Ipsos MORI
Social Research Institute

BMA

Doctors in Training – Contract Proposals

Feedback from doctors

22nd July 2013

Legal notice

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In June 2013, the British Medical Association (BMA) asked its members, in particular junior doctors and medical students, about the issues that would be covered in possible negotiations with NHS Employers to achieve a new contract for doctors in training. The main channel for the feedback was an online questionnaire on the BMA website. The questions were designed by the BMA and covered working hours, pay, quality of life and training, as well as key demographics such as gender, region, grade and speciality.

Responses from junior doctors and final and penultimate year medical students received in the first 17 days following the launch of the questionnaire have been analysed by Ipsos MORI to provide an interim set of findings. All responses will be analysed in detail for a final report to feed into contract negotiations if they go ahead. This interim analysis is based on 1,661 respondents and includes thematic coding of responses, which allowed us to explore the key messages emphasised by those who answered the questions. Those responding to the online questions were entirely self-selecting and so are not representative of the overall population. This means that the findings cannot be extrapolated to the overall population of junior doctors and final and penultimate year medical students.

A summary of the emerging findings suggests that the important issues for those responding to the online consultation were:

Limits on hours worked – Opinions were divided on the 48 hour average limit on hours worked per week, with some finding it acceptable while others suggested changes. Respondents noted large fluctuations in weekly hours worked, with some weeks consisting of significantly more hours worked, others with significantly less. When hours worked were longer than scheduled, the extra hours often went unrecorded and unpaid. That said, respondents acknowledged that long hours resulted from a dedication to patient care and were a necessary part of their chosen career. Many felt that the limit should be raised to better reflect reality.

Scheduling – Respondents reported experiencing some weeks of long shifts, which they attributed to the restrictions of the 48 hour limit, the averaging of hours worked and understaffing. As a result, respondents emphasised the risks to doctors and patient safety.

Suggestions for tackling scheduling challenges included limiting shift lengths, consecutive shifts and night shifts, as well as enforcing rest and break periods.

Greater clarity over pay – Respondents felt the banding system is complex and confusing. Payslips were also thought to be unclear. Some suggested that adopting a system of clocking in and out or an Australian-style timesheet system might help clarify how hours worked is reflected by pay. Level of pay was also believed to be unrepresentative of intensity and antisocial hours, a linkage which respondents thought could be stronger.

Advance notice of banding and pay in different rotations – Respondents were concerned that there is little advance notice of how pay and banding applies in different roles. This caused difficulty in managing personal finances and other non-work commitments and responsibilities.

Advance notice about rotations – Rotations were felt to be announced with little notice, resulting in respondents being unable to plan their home life properly, including finding accommodation or arranging childcare. Respondents typically suggested that a minimum of a few weeks' notice should be given.

Flexibility for annual leave – Restrictions on when respondents could take annual leave was highlighted as a major quality of life issue. These restrictions also made it difficult to accommodate unexpected life events, such as bereavement and illness.

Training and study time – This was felt to be poorly enforced, being sidelined in preference to service provision, often to cover for absences. It was seen to be poorly organised, with some respondents reporting that they were required to find their own cover when intending to use training time. One popular solution to this was to make the use of training and study time mandatory and protected by contracts, including penalties for employers that do not provide adequate training facilities or use of training time.

1. Background & Methodology

1. Background and Methodology

Background

The current contract for all doctors and dentists in training across the UK has been in place since 2000. There have been increasing questions about how it might be improved. In 2009, following a request from the Review Body on Doctors' and Dentists' Remuneration, NHS Employers undertook a scoping exercise that reviewed the viability of the current contract for doctors in training. The report took into account the views of a wide range of employers within the NHS, with results published by the Department of Health in December 2012[1].

This scoping report proposed working towards a new contract for doctors in training. In essence, this new contract would aim for doctors in training to feel valued and engaged, leading to better patient outcomes and improved relationships between doctors, employers and deaneries.

Since the publication of the scoping report, NHS Employers and employer representatives in the devolved nations and the British Medical Association (BMA) have held exploratory talks about possible changes to the contract; covering the employment terms and conditions for all those training in the UK. As a consequence of these exploratory talks, a draft heads of terms document has been produced to outline the scope for possible formal negotiations to achieve a new contract[2].

NHS Employers and the BMA are now considering these heads of terms to determine if they wish to proceed to formal negotiations on the junior doctor contract.

