Centre for Employment Relations Innovation & Change
LEEDS UNIVERSITY BUSINESS SCHOOL

An Enquiry into the Morale of Junior Doctors

Policy Report No. 8

Ioulia Bessa, Andy Charlwood, Hugh Cook and Nick Jephson
Acknowledgements

The research described in this report is part of a wider project examining the role of social norms in happiness at work, originally supported by a British Academy mid-career fellowship awarded to Charlwood. The support of the British Academy in developing this research is gratefully acknowledged.


About the Authors

Ioulia Bessa is Research Fellow at the Centre for Employment Relations Innovation and Change.

Andy Charlwood is Professor of HRM at Loughborough University and an associate member of the Centre for Employment Relations Innovation and Change.

Hugh Cook is Lecturer in Employment Relations and HRM at Leeds University Business School.

Nick Jephson is Teaching Fellow at Leeds University Business School.

About CERIC

Leeds University Business School’s Centre for Employment Relations, Innovation and Change (CERIC) engages with contemporary issues in the areas of work and employment that have direct policy relevance and significance. Members of CERIC have a recognised external reputation and an outstanding track record of publications at the level of international excellence. Research conducted by members of CERIC has led and contributed to not only academic debate but provided an important evidence base for policy makers. Engagement with end-users and knowledge translation forms a central component of the research activity of much of the Centre’s work.
Contents

Executive Summary............................................................................................................. p3
Introduction.......................................................................................................................... p4
What is morale? Understanding the subjective wellbeing of junior doctors......................... p8
Introducing our study.......................................................................................................... p15
Findings............................................................................................................................. p18
References......................................................................................................................... p28
Methodological Appendix................................................................................................... p29

List of Figures

Figure 1. Average (mean) levels of job satisfaction............................................................. p10
Figure 2 Average (mean) levels of life satisfaction.............................................................. p11
Figure 3 Average (mean) levels of life satisfaction.............................................................. p11
Figure 4 Average (mean) levels of worthiness of things in life (eudemonic wellbeing)........p12
Figure 5 Average (mean) levels of psychological wellbeing................................................p12
Figure 6 Average (mean) levels of anxiety........................................................................p13
Figure 7 Average (mean) levels of happiness....................................................................p13
In the wake of the recent industrial dispute between junior doctors and the Department of Health over the introduction of a new contract, the Secretary of State for Health has commissioned an inquiry into the morale of junior doctors led by Dame Sue Bailey.

Junior doctors themselves claim their morale is low, but have refused to cooperate with the inquiry because they disagree with its terms of reference.

In this context, the report provides an enquiry into the morale of junior doctors based on semi-structured interviews with 20 junior doctors, conducted during the dispute. The report therefore provides an account of junior doctors’ morale in their own words.

Junior doctors reported high morale when they had identified an area of medicine and future career path that they wanted to follow, but many felt insecure because they had not yet identified their future careers.

Low morale could often be attributed to four factors: workload and work intensity; feeling undervalued by management; dissatisfaction with the way that junior doctors are managed by non-clinical managers; feeling that there is a conflict between personal values of ‘being a doctor’ and the requirements of the job.

The industrial dispute appears to have had the effect of intensifying negative feelings related to these four factors, by focusing doctors’ attention on them.

The misfit between doctors’ personal values of what it means to ‘be a doctor’, centred on an ethic of patient care and a working environment where doctors feel that they cannot adequately practice that ethic, are likely to lead to significant numbers of doctors seeking to practice medicine elsewhere.

To prevent this from happening, urgent action is needed to address low morale among junior doctors.
The purpose of this report is to enquire into the morale of junior doctors in the wake of the recent industrial dispute, drawing on the voices and accounts of junior doctors themselves. This is important because junior doctors’ leaders claim that “morale is desperately low with high levels of anxiety, stress and burnout” (Trainee Doctors Group, 2016). In response to this, the Secretary of State for Health announced an inquiry into the morale of junior doctors, headed by Dame Sue Bailey, Chair of the Academy of Medical Colleges. The inquiry is scheduled to report at the end of 2016. However, the terms of reference of the inquiry are to examine long standing non-contractual issues known to affect morale, including relationships between junior doctors, the hospitals in which they work and their more senior colleagues; competing demands between junior doctors’ training needs, career development and NHS requirements; work environments, bullying and flexibility (Department of Health, 2016). Junior doctors have refused to cooperate with the inquiry because of its failure to consider issues of pay and conditions of service (Trainee Doctors Group, 2016). Therefore this enquiry brings the junior doctors perspective on their own morale to the fore, in a way likely to be missing from the official inquiry.

