ACUTE PERSPECTIVE

David Oliver: No wonder training grade doctors are unhappy

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Being a junior doctor has never been an easy gig during my career. When I started I worked for nine years in 10 hospitals in seven towns, never staying in one place longer than a year. We did brutal “1 in 3” and “1 in 4” rotas, including 36 or 80 hour continuous on-call shifts. We got only a third of the base pay rate for each hour over the first 40. Just as now, we had professional exams to contend with but, worse than today, the lack of run-through training or matched training numbers meant that we could get stuck at one grade waiting for jobs—not least consultant jobs with ridiculous competition.

We often received little in the way of induction, structured supervision, or appraisal and pastoral support. Any talk about wellbeing was patchy, in what was still quite a macho “get on with it” culture, and teaching styles often bordered on bullying. Willingness to recognise or tackle sexism and racism was far less common. I get fed up hearing how much easier it was back then, from people who weren’t there. However, I wouldn’t for one moment trade it for one moment trade it for the situation younger doctors face now. I can only empathise with their unhappiness.

I’ll happily defend the importance of rotational training to expose trainees to a range of clinical settings and hospital types. And I completely support increased emphasis on early experience of generalism—after all, modern day patients in most disciplines have multiple conditions requiring broad skills in managing comorbidities.

But there are many reasons why the current set-up is causing such unrest. For a start, students are finishing university with tens of thousands of pounds of debt. My generation had free university education, with student grants for living expenses. Secondly, the professional exams doctors must take if they want to progress cost hundreds of pounds. These often have high failure rates and are disproportionately expensive for international graduates from poorer countries. Portfolios for appraisal also cost hundreds, as do courses that doctors feel obliged to take to get through exams and to bolster their applications for training rotations. Remember, these are young people through exams and to bolster their applications for training rotations. Remember, these are young people

The current cost of living crisis means that the standard of living an early career doctor could afford back in the 1980s and ’90s is unattainable. I and many peers were able to buy our first property in our 20s, on a senior house officer’s salary, and to have a few decent holidays a year. It’s hard for trainees not to look at the conditions for doctors in other high income countries or other sectors where they could use their skills.

Fragmented teams

When I was a junior doctor we generally had basic accommodation on hospital grounds or perimeter roads, but it was free or came at token rent. We had somewhere to park our cars without being charged for the privilege. And because we hadn’t yet moved to a shift system, despite the hours of full on-call rotas we at least stayed with our own team, week in, week out, with a traditional “firm” structure, and we had regular social events thanks to living on hospital premises.

Now teams are fragmented, and it’s possible for someone not to be with their own ward team and supervising consultant for weeks, with the demands of on-call rotas, night shifts, and cross cover. Trainees are also endlessly pressured to fill gaps by rota coordinators. Persistent understaffing begets further disengagement.

We have inflexibility over booking leave, inadequate advance notice of rotas, and a load of guff about “resilience.” Of course, resilience is important for dealing with the timeless stresses of medical practice, but it shouldn’t be a smokescreen for short staffing and an unmanageable workload, blaming individuals for system failings. Staff often have insufficient rest areas, no access to food and drink, and nowhere to park a bike or to shower after riding to work to avoid car parking fines. After real terms pay cuts of around 25% for junior doctors since 2008, the final insult is an offer of a 2% pay rise after two years of practising medicine in a pandemic.1

Finally, trainees look to their seniors. Back in the day, at least they knew that after a decade of postgraduate training and working they could look forward to professional autonomy and security, retirement at 60 on a generous final salary pension, and less time spent on site, out of hours. They now look at their often demoralised and tired seniors and think, “If this is the pot of gold at the end of the rainbow, is it something I really want?”

If they want to take industrial action, I don’t blame them.

Competing interests: See bmj.com/about-bmj/freelance-contributors

Provenance and peer review: Commissioned; not externally peer reviewed.