# The millennial doctor – A blue collar worker?

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ABSTRACT

**The face of medical training has transformed over the last two decades. This has impacted education and training, work ethic and pride within the profession. There are serious concerns that rigid working hours, shift systems, erosion of team-working (with all of the implications this carries for the essential 'apprenticeship' of postgraduate medical training) and repeated political interference will transform the millennial doctor into a 'blue collar' worker. Morale is at an all-time low and more needs to be done to support and value junior doctors, raise awareness of work-life balance issues and improve working lives. Initiatives such as the Royal College of Physicians' *Underfunded, underdoctored and overstretched* report and the chief registrar project are crucial triggers to raise morale and restore pride in this most rewarding of professions.**

**KEYWORDS:** Junior doctors, leadership, management, quality improvement, training

## Introduction

The practice of medicine in the UK has changed so significantly over the last 20 years that we risk tomorrow's junior doctor transforming into a blue collar worker. This doctor will merely be a tick-box competent worker bee who clocks in and out of rigid shift patterns of work. We fear they will still be working within a system similar to what we see in 2016; one that is still 'underfunded, underdoctored and overstretched',[1] with management and leadership that is still unable to deal effectively with the changes and challenges confronting it.[2] The majority of junior doctors do not feel valued by their chief executive and non-clinical management teams.[3] Fundamentally, the system needs to demonstrate that it values these young professionals and that it sees them as essential to its future.

While this blue collar extreme isn't quite with us, the NHS landscape we reference certainly is. Clinical medicine has changed markedly over the last two decades and there has been an erosion of its vocational essence; a profession where doctors are dedicated to their patients and committed to delivering the highest quality of care as part of an experienced consultant-led firm. The loss of this 'firm' structure is significant because, within teams, doctors were nurtured and a work ethic developed that created professionals with integrity, compassion, altruism and commitment to professional development. We risk accepting competence rather than excellence; a generation of doctors stifled by protocols, unable to innovate and discouraged from asking 'why' in the effort to change practice for the better. To quote Sir John Tooke in his 2008 Modernising Medical Careers (MMC) enquiry report, 'put simply "good enough" is not good enough. Rather, in the interests of the health and wealth of the nation, we should aspire to excellence'.[4]

## A vocation of the past

Over the last 25 years, two major factors have driven this shift in culture: capped hours imposed by Europe and cyclical meddling with junior doctor education, training and working conditions. Altering training too much and capping the length of time spent training, in combination with the effects of a reduction in hours, poses significant challenges that in the long term may impact the quality of patient care.

No one would wish to go back to the days of dangerously long hours and 90-hour weekends, but at that time, mutual support was uniformly provided by consultant-led teams. The European working time directive (EWTD), with its 48-hour limit, has been viewed as having a negative impact on training.[5] It has meant that teams are no longer 'on call' together, rather one junior doctor is perpetually handing over to an incoming colleague for the next shift. This directive spelt the end of the firm structure and meant available working hours were spent providing out-of-hours emergency care at the expense of training. The rosters prior to the EWTD 48-hour limit imposed in 2004 were just as dangerous as the previous long hours culture.[6] The resultant increase in sick leave was identified early[7] but the effects go wider with teaching and training, mentorship and apprenticeship also being affected.

MMC is often viewed as a regressive step in postgraduate medical education and training. Its predecessor, published in 1993, *Hospital Doctors – Training for the future* (the Calman report)[8] attempted to respond to the perceived need to deliver a higher consultant to trainee ratio. It defined the minimum length of training needed alongside a curriculum that meant training was marked with the award of a certificate of completion. The risk identified by Sir John Tooke was that it may have created doctors who were not ready to assume this consultant role;[4] as a result, the learning curve new

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consultants face can often feel impossibly steep to overcome with the compound effects of EWTD and this shorter training particularly affecting surgical and procedure based specialties.

One wonders if the targeting of the senior house officer role in the 2002 *Unfinished business* report[9] has also created junior doctors who feel less prepared to assume the registrar role. The idea was to bring more structure to training with a broad common foundation and a cap on the length of time spent training as it was felt that too many posts were not part of formal training programmes. While a minority of senior house officers were lost in the non-training scheme wilderness, the freedom delivered by the system allowed trainees to refine and make informed career choices and gain much needed experience. The changes set the ground for the creation of the generalist rather than super-specialist consultant, which is echoed in the *Shape of Training* review today.[10]

The inflexibility brought to training by MMC and the forcing of early career choices can be a disadvantage. Its initial implementation through the Medical Training Application Service (MTAS) scheme caused profound distress and demoralised a whole cohort of doctors.[4] MTAS had major issues with rushed implementation, technical difficulties, poor communication with junior doctors and overloading of the deaneries.[4] We hope that lessons have been learnt for the future to avoid such problems being repeated. The actual changes in training may also not be delivering what trainees or the system needed. This is exemplified by acute care common stem acute medicine (ACCS AM) training, which aims to develop competent multi-skilled acute physicians to manage patients with multimorbidity from 'door to discharge'.[11] However, are such schemes fit for purpose when only a minority of trainees actually progress into higher training in acute and internal medicine?[11]