Methodology

The BMA wanted a better understanding of the opinions of its members on the issues that would be covered in contract negotiations if they go ahead. They can be grouped into four key areas:

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1 http://www.nhsemployers.org/payandcontracts/medicalanddentalcontracts/juniordoctorsdentistsgpreg/pages/junior-doctors-contract.aspx

2 http://bma.org.uk/juniorcontract

- Working hours
- Pay
- Quality of life
- Training

To meet this aim, the BMA launched an online questionnaire and asked members, in particular junior doctors and medical students, to provide their views and opinions on the issues listed above. The BMA established a dedicated page on its website containing all relevant information, including a link to an online response form as well as various links to related resources such as the draft heads of terms document and the 2012 scoping report[3].

The BMA emailed junior doctors and medical students to raise awareness of the consultation and mailed out an information pack to all junior doctors who are members of the BMA. Ipsos MORI was commissioned by the BMA to analyse the initial responses received during the first 17 days the questionnaire was online. This focused on the groups most directly affected; junior doctors and final and penultimate year medical students. All responses will be analysed in detail by the BMA for a final report to feed into contract negotiations if they go ahead.

The findings in this interim report are based on responses from junior doctors and final and penultimate year medical students to the online questions received between 20th June and 5th July. The questions, designed by the BMA without input from Ipsos MORI, comprised a number of precoded "demographic" questions initially, followed by four open ended questions to allow respondents to express their opinion on the topic. The exact question wording can be found in the appendix of this report. Responses to an additional open ended question, asking for any other thoughts or opinions on employment terms and conditions, will be analysed for the final report.

The BMA provided Ipsos MORI with a download of the relevant responses. All data provided to Ipsos MORI by the BMA was anonymised and filtered to ensure only current junior doctors and final and penultimate year medical school students were included, as defined by responses to the demographic questions. Ipsos MORI then coded all responses based on

[3] http://bma.org.uk/juniorcontract

the key themes for each question and used this to guide our analysis of the major findings to emerge from the online responses. In total, 1,661 junior doctors and final and penultimate year medical students responded to the consultation within the interim analysis time frame. Further details of the types of doctors and medical students who responded can be found towards the end of this report.

While a consultation exercise of this kind is a very valuable tool for gathering opinions about a wide-ranging topic, there are a number of things to bear in mind when interpreting the responses. While the questionnaire was open to everyone, the respondents were self-selecting, and certain types of people may have been more likely to contribute than others. In other words, the consultation reflects the views of those who were aware of the consultation and actively responded.

This means that the responses are not representative of the population of any audience as a whole. The findings cannot therefore be extrapolated to the overall populations.

Typically with consultations, there can be a tendency for responses to come from those more likely to consider themselves affected and more motivated to express their views. In previous consultations, we have found that responses also tend to be more biased towards those people who believe they will be negatively impacted upon by the implementation of proposals.

The following report is a summary of the key themes emerging from the online consultation, illustrated by anonymised quotes from the respondents.

2. Working hours

2. Working hours

The first question explored the working hours of doctors in training and aimed to understand what limits they felt should be applied to the present system to improve their own and their patients' safety and wellbeing. Respondents were asked;

"What sort of limits on working hours do you think are needed to keep doctors and patients safe?"

Of the 1,661 junior doctors and final and penultimate year medical students who responded to the consultation, 1,627 responded to this question.

Key themes:

- While some respondents felt that 48 hours average per week was an acceptable limit of working hours, others mentioned a need to increase the working hour limit. Broadly similar numbers of respondents expressed either view.
- Recorded hours should more accurately reflect those worked, and there should be stricter enforcement of the 48 hour average limit.
- Some respondents felt that rotas needed to be improved, with mentions of unrealistic workloads, stress and exhaustion.
- The need for more rest between shifts was also cited, including specific mentions in relation to night shifts.

Limits on hours worked

There were mixed views of how many hours per week doctors should work. Many respondents considered the existing 48 hour average limit – as mandated by the European Working Time Directive (EWTD) – to be appropriate. Others expressed concerns surrounding the way in which, in their experience, it was not always strictly enforced or practical to limit hours in this way.

"The overall limit of 48 hours a week is a laudable goal but is unrealistic and doesn't reflect what we actually do. Particularly on the medical wards and whilst on call, I have consistently had to do additional hours in order to maintain good quality, safe patient care."