Chapter 1

Introduction

What is a junior doctor?

In the United Kingdom, the term ‘junior doctors’ refers to doctors who have graduated from medical school undergoing further training in a specialist area of medicine (e.g. surgery, general practice, children’s medicine) while working as a doctor. This consists of two years of foundation stage training typically followed by 3 years (for general practice) or 7 years of specialist training. The basic starting salary for junior doctors at the beginning of foundation year one is £24,006. This can rise to £47,647 - £71,471 towards the end of specialist training (depending on area of specialism and the shift pattern the doctor works).
What caused the industrial dispute?

The industrial dispute centred on two key issues. Firstly, premium payments for working evenings and weekends. The government wanted to reduce these payments in return for an 11 per cent increase in basic pay. The likely effects of this change differed according to the shift patterns each doctor typically worked, but many doctors believed that they would be substantially worse off as a result of this change. In addition to unhappiness at the loss of income, many doctors expressed concern that reductions in unsocial hours payments would lead to shortages of doctors in areas where doctors faced the largest effective pay cuts. This, combined with concerns that proposed new systems for ensuring that junior doctors could not work excessive hours were not strong enough, led to concern that the proposed contract was unsafe because it would result in too few doctors working too many hours. Secondly, the government proposed ending annual pay increments, with increments linked to completion of training stages. This would disadvantage (the mainly female) doctors who progress through training more slowly because of periods of maternity leave and part-time work. The final contract, agreed by the BMA in May, but rejected by a majority of junior doctors in July, largely met doctors’ concerns over the equality implications of the contract and controls for overtime, but gave little ground on the central issue of pay.

This enquiry is based on the analysis of interviews we conducted with 20 junior doctors between October 2015 and June 2016. In these interviews we asked a standard set of survey questions that occupational psychologists use to assess subjective wellbeing at work and then asked our subjects to explain why they had answered in the way that they had. We then undertook a systematic analysis of the interviews to identify the key themes that interviewees said accounted for their answers. Because the size of the sample was relatively small and because participants were not selected entirely at random, we do not claim that our results are representative of all junior doctors. Nevertheless, our findings are of value for contextualising and making sense of more broadly representative survey data. Our approach gives an insight into the lived experience of working life that underpins responses to questionnaires and surveys about morale at work. It is therefore a valuable source of evidence in assessing and understanding the morale of junior doctors.
Timeline of the junior doctors’ dispute

**OCTOBER 2013** – Negotiations over a new contract for junior doctors between the BMA and NHS employers begin.

**AUGUST 2014** – The BMA reject the proposed contract and break off negotiations. BMA organises public protests.

**OCTOBER 2015** – BMA ballots junior doctors on strike action, 98% vote for a series of one and two day strikes.

**DECEMBER 2015** – First three 24 hour strikes called off to allow more time for negotiations.

**JANUARY/FEBRUARY 2016** – Two 24 hour strikes.

**MARCH/APRIL 2016** – Two 48 hour strikes, emergency cover also withdrawn for the 2nd strike.

**MAY 2016** – New contract agreed by BMA and Department of Health.

**JULY 2016** – Junior doctors vote to reject the new contract, Department of Health says contract will be imposed without agreement.
Policy Report No. 8 | An Enquiry into the Morale of Junior Doctors

IMAGE SOURCE: John Gomez / Shutterstock.com
Morale is a psychological state of enthusiasm and loyalty. In a work setting, occupational psychologists have developed a number of approaches to measuring morale and closely related attitudes and emotions. This report focuses on one of these approaches: subjective wellbeing (SWB). SWB is a broad term that encompasses a number of indicators of psychological health and wellbeing (Indicators of morale not directly related to SWB would include commitment and loyalty).

