently formulating management plans. There is scope to explore a wide variety of specialties, research and education opportunities. Working life as a junior doctor presents a very different reality. Trainees perceive little decision latitude over their work, both in terms of scheduling and tasks. Despite long and arduous hours spent committing large volumes of information to memory for exams, the significant proportion of the day is spent on administration, documentation and basic practical tasks such as phlebotomy. Opportunities to independently assess, diagnose and manage patients are relatively scarce, particularly during the earliest career stages.

In a recent qualitative study, trainees described how they "couldn't be a person and a doctor" [8]. This was attributed to regular movement between workplaces (disrupting personal life and necessitating periods of separation from friends and family), supplementing long hours at work with completion of an e-portfolio and a lack of flexibility in training pathways, particularly for women. The same study also highlighted divides between managers and clinicians: trainees felt their "*propensity for hard work was exploited by employers and the government who put more and more demands on them ...without providing good training environments*". Similar findings were reflected in an enquiry conducted by Leeds University into junior doctor morale, in which doctors attributed low morale not only to workload, but to feeling undervalued by management and conflict between personal values, expectations and actual job requirements [9].

It seems that today's doctors perceive that they have little control over their own working environments. Furthermore, they don't appear to know or interact with those that do.

### **Strategies to reduce the strain**

Many suggestions to tackle stress and low morale focus on reducing demands, by restricting working hours or training more doctors without changing the conditions in which they work. Such

solutions alone will not address the exodus of doctors from the profession and may prove to be a slippery slope as challenges facing the health service continue to grow.

Instead, let's look for ideas which address Karasek's other dimension of the working environment: decision latitude and autonomy. There is already some momentum behind this. Last year, NHS Improvement published guidance on "Eight high impact actions to improve the working environment for junior doctors" in collaboration with NHS Providers and the FMLM [10]. These actions include better engagement between trainees and the board, clearer communication between trainees and managers, rotas which promote work-life balance and rewards for excellence in practice.

By further diversifying the current workforce, utilising the capacity and skills of administrative staff and allied health professionals, doctors would have more time to spend on tasks specifically requiring doctors. We need to think broadly: to redesign jobs to enable healthcare professionals to work at the top of their license and competency, whilst exploring alternative models of healthcare delivery which use the capacity of emergent technologies to automate repetitive tasks and facilitate more flexible working patterns. Whatever changes are made, these need to be communicated effectively. Today's profession should not only know who their "managers" are - but also have opportunities themselves to manage and to influence the ways in which care is delivered in our hospitals, GP practices and across the wider health care system.

## **Conclusions**

Ongoing challenges lie ahead for our NHS. The population is ageing, with an accumulating burden of chronic physical and mental health conditions. The UK will soon leave the European Union, with unpredictable but inevitable impact on our current workforce. To tackle these and other challenges, the profession must remain healthy, motivated and innovative.

Yet against this background, morale of junior doctors is at an all-time nadir. Whilst this is now being recognised nationally, many of the proposed solutions focus on reducing demands, for example by reducing working hours or increasing recruitment. Karasek's demand-control model suggests that this neglects the other vital dimension of job strain: decision latitude and control. Inspired and engaged juniors ultimately become inspired and engaged consultants. Doctors and managers can work together locally and think creatively about the bigger picture, to formulate strategies which give trainees greater autonomy and input into their working patterns, tasks and environments. We have a duty to engage and empower the emerging medical profession so that they can continue to shape the future of one of our proudest institutions - the NHS.

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**Word count:** 1953

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