Junior Doctor, Wales

A variety of alternative weekly maximum working hours were suggested by respondents, ranging from fewer than forty to eighty or more. Overall, there emerged a widespread sense that some level of change would improve the current system and benefit both doctors and patients. Respondents suggested this might include changing the limit on weekly hours worked or the way in which the existing limit is enforced.

"Current levels are fine, if they are adhered to. Sadly, I have often worked beyond them on a regular basis and surprisingly never when the monitoring weeks occur."

Junior Doctor, England

There were varying levels of dissatisfaction with the way in which weekly hours are averaged out across periods of several months. For some individual doctors, this process resulted in inconsistencies in scheduling, with very few weeks actually consisting of 48 hours at work. In reality some doctors reported working as many as 100 hours over a given week, a practice that could be made compliant by the averaging out of these longer weeks with periods of fewer or no hours at other times during a rotation. This practice was highlighted as a major problem; many of those who have found themselves in the position of working these longer hours expressed worries for their own and their patients' safety during the latter hours of these long weeks as tiredness began to impact upon their ability to work and make decisions safely.

"I think the average working hours over a course of a rotation can be misleading and can lead to overworked doctors during a typical week. My average working week may have complied but on occasion (especially on nights) I would have worked over 100 hours in one week which was not safe by the end."

Junior Doctor, Scotland

Respondents reported that working additional hours outside their scheduled shifts, for example by staying on late at the end of a shift to finish tasks, was a regular occurrence or, in many cases, the norm. Furthermore, they said these extra hours tended to go unrecorded and unpaid.

> *"Current hours are bad enough, especially since we have to stay late unpaid most days to finish ward work due to poor staffing. We need the same hours but more staff, not less staff more hours."*
>
> *Junior Doctor, Wales*

Understaffing was the most frequently cited reason for unrecorded extra hours. Doctors emphasised their obligation towards providing the best possible quality of care to patients. They also felt it important to consider the interests of fellow doctors in the same situation. Many felt that while it was unfair that they themselves should work extra hours unpaid, it would be equally unfair to their colleagues to pass the workload on to them at the start of their own shift.

> *"'We are told that we stay late out of our own choice and that nobody forces us to do this. The fact is that we feel obligated to stay to finish our jobs so that patient care doesn't suffer and we also don't want to 'dump' jobs onto our colleagues working the evening and night shifts."*
>
> *Junior Doctor, England*

At the same time, respondents acknowledged that fulfilling their duty to patients and doing their job properly and thoroughly would inevitably mean longer hours. They accepted this as simply a reality of their chosen career in contrast to the hours typical of other professions.

> *"Imposing limits on working hours does not change the hours doctors actually work – those who do the job properly will stay after hours every day as the workload is not feasible to be completed in an 8am-5pm day."*
>
> *Junior Doctor, England*

Respondents wanted their hours to be more closely monitored and more accurately recorded in order to allow fairer pay and prevent periods of what they sometimes perceived to be

dangerously excessive working hours. However, they found the restrictiveness of the 48 hour average weekly limit to be part of the problem. From this point of view, the shortness of a 48 hour week was viewed by some as impractical and poorly aligned with patient needs.

> *"An 8 hour day is not realistic in the majority of trusts, and it is not ideal for patients. The only thing I think the current contract and EWTD compliance has introduced is widespread lying about the hours we work."*
>
> *Junior Doctor, England*

For this reason, an increase to the limit on the weekly working hours was supported by some respondents. They felt this would allow trainees to be fairly paid for the real number of hours they work and help them to provide the best quality and continuity of care to patients. It would also help doctors in training gain valuable experience and participate in more and better quality training.

> *"A balance (is needed). Training requires time and hours before competence can be achieved. For patient safety we must train the next generation of doctors. For doctors' safety we must not work rotas which are designed to run us into the ground."*
>
> *Junior Doctor, England*

Scheduling of shifts

Aside from changes to the limit on weekly working hours and the averaging out of weekly hours over a period of several months, a number of other suggestions were made for improving the current system of rotas. Recurring suggestions included:

- imposing (and enforcing) limits on the length of individual shifts;
- imposing limits on the number of shifts worked consecutively – especially longer shifts;
- limiting the number of night shifts worked consecutively;
- limiting the number of on-call shifts worked consecutively or within a given time frame;

- allowing longer periods of time off in between long shifts, especially following nights and on-call; and

- allowing for – and enforcing – uninterrupted ('bleep free') breaks to be taken, particularly during longer shifts.