One of the most well-known and widely used approaches to measuring subjective wellbeing at work was developed by Professor Peter Warr of the Institute of Work Psychology at the University of Sheffield (Warr, 1990). Warr presents a model of subjective well-being at work which has three dimensions, enthusiasm/depression, pleasure/displeasure (measured by job satisfaction) and contentment/anxiety. This approach provides the empirical basis for this study. The junior doctors we interviewed were asked Warr’s standard survey questions for measuring subjective wellbeing. They were then asked to explain why they answered the survey questions in the way they had and were prompted to consider the factors that underpinned their assessments of their jobs.

Before we get to the results of our study, it is useful to know about indicators of SWB among junior doctors collected in nationally representative social surveys before the dispute started in order to provide context. Two nationally representative surveys are large enough to allow us to examine SWB among junior doctors: Understanding Society and the Annual Population Survey.

Understanding Society: The United Kingdom Household Longitudinal Study (UKHLS)

The UKHLS is a survey that aims to follow the residents of 40,000 UK households over-time, asking them questions on topics such as their income, employment, family life and health. The survey started in 2009, with further interviews conducted annually. For our purposes, the UKHLS asks questions about job satisfaction, life satisfaction and psychological wellbeing, using a measure known as the GHQ12 (see appendix for details). The UKHLS is large enough that we are able to identify a small sample of 39 junior doctors in the first wave (wave A) of the survey (we define junior doctors as respondents employed in the ‘medical practitioners’ occupational group, who
are aged under 33\(^1\)). The number participating fluctuates somewhat between waves: wave B, 41; wave C, 35; wave D, 39; wave E, 35. The most recent data we have (wave E) mostly comes from interviews conducted in 2013 (i.e. before the start of the industrial dispute).

The Annual Population Survey (APS)

The APS is an annual survey of labour market behaviour and outcomes (e.g. employment status, wages). Around 340,000 individuals are surveyed annually. It is a cross-sectional survey, which means that different individuals are surveyed each year (in contrast to the UKHLS, which aims to keep going back to the same individuals). Since 2011, the APS has included 4 questions about subjective wellbeing, how anxious the respondent felt yesterday, how happy the respondent felt yesterday, how worthwhile the respondent feels the things they have done in their life, and their life satisfaction. Note that none of these questions are directly related to work. Working life may have an influence on responses to these questions, but this cannot be assumed. Nevertheless, these measures mean that we were able to get some insight into the overall subjective wellbeing of junior doctors, and how it compares to other occupational and age groups. The larger sample size of the APS means that we were able to identify 214 junior doctors in 2011, 222 in 2012, 200 in 2013 and 179 junior doctors in the 2014 survey, giving an overall of 815 junior doctors in the APS personal wellbeing in total over the four years. Once again, it is important to note that these interviews took place before the start of the dispute. Initial analysis of both surveys revealed that there were no statistically significant changes in the SWB of doctors or junior doctors over the period covered by these data. Therefore, we pool the data from multiple years.

Analysis

Questions about job satisfaction, life satisfaction and how worthwhile life is are evaluative in nature. Respondents are making an overall judgement about a facet of their lives, taking into account social norms and life goals. Most workers most of the time tend to respond relatively positively to questions about job satisfaction, because they tend to have a strong normative belief that having a job is important, because it provides purposeful activity, social status and allows for some autonomy and independence as a result of the income derived from work. Respondents do take into account the emotional impact that working conditions have, but for most workers most of the time working conditions do not have much of an emotional impact because they make psychological adjustments that allow them to cope with circumstances or conditions that they might initially find stressful or unpleasant. This works the other way around too. When a worker starts a new job with characteristics that they really like they will feel positive emotions, but over time they will become used to these characteristics so that positive emotions diminish (a process known as hedonic adaption). This means that workers

