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FEATURE

DOCTORS FOR THE NHS ESSAY COMPETITION

# Why junior doctors need more autonomy

To tackle low morale, strategies to reduce workload are only partly feasible or desirable, writes **Rose Penfold**: we must also empower doctors in training to give them more control over tasks and working environment. Her essay was the winning entry in a competition run by Doctors for the NHS and *The BMJ*

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Junior doctors are discontented. Our professional bodies acknowledge low morale and high stress, but key concerns remain.

In a national BMA survey conducted in 2017, 61% of 422 English doctors in training said that their stress levels had increased in the past year,[1] and 44% of respondents described their morale as low or very low. Only 19% reported high or very high morale. These worrying statistics seem consistent over the past few years, as 41% of respondents reported low or very low morale in the corresponding survey in 2014.[2]

## An unprecedented strike

Junior doctors took industrial action in 2016, with a nationwide withdrawal of routine and emergency care after negotiations broke down over the terms of the new junior doctor contract.

In a ballot by the BMA some 98% of doctors voted to strike. The media focused on pay: the abolition of automatic progression and the introduction of an NHS providing consistent care seven days a week, meaning longer working hours for similar or lower remuneration.

But this unprecedented protest was not just about hours and pay. It reflected deeper rooted dissatisfaction among a group of professionals who felt "devalued and denigrated," wrote Johann Malawana, former chair of the BMA's Junior Doctors Committee, and they had no apparent way to communicate this other than by withdrawing labour.

The crisis in morale has created another in retention and recruitment, with many medical and nursing vacancies affecting NHS hospital and mental health trusts.[3] A ripple effect can be seen at all stages of training. The number of doctors progressing straight to specialty training is falling, and applications to the foundation training programme are decreasing.[4]

Bodies such as Health Education England, NHS Improvement, and the BMA recognise the need to act. Safeguards to limit working hours formed part of the new 2016 contract for doctors in England. New medical schools have been created.

However, without correctly identifying and tackling the underlying drivers, any strategies to target recruitment, working hours, or financial reimbursement are unlikely to increase morale or to stem the outflow of doctors from the profession. Instead, we must consider whether doctors are performing the job they trained to do, in a working environment conducive to engagement, learning, and development.

## A demand-control model of job strain

In 1979 Robert Karasek, a US sociologist, published a model that has since dominated empirical research on stress factors at work (fig 1).[5] The premise is that stressful, "high strain" jobs impose high demands on workers but give them little individual autonomy.

Karasek hypothesised that such work may be conducive to ill health, including emotional exhaustion and psychosomatic health complaints. Conversely, "active" jobs involve high demands but also confer high individual control: this kind of work should foster more positive outcomes, such as personal challenge and job satisfaction. Individual autonomy can cushion some of the negative effects of high demands and may be better for job satisfaction and wellbeing.

Of course, this model simplifies complex and dynamic work environments. High levels of autonomy may alleviate stress only in professionals with high self belief. Furthermore, if a task's complexity exceeds employees' knowledge and ability, they may still suffer.[6]

Production and retail work are classic examples of "high strain" jobs, with high demands in busy periods and rigid requirements giving workers little flexibility. Classically, medicine is considered an "active" job, with high demands but also extensive latitude to make decisions.

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However, the work of many junior doctors today, especially early in their training, may in fact be high strain, with high demands and limited control.

## Are excessive demands causing the strain?

The NHS faces ongoing challenges. To meet these the profession must remain healthy, motivated, and innovative. Karasek's model predicts that workers may suffer if work demands are excessive or tasks too complex.

Medicine is clearly demanding, and the demands on doctors are set to increase. By 2025 the over 65 population is predicted to increase by nearly a fifth, and the proportion with physical and mental healthcare needs is set to rise by 25%.[7] The UK is soon due to leave the European Union, with an unpredictable but inevitable impact on the current workforce. We can try to predict and mitigate this, but the NHS workforce will undoubtedly continue to feel the strain.