Among the majority of respondents suggesting these changes, there was an underlying sense of concern for the safety of both doctors and patients. Under the current system, some respondents reported having worked stretches of up to twelve or thirteen consecutive shifts with no full days off in between. This could result in 80+ hour working weeks, even before any unscheduled extra time was considered. Respondents described the effects of such long hours as fatigue, low morale and an inability to carry out their work as effectively as they would like to.

> *"The notion of averaging working hours over X number of weeks is of little value when you find yourself working for the 13th consecutive day and unable to think clearly because of fatigue."*
>
> *Junior Doctor, England*

For this reason they called for fairer implementation of limits on hours and shift lengths, and stricter monitoring of actual hours worked. They wanted these limits to be applied in particular to antisocial working hours such as nights and on-calls. Too many of these in a row, or switching too quickly or too frequently from night shifts to day shifts without appropriate time to rest in between, was a common cause for concern among respondents. They described such irregular shift patterns as having a damaging effect on their sleeping patterns, energy levels, psychological state and general wellbeing, expressing concerns for both their patients' safety and their own.

This was more of an issue for respondents who had to travel larger distances to and from work. Travel time reduced the amount of time they could spend sleeping and recovering between the end of one shift and the beginning or another – upon which a legal limit of 11 hours is currently in place. Working long shifts, especially overnight and towards the end of a long run of consecutive shifts, led to worries about their safety when driving home.

"Night working needs more controls in order to keep doctors safe. I can manage a run of intense 13 hour night shifts in a busy tertiary centre but I am terrified about falling asleep on the 37 mile drive home."

Junior Doctor, England

Understaffing and lack of resourcing, particularly out-of-hours, was highlighted by some as a problem within the current scheduling system. Again, there were worries about the implications that this could have for the physical and mental wellbeing of both doctors and patients.

"The hours do not bother me, but patient safety is hugely compromised when only one junior doctor is working (e.g. on an on-call shift). It's not safe for the patient or the doctor (adds huge amounts of stress, and puts a lot of pressure on them)."

Junior Doctor, Scotland

As well as increased numbers of staff, at critical times some respondents called for the enforcement of uninterrupted ('bleep free') breaks, particularly during longer shifts. They described hectic periods at times in busy departments, in which they would sometimes work 12 hours or more without what they consider to be adequate breaks for food and rest. This again led to concerns about the impact that fatigue and hunger could potentially have on their performance and decision-making and, as a result, on their own and their patients' safety.

"Having proper breaks is also important on longer shifts. If you are tired and hungry you cannot function safely but often, due to demands, you do not get a break. This happened to me on 12 hour ward cover shift when I was 6 months pregnant, I was certainly not safe without a break but I kept getting bleeped for urgent things and the other doctors on-call were all too busy to help."

Junior Doctor, England

3. Pay

3. Pay

The second open-ended question was about pay. In particular, respondents were asked to suggest ways in which pay for doctors in training could be made fairer and easier to understand. Respondents were asked:

"How could the way that doctors are paid be made fairer and easier to understand?"

Of the 1,661 junior doctors and final and penultimate year medical students who took part in this consultation, 1,518 provided a response to this question.

Key themes:

- Many respondents said pay for a specific role should be based upon the number of hours an individual actually works, rather than a contractually established limit.
- They also suggested basing pay upon workload, intensity of role or antisocial hours.
- Respondents wanted advance notice of banding or pay scale for each post.

A minority of respondents stated that the way in which their pay is currently calculated is easy to understand and requires no change. A range of potential areas for improvement were suggested.

It is interesting to note that there were relatively few suggestions that pay overall should be increased.

Greater clarity

A clear overarching theme to emerge from this question was respondents' views that the way in which doctors in training get paid can be confusing and unclear. Specifically, the banding system was believed to be complex. A number suggested that better definition could be provided by both their HR departments and also by the BMA as to what constitutes the different bandings.

"Banding is too complicated – making the process easier to understand would be ideal, as it is difficult to see how doctors can be paid fairly without a banding process."

Medical student, England

Respondents also highlighted a need for transparency in banding calculations so they knew the exact amount they would be 'taking home' each month. This issue was particularly pertinent for junior doctors and final year medical students, who undertake different rotations over the course of a year.

