



Morale and satisfaction of doctors and trainees in the UK

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Abstract

Doctors in the United Kingdom have recently been confronted by rapid changes in their clinical and professional practice over which individual doctors have had little or no control. These factors have ranged from the disastrous attempt to implement a new system for appointing junior doctors, radical redesign of health care delivery and increasing political interference in the regulation of doctors to the impending introduction of compulsory revalidation for all doctors. Not surprisingly morale could be better but it is encouraging that trainees express high and rising satisfaction with the training they receive and that senior doctors expressed high job satisfaction although reporting they had insufficient leisure time which adversely affected their morale. Female doctors working part-time were more likely to report a better work-life balance.

Introduction

Current wisdom is that morale is low among British doctors. While this is a non-evidence based view which has been believed by British doctors for decades, there are some new major drivers which have damaged morale and these include the chaos caused by synchronous introduction of new appointments processes and a new training scheme in 2007 (Douglas, 2007) which has affected morale at all levels but particularly among trainees and the imminent introduction of reaccreditation (Donaldson, 2008) for all doctors which is particularly concerning older doctors.

This article reviews some of the drivers affecting morale of doctors and the accompanying evidence. As the drivers vary with career progression, the paper will chronologically follow career steps.

Medical students

UK students used to have their expenses covered by grants with no tuition fees payable, but for the past decade fees have been charged and grants have been replaced with loans to be repaid once in work. Given the length of the course at 5-6 years, medical students now graduate with significant debt estimated at £22,000 (Gardner, 2006) which, although not large by international comparison, is more than their pre-tax annual salary on graduation. This is a new concept in the UK and understandably concerns the students. Furthermore their salaries are controlled by an effective governmental employment monopoly with the National Health Service limiting the earnings from which the loans will be repaid.

Students are also very concerned about career prospects for the reasons covered in the next section. They have additional concerns caused by a near doubling of medical student numbers in England in the past decade. This will produce significantly more UK medical graduates than the UK needs, in senior posts, on current employment practice. Thus competition for posts will be greater and with a monopoly employer there is real concern about achieving the status, responsibility and pay that their predecessors enjoyed.

Junior doctors

Undoubtedly the main morale sapping factor in British medicine in the past few years has been the debacle over the introduction of a new training structure -!Modernising Medical Careers, MMC – at the same time as bringing in an untested and dysfunctional applications process based on a centralised computer appointments system – the Medical Training Applications Service, MTAS. This system was brought in synchronously for all junior trainees and proved very attractive to overseas graduates resulting in over 30,000 applications for 18,000 posts. Concerns were compounded by the use of a new application form, with untested questions, considered by many to be tests of creative writing which were widely plagiarised. Thus there was little faith among the candidates that the best were selected for interviews, which were performed initially to a new Human Resources driven and very “politically correct” formula, without curricula vitae being available in case these introduced bias. Some excellent candidates did not initially get interviews and tension rose, with marches in the streets of London and Glasgow, to the level that the Minister of Health appointed a Review Group to manage the situation (Douglas, 2007). Although improvements in the process were made, many good doctors did not get training posts, partly because there were too few posts available, for although there were more than the normal number of jobs, there were up to five trainee years competing for the same posts. This was partially offset by the creation of more training posts in some fields by the Review Group. However, the lasting effect on morale and self-confidence in the profession is great. This effect is not limited to trainees as seniors were distressed by the difficulties faced by the trainees, by the inappropriateness of the new system and by the huge amount of time many seniors spent shortlisting and interviewing the large number of candidates.

Other factors causing major concern among trainees include :

- Lack of clarity about the end point of their training. Traditionally UK trainees completed training and went on to get a hospital consultant post or a principal's post in general practice. Uncertainty has been created in the hospital sector by financially driven desire to employ doctors at a "sub-consultant" level without any clear career progression. This lack of clarity is sapping morale among trainees.
- Increasing use of role substitution with other professional grouping such as nurses or pharmacists performing duties that have traditionally been the doctor's role, such as prescribing or endoscopy. This raises concerns in trainees' minds as to what the profession's role is going to be in the future.
- Decreasing hours and thus experience in training. The European Working Time Directive will decrease juniors' working hours to 48/week from 2009. There is real concern, particularly in the craft specialties, that doctors at the end of training will not have the judgement and skills their predecessors had acquired by that stage and doubts as to whether they will be fit for independent practice.