High demand is not a new challenge for the medical profession. Many senior clinicians report having worked much longer hours during their training, with more patients and with more responsibility for out-of-hours care.

Junior doctors now spend much of their time on administrative and basic clinical tasks, and it seems unlikely that task complexity exceeds their ability in general. But many recent national strategies have focused on reducing demand.

The new terms and conditions for junior doctors, for example, state that no doctor should work for more than 48 hours a week on average or more than 72 hours in any consecutive seven days.[8] These limits are essential for the safety of patients and doctors: we don't want to return to 24 hours on call or 100 hour working weeks. However, if the NHS is to continue to serve everyone, free at the point of clinical need, high demands on doctors are inevitable and may be necessary to facilitate sufficient training opportunities.

But what about the other axis in Karasek's model? We must also consider decision latitude if we're to return medicine to the "active" quadrant.

## Or is it a lack of control?

At medical school we train by conducting systematic histories and examinations, prioritising differential diagnoses, and independently formulating management plans for patients. Students have the scope to explore many different specialties and opportunities for research and education.

A junior doctor's work is very different. Trainees perceive little decision latitude in scheduling or how tasks are done. Despite long and arduous hours spent committing large volumes of information to memory for exams much of the day is spent doing administration, documentation, and basic practical tasks such as phlebotomy. Opportunities for independent assessment, diagnosis, and management are relatively scarce, particularly early on in training.

In a recent qualitative study trainees described how they "couldn't be a person and a doctor" because of regular movement between workplaces—disrupting personal and family life, supplementing long hours at work with completion of the e-portfolio, and a lack of flexibility in training pathways, particularly for women.[9]

The study also highlighted divides between managers and clinicians: trainees thought that 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." An inquiry by Leeds University found similar results: doctors attributed low morale not only to workload but to feeling undervalued by management and to conflict between personal values, expectations, and actual job requirements.[10]

> Further diversification of the workforce, using the capacity and skills of administrative staff and allied health professionals, would give doctors more time to spend on tasks that only doctors can do

## Stress reduction strategies

Solutions to reduce stress and low morale that focus only on reducing demands on junior doctors will not stem the exodus from the profession, and they may prove counterproductive as challenges facing the health service grow.

Some existing efforts seek to increase junior doctors' decision latitude and autonomy. Last year NHS Improvement, which oversees trusts, published guidance on "eight high impact actions to improve the working environment for junior doctors" in collaboration with NHS Providers, the trade association for trusts, and the Faculty of Medical Leadership and Management.[11] These actions include better engagement between trainees and trust boards, clearer communication between trainees and managers, rotas that promote work-life balance, and rewards for excellence in practice.

Further diversification of the workforce, using the capacity and skills of administrative staff and allied health professionals, would give doctors more time to spend on tasks that only doctors can do. We need to redesign jobs to enable healthcare professionals to work at the top of their licence and competency, using emergent technologies to automate repetitive tasks such as documentation and information transfer (and, soon, requesting and analysing basic diagnostic tests) and facilitating more flexible working patterns.

Changes must be well communicated. Doctors should not only know who their managers are but also have opportunities to influence how care is delivered in hospitals, general practices, and the wider healthcare system.

Inspired and engaged juniors ultimately become inspired and engaged consultants. Doctors and managers should work together locally to formulate strategies to give trainees greater autonomy over their working patterns, tasks, and environments. We have a duty to empower emerging medical professionals so that they can continue to shape the future of one of our proudest institutions—the NHS.

**Biography**

Rose Penfold is a junior doctor in the NHS currently undertaking a national medical director's clinical fellowship, having completed her foundation training in London and a master of public health degree in Boston, MA. As she continues clinical training in internal medicine next year she intends to build on longstanding interests in management, policy, and medical education by developing, and advocating for, initiatives to improve junior doctors' working lives.

This is an edited version of her essay that won a competition run by Doctors for the NHS and *The BMJ* with the title "Our profession in today's NHS." Entries by Rob Rulach and Emily Whitehouse were also highly commended and are published at www.doctorsforthenhs.org.uk.