Factors for consideration in banding calculations

Some respondents suggested that banding should be based upon the actual hours they work, rather than what their contract defines as time spent at work. They felt that introducing hourly pay, strict and accurate workload monitoring or pay for all overtime worked in addition to contracted hours would go some way to rectify the current system.

A small handful directly referenced the system currently in place in Australia, where timesheets are submitted for hours worked and pay is a reflection of the type of hours worked (i.e. greater pay for overtime/extra hours on-call). Others suggested the introduction of a 'clocking in/out' system as a way of more accurately reflecting the hours worked, in reality, as opposed to those officially recorded.

"It would be better if the amount paid was proportional to the amount worked. I know doctors who work crazy hours that definitely deserve 1a banding but are only 1b, because the amount they officially work is much less than the amount they do work."

Medical Student, England

As well as banding to reflect the actual hours worked, many respondents suggested that the intensity of the workload as well as the number of antisocial hours involved should be taken into consideration. A number of respondents specifically highlighted the way 'high intensity' roles in specialities such as emergency medicine can warrant the same pay as perceived 'low intensity' roles in specialities such as psychiatry, dermatology and rheumatology. A number also questioned why a 12 hour on-call shift within these high intensity roles is equivalent to a 12 hour on-call shift in smaller sub-specialties, where doctors can be based at

home. The common theme was a perceived unfairness in the current system that appears to allow individuals in different roles to be within the same pay band.

> *"I think banding should correlate to hours worked, unsociable hours and intensity of work done. I did an A+E rotation at F2 level and I was on the same banding as someone in psychiatry! The difference in the demands of the jobs was so large that that should not have happened."*
>
> *Junior Doctor, England*

In essence, many of those taking part advocated a move away from a perceived 'one size fits all' approach. A system of calculating pay that more accurately reflects the day to day work carried out by doctors in training was seen as a fairer solution.

> *"A simple system that takes into account hours, intensity and degree of unsocial hours is fair, logical and easy to understand."*
>
> *Junior Doctor, England*

Advance notice of pay for rotations

Among those who answered this question, there was a desire to have advance notice of the banding or pay scale allotted to a particular post they may be moving into. It was suggested this information should be provided at the application stage for a post or, at the latest, prior to receiving the first pay slip. Reference was frequently made to the perception that this would not happen for other occupations, with many questioning why it was allowed within the medical profession.

> *"Much more advance notice of pay and job demands. Often banding is revealed within weeks of a job – this is unacceptable for personal planning."*
>
> *Junior Doctor, Scotland*

As the majority of respondents were junior doctors, many used their own experience of rotating through many different roles to explain their concerns. As mentioned previously, a number of respondents expressed frustration that rotations had different pay scales or required hours of work, and that there did not seem to be a generalised scale upon which pay was graded. This fluctuation in pay across differing roles, coupled with the uncertainty of

pay prior to starting a new role, ultimately caused difficulty in managing personal finances, responsibilities outside of work and planning for the future.

> *"No information is available when applying for rotations therefore, with mortgages and kids, applying for jobs can leave you in financial limbo."*
>
> *Junior Doctor, England*

> *"I would like a mandatory notice of the banding of each job before its application deadline. I think it is only fair that we know the pay of each job before we apply, and at the very least know by the time we are accepted. This makes planning housing and other costs possible."*
>
> *Junior Doctor, England*

4. Quality of life

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The questions then moved on to discuss how employment terms and conditions should improve the quality of life for doctors in training. Respondents were asked:

"How should your employment terms and conditions improve your quality of life?"

Of the 1,661 junior doctors and final and penultimate year medical students who took part in this consultation, 1,446 provided a response to this question.

Key themes:

- Respondents requested advance notice of rotations and rotas.
- Some also suggested changes to annual leave processes such as abolishing fixed annual leave and providing more flexibility over taking annual leave.
- They also mentioned the need for fair remuneration and pay for overtime.

Notice of rotations and scheduling

When considering how employment terms and conditions should improve quality of life, the most common mention was the need to have advance notice of future rotations and/or rotas.

The unpredictability of not knowing where a doctor in training will be placed for their next rotation was a concern for many respondents. They cited the effect this has on their home life, a particularly important point for respondents with families, where the need to plan and manage childcare in advance is a key priority.