Given all these issues, it is perhaps not surprising therefore that a cohort study of 435 doctors who graduated in 2006 has shown that the number who reported they strongly wished to practise medicine had halved in the first year since graduation (BMJ 2008). Equally concerning there was a rise from 15% to 26% who rated their desire to practise medicine lukewarm or weak. Only 8% were confident of automatically getting a job on completion of training, down from 16% at the time of graduation.

Junior hospital doctors identified improved support for education and training as their first choice to improve their working lives (Dornhorst, 2005), while among the female trainees, it was improved support for childcare. Greater opportunities to develop new skills was an important issue for doctors in the surgical specialties and improved access to mentoring was important for all junior doctors and doctors of whatever grade from black and ethnic minority groups.

Nevertheless it is comforting that a high and rising percentage (79%) of UK trainees express satisfaction with their training (PMETB Survey, 2008).

Senior doctors

Generic issues

While MTAS was undoubtedly the major factor worrying seniors in 2007 and has not ceased to be a concern, the main factors sapping confidence at present are revalidation and service redesign.

Revalidation

In July 2008, the Chief Medical Officer of England Sir Liam Donaldson announced the details of the processes of recertification and relicensing that will be introduced from 2010 (Donaldson, 2008). This process will mean that each doctor will have to prove every five years that they are up-to-date and providing a satisfactory level of clinical care. While this is being packaged as a supportive process to facilitate doctors to keep

up-to-date, there is no doubt the major drivers were notable cases of medical malpraxis such as Shipman and Ledward and thus many doctors see this as an exercise in catching bad apples and fear the fairness and the results of the process. Predictably many older doctors are indicating they will retire early rather than go through this process. It certainly is not improving morale!

Service Redesign

Health services controlled by politicians will always change and the current turmoil is perhaps not exceptional but, in conjunction with the factors previously listed, they are destabilising medical confidence. Changes introduced or announced in the last few years in the health service in England include increasing independence for hospitals, increasing use of the private sector, movement of more care away from hospitals and into the community, and the imposition of large polyclinics competing with traditional general practices whether or not there is local need for their services.

Specialty specific issues

General Practice

Considerable work has been done on factors influencing morale in UK GPs. In a study of urban GPs, significant associations were found between mental health scores, total job satisfaction scores, and GPs' perceptions that work had affected their physical health. Problems with physical and mental health were associated with several aspects of workload, including list size, number of sessions worked per week, amount of time spent on call, and use of deputizing services. GPs reported overwork and excessive hours, paperwork and administration and NHS reorganisation were the most stressful parts of their work (Appleton, 1998). Early in this decade more than two thirds of GPs reported their morale to be low or very low (Kmietowicz, 2001). Only a third would recommend a career in general practice to young doctors. Nearly half were planning to retire before they were 60 years old and the bulk of the remainder at 60. Among the stressors related to morale were high workload, insufficient time to function to the desired level, inappropriate patient demands (Simoens, 2002) and internal practice organization (Huby, 2002).

A more recent study has shown that overall stress in 2004 was lower than in a similar survey 2001 but still higher than in 1998 (Whalley, 2006). After allowing for personal, practice and job characteristics, higher satisfaction was associated with lower job stress, involvement in decision making, increasing job interest and ability to meet conflicting demands. Higher job satisfaction was associated with being female, older, having two or more children aged under 18 years, and being in good general health.

Thankfully, there seems to be no relationship between GP morale and their patients' satisfaction (McKinstry, 2007).

Since these studies there has been a significant change in the pay and pay structure of GPs with real increases in take home pay. However there have also been increases in administration and the number of targets to be achieved. There is little evidence that GP morale has increased in line with pay.

Hospital Practice

Most hospital doctors report fairly high levels of job satisfaction, but lower levels of satisfaction with the time available for leisure (Taylor, 2008). Women tended to have slightly higher satisfaction with their leisure opportunities and this was significantly linked to the fact that more of them were working part-time. Doctors from this 1977 graduating cohort who were working in the NHS were significantly less satisfied with their leisure time than those now working outwith the NHS or overseas.

Improved secretarial or managerial support was considered by hospital consultants to be their greatest need to improve their working lives (Dornhorst, 2005). Other aspects of the need for more clinical and non-clinical support represented their next 3 most important factors.

A recent report of morale levels among physicians needs to be viewed with care given that the poll was carried out among doctors who attended a meeting on the topic in the height of the MTAS debacle (Goddard, 2007). Only 16% described themselves as “happy” with the NHS.

Conclusion

Morale remains concerning in the NHS, particularly among junior doctors with increasing concern about whether they have made the correct career choice and whether there will be posts for them if and when they complete training. The increased production of medical graduates in the UK and the inability of the UK to control migration are significant drivers to the trainees justified anxieties.

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