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## Figure

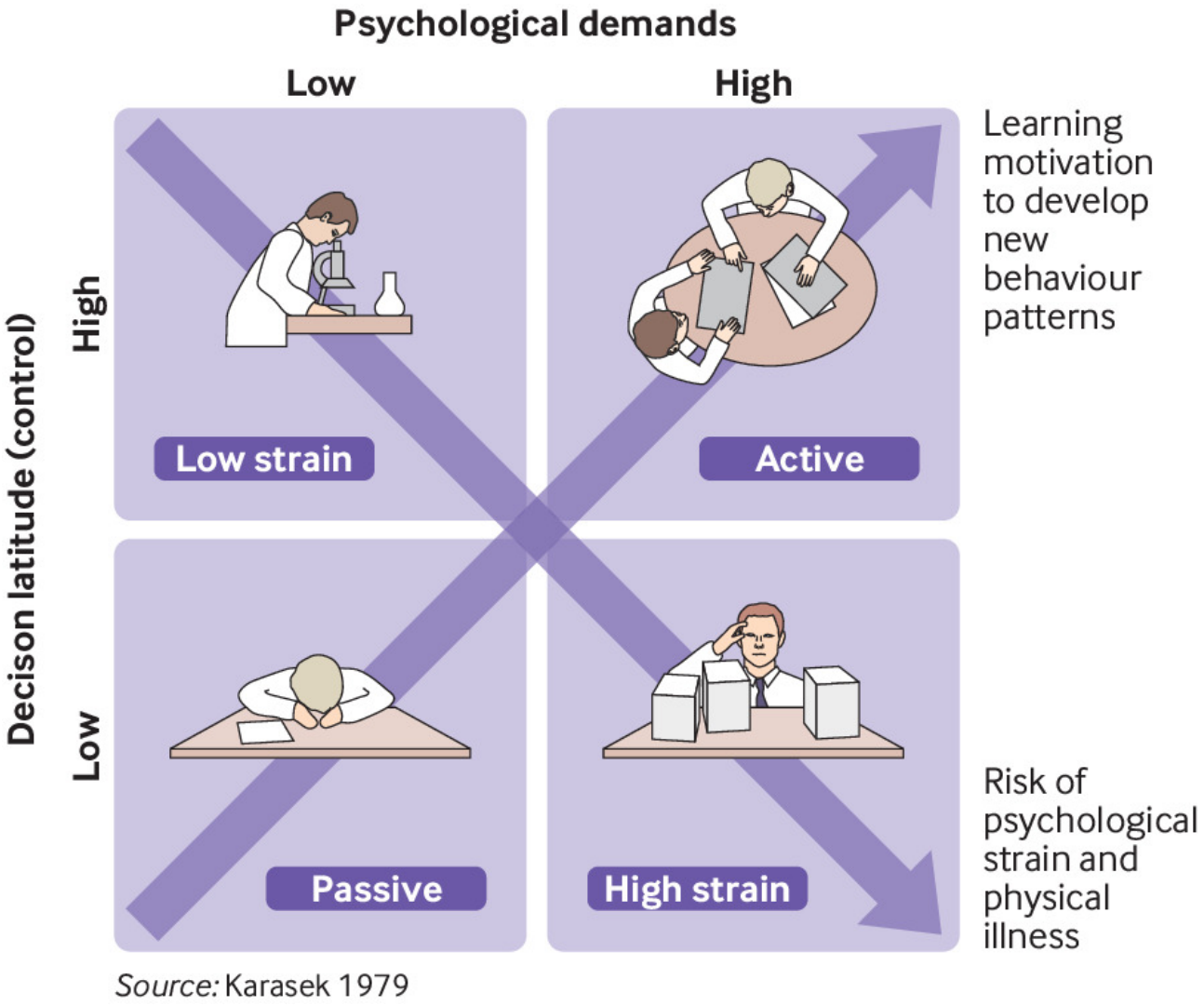


**Fig 1** Karasek's job demand-control model. Source: Karasek (1979)