> *"It is totally unacceptable that I will finish my F1 job on a Tuesday and start my F2 job the following day, even though I need to relocate."*
>
> *Junior Doctor, England*

Some respondents also cited the additional travel time that may need to be taken into account when moving to a new rotation, particularly if they currently work within a deanery with a large geographical coverage.

> *"It would be useful to know at least a few years in advance where your preliminary postings will be. It's not so bad in smaller deaneries but in larger ones, you cannot always commute to different posts."*
>
> *Junior Doctor, England*

Some respondents suggested minimum notice periods should be given ahead of starting a new rotation; this ranged from a few weeks' to a year's notice. This was especially important for those with families, for example.

> *"It would be great to know where you will be rotating to more than a couple of months in advance so that you can plan you life and annual leave; especially if you have a family so that you can all go on holiday together."*
>
> *Junior Doctor, England*

Related to this desire to receive notice of the location of future rotations in advance, respondents were equally keen to have advance notice of the actual rotas they are expected to work. This was highlighted as a necessity prior to starting a new rotation and also as an ongoing requirement of the rotation itself.

Some cited that they currently receive their rotas for the following week very late the previous week; this makes it hard to plan their life outside work effectively.

> *"I currently get my rota on a Sunday evening for the week ahead – this means I have no life and cannot make any plans."*
>
> *Junior Doctor, England*

Again, there was a range of suggested timeframes for notice of rota requirements. However, the key theme was that the current setup does not allow stability in their life away from work. Some respondents mentioned the inherent unfairness currently perceived to be in place, whereby doctors in training may be required to give many weeks' notice of any anticipated leave, but employers were not required to provide rotas similarly far in advance.

Greater flexibility for annual leave and personal circumstances

Flexibility for when doctors in training can take annual leave was a key quality of life issue for some. There were particular mentions of the need to abolish fixed annual leave. There was a widespread view that fixed annual leave was incompatible with life away from work, with many respondents struggling to fit their leave around the needs of their family and friends.

> *"Many of us are working parents with working spouses – fixed leave etc is incompatible with our family life."*
>
> *Junior Doctor, England*

Many respondents cited the need for greater flexibility and more choice for when they can take annual or, as explored in the next chapter, study leave. They felt that being able to plan annual leave more than a few months in advance and to be able to schedule leave with spouses, family or friends was imperative to maintaining a good quality of life.

> *"I am sick of never being able to take more than 3 days annual leave in a row, never having time off with my husband and never being able to plan leave more than 4 months in advance."*
>
> *Junior Doctor, England*

Having the flexibility to alter annual leave to accommodate a variety of personal commitments such as weddings, family emergencies and bereavements was highlighted by some as a need for doctors in training. At present this was seen as problematic due to the nature of doctors' working hours and the difficulty they often face in planning and securing cover for absence.

Maternity leave was only specifically mentioned by a handful of respondents to this question. In most cases it was noted that there needed to be greater flexibility in the leave available for maternity. There were also mentions for a change in attitude to allow prospective mothers, and fathers for paternity leave, to have the time off they require and are entitled to without feeling pressurised to be back at work.

Other issues

A number of other issues were mentioned that respondents suggested affect the quality of life for doctors in training. Also covered specifically by other questions, but highlighted here as well, respondents again reiterated the need for:

- Fair remuneration for working overtime or during unsociable hours. Again, respondents acknowledged that the needs of the medical profession sometimes requires doctors to work overtime or long hours, but many felt there should be both financial and managerial recognition of this practice.

- Sufficient time off between shifts to allow rest and recuperation, and a particular desire for fewer consecutive shifts (particularly night shifts) was cited by a number of respondents. It was widely perceived that better scheduling would greatly improve the quality of doctors' lives.

  "7 nights in a row should not be permitted...no quality of life at all for the week on nights and then it takes a considerable time to re-adjust while being expected to be back in work 2 days later for a full week. I expect to have sufficient time for hobbies and family and at the minute as a FY1 I don't feel I have enough time for life outside work."

  Junior Doctor, Northern Ireland

  "I better serve society and my patients if I can pursue my interests outside of work. I should not have to work 12 day stretches, [or] 12 hour shifts; it's not safe and means no quality of life outside work."

  Junior Doctor, England

- Better provision and enforcement of breaks during work, as well as good quality rest areas and appropriate facilities to allow them to return to work/attend to on-call duties feeling alert and refreshed.