\(^1\)Our classification of junior doctors may contain some measurement error. It may include some GPs who have completed their training in the shortest possible time along with some younger doctors working in staff grades rather than on a training contract. It may also exclude junior doctors who have taken longer to complete their training, either because they work part-time, changed specialisms, undertook a spell working on a staff grade between training contracts, or interrupted their training for some other reason, for example a period of maternity leave.
often respond positively to questions about job satisfaction even if they do not really enjoy the
day to day experience of working, because they have stopped noticing or paying attention to the
things they don’t like, while social norms mean that they believe that having a job is important and
valuable. Consequently, measures of subjective wellbeing based on capturing workers momentary
moods and emotions may suggest different patterns of subjective wellbeing to the analysis reported
below; results which need to be understood in this context. However, it is noteworthy that on most
of the key indicators of subjective wellbeing reported hereafter, junior doctors score even more
positively than workers in other occupations.

**Figure 1. Average (mean) levels of job satisfaction.**

Source, waves A – E, UKHLS, weighted base 118,768 observations. Responses are on a 1 – 7 scale, where a higher
score indicates greater life satisfaction. The question is worded as follows: On a scale of 1 to 7 where 1 means 'Completely
dissatisfied' and 7 means 'Completely satisfied', how dissatisfied or satisfied are you with your present job overall? The
error bars indicate the range of actual values that fall within 95% confidence intervals. If a value is significantly different
from that of junior doctors (p-value<0.05) it is indicated with a *. 
Figure 2 Average (mean) levels of life satisfaction.

Source, waves A – E, UKHLS, weighted base 107,167 observations. Responses are on a 1 – 7 scale, where a higher score indicates greater life satisfaction. The question is worded as follows: please choose the number which you feel best describes how dissatisfied or satisfied you are with your life overall. 1 “Completely dissatisfied” and 7 “Completely satisfied”. The error bars indicate the range of actual values that fall within 95% confidence intervals. If a value is significantly different from that of junior doctors (p-value<0.05) it is indicated with a *.

Figure 3 Average (mean) levels of life satisfaction.

Source: 2011-2014, APS personal wellbeing, weighted base 355,285 observations. Question wording: Life satisfaction (APS) Overall how satisfied are you with your life nowadays? 0 = “not at all satisfied” 10 = “completely satisfied”. The error bars indicate the range of actual values that fall within 95% confidence intervals. If a value is significantly different from that of junior doctors (p-value<0.05) it is indicated with a *.
The results reported above suggest that junior doctors have higher job satisfaction than workers in most other occupations, and that they also have higher levels of life satisfaction and eudemonic wellbeing (i.e. they are more likely to think that they have done worthwhile things in their lives).

Figure 5 Average (mean) levels of psychological wellbeing.

Source: UKHLS waves 1 to E. Weighted base 107,118 observations. The Caseness score is derived from responses to the GHQ12 (see the appendix for full details of this measure). The scale runs from 1 – 12, a score of 4 or higher is usually taken as a sign of psychiatric morbidity. The error bars indicate the range of actual values that fall within 95% confidence intervals. If a value is significantly different from that of junior doctors (p-value<0.05) it is indicated with a *.
Results for these more direct measures of experienced emotion suggest that junior doctors were slightly less likely to experience symptoms of poor mental health, slightly more likely to report experiencing happiness the day before taking part in the APS and no more or less likely to report feeling anxious than workers in other occupations. Overall then, these results suggest that prior to the industrial dispute, junior doctors enjoyed relatively high levels of subjective wellbeing, typically better than most other groups of workers.
Introducing our study

The qualitative data reported below are part of a wider project investigating subjective well-being at work among five occupational groups. In designing the wider study, we followed the principles of ‘theoretical sampling (Mason, 2002). This means that we looked to sample groups of workers likely to have something interesting to tell us about why they experienced high or lower levels of subjective wellbeing at work. Junior doctors were selected as a group because they tend to report relatively high levels of job satisfaction and life satisfaction. Once the decision was taken to sample junior doctors, initial contact was made with two junior doctors through the researchers’ social networks. We then utilised a ‘snowball sampling’ technique (Bryman, 2012) to establish contacts with further junior doctors who were willing to participate in the study. All interviews were recorded electronically with the consent of participants. The recordings were transcribed and analysed using thematic analysis (see the appendix for further details of the methods used). Because the same themes tended to come up in responses to different questions about SWB, we report results thematically rather than reporting answers to individual questions.