Fixed training with the hours restriction imposed by EWTD has resulted in some junior doctors' struggling to obtain the competencies that they require. MMC has seen the rise of the all-consuming e-portfolio and the box ticking exercise that it demands to demonstrate competency from training. Supervisors become fatigued when dealing with never-ending curricula and the validity of carrying out assessments solely to tick a competency and curriculum box has to be questioned. This tedious, seemingly disengaged system is a huge source of frustration for trainees and we feel that this is something that could be addressed with relative ease. Worse still, junior doctors in specialty training who want to change careers subsequently cannot easily transfer the competencies they have already acquired.

MTAS and the early MMC initiative highlight how the Department of Health's desire to implement change failed to involve its key stakeholders sufficiently, a trend and risk that continues to the present day. While modern reports such as the *Shape of Training* review have made better efforts at consultation, the track record of changes to medical education and training will undoubtedly be a cause for concern for many trainees and their consultants.

## The slippery slide towards a blue collar worker

The expectation on the millennial doctor and the quality of care that is mandated to be delivered from them has never been higher, as evidenced by the requirements of *Good medical practice*.[12] This is all in the context of an NHS that is 'underfunded, underdoctored and overstretched'.[1] In this setting, when fire-fighting through shifts is what the modern junior faces every working day, how could anyone aspire to excellence?

The current treatment of doctors and its effect on perceived status risks engendering the feeling that we are 'just another grunt in the healthcare factory, with no base and little identity'. The erosion of the doctor's mess is concerning. The mess was a place where trainees shared their worries, reassured one another, let off steam and most importantly, bonded and built morale. In 2008, free accommodation was taken away from junior doctors.[13] Many moved out of hospital accommodation further eroding team spirit and morale. Reductions in working hours have effectively cut junior doctors' pay and, like other NHS staff, below-inflation pay increases have compounded this. Doctors' salaries are no longer viewed in the same bracket as comparable professionals; a further challenge if we wish to continue to attract the most talented people into our profession. The British Medical Association has estimated that today's medical students can expect to face lifetime debts of over £100,000[14] and the impending contract is also likely to have a further detrimental impact on work-life balance.

Morale in the profession is at an all-time low[15] and has been hit further with the junior doctor contract dispute of 2016 – the first doctor's strike in 40 years.[16] This dispute has harmed the relationship between the government and doctors irrevocably. A new contract that adversely disadvantages women and working families is concerning, as is the independence of the guardian role. Doctors earn a salary based on a mandated 40–48 hour week. Residual work ethic and a determination to provide high-quality care for their patients means that the majority of doctors routinely exceed these hours for no monetary gain. With recent public attacks by the government and the media demoralising and demotivating the junior doctor workforce, there is real concern of a slide toward a clock-on/clock-off culture. To compound this, there is a conflicting evidence base for the benefit of 7-day working despite the fact that this is the fundamental political driving force behind all of the changes in the junior doctor contract.

Doctors have among the highest suicide rate of any profession, partly due to the extreme pressure and high risk decision making that they regularly undertake.[17] The shift intensity has risen over recent years and the shift patterns that they are mandated to work can have drastic consequences – there have been multiple fatal accidents involving doctors falling asleep at the wheel and the evidence for this risk is long standing.[18] From a holistic point of view, doctors can be informed that they have to move tens, if not hundreds, of miles away to another city with only a few days' notice. This can have financial, social and mental health implications. Short notice of mandatory shifts, which could be day or night, the weekend, or even a day where childcare could be compromised, can disrupt private and family life, puts considerable pressure on junior doctors and is unacceptable in any profession in the 21st century.

The NHS is under increasing strain and pressure with rising emergency department attendances, hospital admissions and extended waiting lists for elective hospital treatment. Almost half of NHS trusts admit to likely end of year deficits in 2016[19] and the true percentage facing financial difficulties is likely to be far higher than this. The NHS faced a tripling of its

aggregate deficit to the dizzy heights of £1.85 billion in the last financial year[20] and funding has not kept pace with the increasing demand our aging population requires.[21] Trusts are having to come up with innovative ways to save money. Quality, innovation, productivity and prevention (QIPP) programmes are not delivering enough savings[22] and the language has moved away from QIPP to CIPs – cost improvement programmes; cost cutting dissociated from quality improvement in a trend that could potentially adversely affect care. This situation means just getting through the day with the trust on red alert is now the norm. For the junior doctor it means yet another shift on the NHS coal face putting out one 'fire' after another.