  "Breaks should be given rather than implied as something that might happen if you're lucky. Hospitals should reverse the policy of removing sleep off room for night staff."

  Junior Doctor, Wales

5. Training

5. Training

The final topic explored was training. The question, to which 1,382 junior doctors and final and penultimate year medical students responded, asked;

"How should your employment terms and conditions facilitate access to training opportunities?"

Key themes:

- Some respondents wanted training hours and study leave to be mandatory, enforced and/or part of their contract.
- They felt there should be protected time on rotas for all training and study leave.
- Some respondents said training or study time should be 'bleep free' or protected from being used for service provision, with a need for balance between training and service provision.

Better enforcement of training and study time

The issue emerging most frequently from responses to this question was the assertion that study and training time was frequently sidelined in favour of service provision. This was primarily attributed by respondents to a lack of staff to cover absences. As a result, respondents wanted greater cover during their training time.

> *"If clinics are meant to be part of our educational achievements then time away from the wards and on-calls MUST be provided without question. (Again – we need more doctors desperately!)"*
>
> *Junior Doctor, England*

To resolve this problem, respondents suggested that training and study time in their rotas should be mandatory, written into their contract and protected. They felt that deaneries or Trusts should be obligated to provide the necessary cover to facilitate this. Additionally, some respondents felt that their employers should face penalties if they fail to provide adequate training opportunities or allow trainees to use their full study leave entitlement. Many respondents reported having faced difficulties in their efforts to dedicate what they felt was a

sensible and necessary proportion of their time to study and training. Therefore, a significant number of respondents said that they wanted the process of obtaining study leave to be made easier and more flexible.

> *"Study leave should actually be accessible. We were told in no uncertain terms at the beginning of our block that we would not be able to take all the study leave we are entitled to."*
>
> *Junior Doctor, Scotland*

As indicated from previous questions, some of the respondents felt that general problems in obtaining study leave stemmed from:

- last-minute issuing of rotas;
- the notice period required for the submission of applications for leave; and
- lack of flexibility within these rotas due to the limited numbers of staff scheduled to work at any given time.

Lengthy and complex application forms requiring the signatures of clinical supervisors were also identified by some respondents as a concern. These supervisors, in turn, had little or no influence on rota co-ordination or cover arrangement. Where study leave entitlement had been allocated in advance, important courses and training opportunities arose outside these times. Where this was the case, attendance was usually not possible. A number of respondents expressed frustration at having been required to find their own cover for intended study leave. Furthermore, they said they were typically denied their desired leave when they were unable to find cover. Others reported using their annual leave to attend courses and conferences because they were not able to obtain the study leave to which they were entitled.

As a result of these administrative difficulties, respondents tended to say that prioritising training and taking study leave was discouraged and negatively viewed. Some suggested this was seen as little more than a hassle by their superiors.

"In many cases (study leave is) frowned upon as you are seen to be leaving your team shorthanded."

Junior Doctor, England

Some respondents felt that training should be seen more positively by employers. Educational development was widely perceived to be of vital importance to respondents' medical careers and success in their profession. They highlighted the negative impact that neglecting this could have upon the welfare of patients. It was commonly felt that a shift in ethos was required, to a culture in which trainees' desire to learn could be encouraged and supported. This, it was felt, would require a better balance between service provision and education.

"It should be compulsory that a certain amount of training/conferences are attended. At the moment we are made to feel like we're shirking our responsibilities by attending teaching and I have found it impossible to get study leave to attend any conferences. The ethos needs to change and learning encouraged."

Junior Doctor, Scotland

Increased learning budget

Respondents felt that an increase in the amount of funding dedicated to study and training would improve their ability to cope with the financial demands of their medical education. There was some confusion surrounding the process of obtaining funding for exams and courses, and the amount of funding available to doctors in training. Some respondents felt that they were required to fund their own education, while others found the funding budget currently available to them to be inadequate.

"Funding should be available… it is grossly unfair that other healthcare professionals within the NHS get their postgraduate development funded while junior doctors have to pay thousands of pounds for courses and exams which are effectively a requirement of their continued employment."

Medical Student, England

"Training budgets (ours is around £500/annum) are not sufficient to cover all costs. Mine goes on transport to 10 regional training days per year, after which there are minimal funds left for anything more (courses/conferences etc)."