Table 1, below, summarises the key characteristics of our interviews; who they are, their gender (indicated by name; names have been changed to disguise the identity of interviewees), the stage of training they are at and their responses to the questions we asked them about their subjective well-being. As the table shows, our interviewees were more likely to be at foundation stage than in an area of more specialist training. Their reported job satisfaction was 4.68 while their life satisfaction was 5.24, suggesting that our sample were more likely to be dissatisfied with their jobs and slightly more likely to be dissatisfied with their lives overall than the wider population of junior doctors were in the year prior to the dispute. It needs to be kept in mind that the methods we used to construct our sample mean that our interviewees should not be regarded as representative of the wider population of junior doctors. Instead, our data provide insight into the factors that junior doctors themselves say shape their subjective wellbeing at work.
Table 1 Summary of subjective well-being scores for junior doctors who participated in the study

<table>
<thead>
<tr>
<th>Date of interview</th>
<th>Name (Anon)</th>
<th>Career stage</th>
<th>Age</th>
<th>Anxious-Contented score</th>
<th>Depressed-Enthusiastic score</th>
<th>Job Satisfaction</th>
<th>Life Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/11/2015</td>
<td>Naomi</td>
<td>Foundation Trainee</td>
<td>25</td>
<td>1.5</td>
<td>2.5</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>14/11/2015</td>
<td>Sam</td>
<td>Foundation Trainee</td>
<td>25</td>
<td>1.7</td>
<td>1.7</td>
<td>3</td>
<td>2.5</td>
</tr>
<tr>
<td>15/11/2015</td>
<td>Jennifer</td>
<td>Foundation Trainee</td>
<td>26</td>
<td>3.2</td>
<td>4.5</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>22/11/2015</td>
<td>Joanna</td>
<td>Foundation Trainee</td>
<td>25</td>
<td>4.7</td>
<td>4.8</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>24/11/2015</td>
<td>Scott</td>
<td>Foundation Trainee</td>
<td>28</td>
<td>2.4</td>
<td>3.0</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>03/12/2015</td>
<td>Ellen</td>
<td>Foundation Trainee</td>
<td>26</td>
<td>2.2</td>
<td>3.7</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>10/12/2015</td>
<td>Anna</td>
<td>Foundation trainee</td>
<td>25</td>
<td>2.6</td>
<td>2.5</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15/12/2015</td>
<td>Tabitha</td>
<td>Foundation trainee</td>
<td>26</td>
<td>2.5</td>
<td>3.1</td>
<td>5</td>
<td>5.5</td>
</tr>
<tr>
<td>18/12/2015</td>
<td>Sonia</td>
<td>Foundation Trainee</td>
<td>25</td>
<td>2.5</td>
<td>4.0</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>19/12/2015</td>
<td>John</td>
<td>Core Trainee/Registrar</td>
<td>28</td>
<td>3.1</td>
<td>3.7</td>
<td>5.5</td>
<td>4</td>
</tr>
<tr>
<td>06/02/2016</td>
<td>Sophie</td>
<td>Foundation Trainee</td>
<td>26</td>
<td>3.3</td>
<td>4.2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>18/02/2016</td>
<td>Nathan</td>
<td>Foundation Trainee</td>
<td>26</td>
<td>3.7</td>
<td>4.5</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>19/02/2016</td>
<td>Adam</td>
<td>Foundation Trainee</td>
<td>28</td>
<td>2.0</td>
<td>2.1</td>
<td>4.5</td>
<td>4</td>
</tr>
<tr>
<td>21/02/2016</td>
<td>Tamara</td>
<td>Core Trainee/Registrar</td>
<td>26</td>
<td>3.6</td>
<td>4.3</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>22/02/2016</td>
<td>Heather</td>
<td>Foundation Trainee</td>
<td>26</td>
<td>3.7</td>
<td>3.8</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>25/02/2016</td>
<td>Ali</td>
<td>Registrar</td>
<td>31</td>
<td>4.5</td>
<td>4.0</td>
<td>5.5</td>
<td>6</td>
</tr>
<tr>
<td>29/02/2016</td>
<td>Jocelyn</td>
<td>Foundation Trainee</td>
<td>27</td>
<td>2.2</td>
<td>3.5</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>15/03/2016</td>
<td>Holly</td>
<td>Foundation Trainee</td>
<td>25</td>
<td>2.0</td>
<td>3.8</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>18/05/2016</td>
<td>Ruth</td>
<td>Registrar</td>
<td>32</td>
<td>1.8</td>
<td>2.5</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>20/06/2016</td>
<td>Bryony</td>
<td>Registrar</td>
<td>32</td>
<td>4.3</td>
<td>4.7</td>
<td>6</td>
<td>5.5</td>
</tr>
</tbody>
</table>