## The future – blue collar or true blue professional?

The welfare of doctors and other healthcare professionals within the NHS needs to be championed. The Francis, Keogh and Berwick reports highlight the importance of listening to and supporting staff in order to produce an effective NHS workplace that benefits patients.[23–25] In 2016, the Royal College of Physicians launched its *Underfunded, underdoctored, overstretched* report,[1] which highlights that, among other things, 85% of physicians feel that the current health service is insufficient to meet demand, 7/10 doctors work on a rota with a permanent gap and doctors in training work an extra 5 weeks a year on top of rostered hours.

There is clear strain on junior doctors and many feel that training has suffered as a result. The Joint Royal Colleges of Physicians Training Board (JRCPTB) have developed a series of 'quality criteria' for core medical trainees, a list of requirements that cover various aspects of training that deaneries should ensure is achieved.[26] The JRCPTB are also attempting to reduce the tick-box culture affecting doctors in training with a new internal medicine curriculum that is under development. This aims to replace mindless jumping through hoops with a simpler system that should free up more time to allow doctors to get back to treating their patients.

There needs to be greater flexibility in the ways that trainees progress to consultant. If certain trainees complete competencies earlier than others, it should be made easier for them to finish their training or to transfer their competencies if they change training schemes. The General Medical Council is pushing towards competency-based rather than time-based training and the JRCPTB have also adopted this stance;[27] however, this is not frequently exercised. Conversely, if a trainee has struggled to obtain competency in certain areas, there should be more flexibility for them to extend their training without the stigma of a formal annual review of competence progression panel forcing a junior doctor to extend their training.

In industry, there are frequent use of 'away days' to build morale and team-working skills. Use of 'away days' for junior doctors may go a long way to improving morale. The allocation of all junior doctors to a mentor other than their educational/clinical supervisor, as well as more consultant one-to-one supervision and feedback will also lead to a more holistic approach to the treatment of doctors in training.

More needs to be done so that the NHS is receptive to junior doctors' concerns, empowers them and facilitates them undertaking quality improvement projects. Doctors need to feel valued by their executives and be engaged more by their trusts. The Future Hospital Programme's (FHP) chief registrar project aims to train future leaders of the NHS as well as act as a conduit between hospital management and doctors. It employs physicians in training in a split role with 40–50% of time dedicated to leadership and management and 50–60% in a clinical capacity.[28] The Faculty of Medical Leadership and Management is supporting this project and providing an educational training element. The FHP aims to expand this programme so that eventually every hospital has a chief registrar. The FHP have also introduced development sites that are committed to improving, designing and delivering medical care that meets the current and future needs of patients.[29] They aim to focus on delivering patient-centred care across integrated healthcare services. Future training programmes also need to reflect this shift in care and provide doctors in training with the exposure and experience they need in order to meet patient needs and be successful consultants of the future. Thought is also required on how to ready doctors for changes in the doctor-patient relationship. Patients are more empowered and often want more involvement in decision making; this trend is likely to continue in the future. Again, training needs to accommodate this and prepare the next generation of consultants for this shift in the doctor-patient relationship.

In the long term, more staff – particularly doctors in higher training and consultants – need to be trained in order to reduce the burden on the profession. In the medium term, innovative use of allied healthcare professionals, such as physician associates, could improve the training and working life of junior doctors.

In December 2016, the Royal College of Physicians published two reports entitled *Keeping medicine brilliant*[30] and *Being a junior doctor.*[31] These reports explore and highlight the courses and impact of poor morale on physician wellbeing and patient care, as well as practical recommendations to create a more productive workforce and improve morale. This will help to ensure junior doctors are afforded the training and work-life balance that they require. Simple measures, such as providing adequate notice of shifts to be worked, which area of the country people will be based in, provision of free accommodation when felt unsafe to drive, round the clock hot food provision and a mandatory doctors' mess, can go a long way to improving the working life and work-life balance of doctors in training.

Public campaigns that raise awareness of training and work-life balance issues are crucial as they will support doctors and help build morale. Medicine is brilliant and we need to remind people of that.

## Conclusion

There have been too many detrimental changes to the training, working conditions and work-life balance of junior doctors. Morale is low and excessive pressure is placed upon them. Junior doctors, along with other healthcare professionals within the NHS, continue to strive to achieve the best for their patients. However, professional pride has been eroded over recent decades and with it comes disgruntlement, dissatisfaction and resentment at how healthcare is changing. This has led to a generation of doctors who are disillusioned

with the NHS and what the future holds. We must fight to maintain the fundamental values of our profession: transparent self-governance, all-pervading altruistic culture and leadership from doctors at all levels, political as well as clinical. It's fairly easy to turn a white collar blue but a lot more difficult to return it to snowy whiteness.

The government and wider NHS need to truly respect and value junior doctors. Safeguards to protect doctors' rights, improve their training and work-life balance are critical. A sustained drive to improve the morale and working lives of junior doctors will go a long way to restoring pride in this wonderful profession. Now, where is my clean white shirt and tie? ■

## Conflicts of interest

The authors have no conflicts of interest to declare.

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