Junior Doctor, England

Other respondents called for easier access to available funding. They described the existing process of acquiring funds from study budgets as an overly complicated and confusing one of 'jumping through hoops'. In light of this, some respondents called for a simplified approach in which trainees could perhaps be given autonomy over their own study budget allowance, to use as they saw fit.

"Currently there is a bizarre system where you book courses, pay for them then have to ask if the unit will fund it, and (there is) a difficult set of paperwork to go with it."

Junior Doctor, Scotland

Appendix

Appendix

Questions

The BMA designed the questions for the feedback, of which four key questions formed the core. They were:

- Q1. What sort of limits on working hours do you think are needed to keep doctors and patients safe?
- Q2. How could the way that doctors are paid be made fairer and easier to understand?
- Q3. How should your employment terms and conditions improve your quality of life?
- Q4. How should your employment terms and conditions facilitate access to training opportunities?

Who responded to the feedback questionnaire?

The questionnaire was launched on the BMA website on the 20th June, with daily downloads of data (solely consisting of junior doctors and final and penultimate year medical students) provided to Ipsos MORI until Friday 5th July, the agreed date for interim analysis of responses.

In total 1,661 junior doctors and final and penultimate year medical students responded to the consultation within this timeframe. Again, it is important to note that those responding are self-selecting and not representative of the wider population.

(It should be noted that all percentages referred to below are rounded to the nearest whole number, and that when two or more such figures are added, it can create rounding error; the rounded figures given in a column, therefore, may not sum to exactly 100%. An * represents a percentage lower than half of one per cent but higher than zero).

Below is the key profile information of the data that was sent to Ipsos MORI for interim analysis.

A. Are you a junior doctor or medical student?

Consultation responses by job role		
	Number of responses	% of total responses
A Junior Doctor	1426	86%
A Medical Student	235	14%
Total	***1661***	

B. What is your gender?

Consultation responses by gender		
	Number of responses	% of total responses
Male	882	53%
Female	767	46%
Prefer not to say	9	1%
[No response]	*3*	*%
Total	***1661***	

C. Where do you primarily work or train?

Consultation responses by nation		
	Number of responses	% of total responses
England	1370	82%
Wales	59	4%
Scotland	177	11%
Northern Ireland	55	3%
Total	***1661***	

D. Are you a penultimate or final year student (as of 2012/13)? *[all respondents who are currently a medical student]*

Consultation responses by medical school year		
	Number of responses	% of total responses
Yes, I am a final year student and I am due to start work as a FYI in August/September 2013	101	43%
Yes, I am in my penultimate year	134	57%
Total	***235***	

E. What is your grade? *[all respondents who are currently a junior doctor]*

Consultation responses by grade		
	Number of responses	% of total responses
Foundation Trainee	411	29%
GP trainee/registrar	120	8%
Specialty trainee	799	56%
FTSTA (Fixed Term Speciality Training Appointments)	5	*%
LAT (Local Area Teams) / LAS	25	2%
Locum post	11	1%
Trust grade	12	1%
Non-standard research/academic post	17	1%
Armed forces post	2	*%
Post CCT Fellow	10	1%
Qualified CCT holder	4	*%
Other	9	1%
[No response]	*1*	*%
Total	***1426***	

F. What is your current specialty? *[all respondents who are currently a junior doctor]*

Consultation responses by current specialty		
	Number of responses	% of total responses
Hospital practice	1259	88%
General practice	101	7%
Public health medicine	9	1%
Community health	9	1%
Research/academic medicine	28	2%
Other	18	1%
[No response]	*2*	*%
Total	***1426***	

G. What is your hospital specialty? *[all respondents who are currently a junior doctor and work within a hospital practice]*

Consultation responses by hospital specialty		
	Number of responses	% of total responses
Core training	113	9%
Acute Care Common Stem	70	6%
Anaesthetics	174	14%
Clinical Radiology	20	2%
Medical specialty	263	21%
Histopathology	12	1%
Medical Microbiology and Virology	4	*%
Neurosurgery	11	1%
Obstetrics and Gynaecology	76	6%
Ophthalmology	15	1%
Oral and Maxillo-Facial Surgery	3	*%
Paediatrics	99	8%
Psychiatry	56	4%
Public Health	-	-
Surgical specialty	240	19%
Other	103	8%
Total	***1259***	

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