Anxiety – contentment is measured on a 1 – 5 scale where 5 indicates enthusiasm and 1 indicates depression.

Depression – enthusiasm is measured on a 1 – 5 scale where 5 indicates enthusiasm and 1 indicates depression.

Job Satisfaction and Life satisfaction are both measured on 1 – 7 scales where 1 is completely dissatisfied and 7 is completely satisfied.
Findings

A quarter of our sample gave answers of six (relatively highly satisfied) for the question on the job satisfaction measure of SWB. Respondents who were highly satisfied with their jobs also tended to report above average scores in the other dimensions of subjective wellbeing at work. The more satisfied respondents tended to explain their job satisfaction in terms of having identified (and in most cases applied to) the specialist area of medicine which they wished to pursue for their career. Having made an important – and arguably career-defining – decision to pursue specialist training, these junior doctors had a stronger sense of ultimate vocation and thus a clearer and more defined career path. This was illustrated by one foundation year 2 trainee who had settled on a career in specialist hospital medicine:

“at the moment I’m doing the job I love and I’m applying for the job I love” (Jennifer, 26, Foundation Trainee yr2)

Interestingly, despite reporting the highest levels of job satisfaction in our sample, the same doctor also noted how a love for her job resulted in it encroaching on her life outside of work:

“At the moment work’s the most important part of my life because it’s the only place that I feel truly happy, which is sad, because I should be happy outside of work too, but there are a lot of issues there that aren’t, you know, such as location and social activities.” (Jennifer, 26, Foundation Trainee yr2)

Conversely, six respondents reported job satisfaction scores of 4 or lower, indicating that they were not satisfied with their jobs. We identified three key themes our interviewees said explained why they reported lower levels of job satisfaction and other measures of SWB: firstly, work intensity (hours and understaffing); secondly, undervaluing of staff (to some extent pay, but wider overtime and workload issues); thirdly, incoherent managerial practice (specifically bureaucracy trumpping patient care and tensions between clinical and non-clinical management). A fourth overarching theme derived from the other three, related to tensions between normative occupational values and identities (the need to deliver care and feel as though they are ‘being a doctor’) and demands of the job which prevented them acting in accordance with these values and identities. Below, we explore these themes in more detail, drawing on junior doctors’ own words to illustrate each. The wider context of the industrial dispute is a recurring thread
may even say that like I’m getting married and they might say, well you might be able to have your wedding off, or not. That is incredibly frustrating for a professional job that you have no kind of say from that aspect.” (Bryony, 32, Specialist Trainee Yr6/Registrar)

A lack of control and flexibility over working patterns seemed to exaggerate the negative feelings associated with unsociable working, which was attributed to the management practices and capabilities (a theme we develop below). The industrial dispute intensified dissatisfaction over working time and effort because the reductions in pay premiums for working evenings and weekends proposed in the new contract brought these issues to the forefront of our interviewee’s minds.

A compounding factor was the intensity of work during shifts. The quantitative measures of satisfaction with ‘the amount of work’ and ‘the work itself’ were not particularly poor, however the discussion around these items uncovered working environments where the volume of work often exceeded what was seen to be reasonably possible. It was widely reported that breaks were cut short or not taken, and that working pressure was dangerously high, potentially resulting in poor clinical decisions being made:

“There are sometimes nights, around four, five in the morning when you don’t have to work quite as fast. You’re always working, never stop working, you only have your half hour break in a shift and that’s literally all you have, but you might just slow down for a little and you won’t have to be running around as much.” (Jocelyn, 27, Foundation Trainee Yr2)

Interviewees attributed the intensity of work effort to understaffing. Most thought that
the departments they were working in were understaffed:

“We were constantly understaffed. One of the jobs I did, there were just three junior doctors, whereas you know there should have been five on the rota, so it’s like three people trying to do the job of like what five people should be doing yeah, it’s insane.” (Anna, 25, Foundation Trainee Yr2)

Again, it was a widely held belief that the proposed new contract would intensify the problem of understaffing, because the cuts to anti-social hours payments would reduce the number of doctors willing to work in departments that require high levels of night and weekend staffing (for example emergency and paediatric medicine). This was summed up by a specialist registrar in her sixth year of training, who highlighted an observed lack of willingness from foundation trainees to enter such specialties, principally due to the unyielding intensity of work:

“I think this [the contract dispute] has come at the end of everybody being pretty exhausted and stretched, particularly if you work in the acute specialties, like A & E, paediatrics, and all of those kind of areas, where it’s heavy duty, with ‘need to do it kind of now’ type situations, not your out-patient, like dermatology and things like that aspect. So I think everyone’s just a bit past it and a bit knackered because they were a bit knackered to start with, and then you’ve had another year with even less people about and Deaneries, being less supportive of people making personal decisions, such as wanting to take a year out and wanting to go and do something different, and allowing that kind of flexibility. So I think everyone’s just a bit more knackered and a bit more fed up. But I don’t think there’s any less inclination to do the work to help people, I think it’s just the personal exhaustion to keep going.” (Bryony, 32, Specialist Trainee Yr6)

Finally, it was clear that our interviewees believed that understaffing was set to continue as their careers progressed. That is the junior doctors saw consultants, and those holding positions they would likely occupy in their future careers, being as overworked and short-staffed as they were:

“We’ve been losing trainees at a rate of knots, like the younger trainees do not want to be the senior trainees because the workload is becoming so high, which just puts more work on a lot of the [doctors]”

The same interviewee continued in a similar vein:

“Although these changes [the new contract] will minimally affect my actual work, the next change and what will happen with all the consultant contracts will have, and this is just the start of all of that …it’s very significant…… And I think everyone’s so angry, just because of how busy and how over-stretched everything is at work.” (Bryony, 32, Specialist Trainee Yr6)
Perceptions of undervaluing: recognition and career comparisons

“Even offering us a pay rise isn’t what we want, what I want, I just want someone to appreciate that actually the anti-social hours are crap and that maybe we prefer to be paid for that aspect of the job.” (Holly, 25, Foundation Trainee Yr2)

Our interviewees believed that the work they did was under-valued. Although when initially questioned about pay the overriding response was that pay rates were good, perceptions of pay turned negative when discussed in the context of unsociable working. Although interviewees said they did not necessarily want to be paid more, they strongly conveyed a need for recognition of the hours they work:

“This response to doctors’ working conditions was compounded when doctors made comparisons to those in other professions, who they perceived as enjoying better terms and conditions despite being less skilled. The freedom to move between employers within the private sector was contrasted with the feeling of being confined to the NHS and whatever terms of employment are eventually imposed:

“Even offering us a pay rise isn’t what we want, what I want, I just want someone to appreciate that actually the anti-social hours are crap and that maybe we prefer to be paid for that aspect of the job” (Holly, 25, Foundation Trainee Yr2)

This perception of undervaluing was further fuelled by widespread reports of working additional unpaid overtime, a problem which many believed would get worse under the new contract, and which was not fully appreciated or understood by the negotiators for the employers:

“Even offering us a pay rise isn’t what we want, what I want, I just want someone to appreciate that actually the anti-social hours are crap and that maybe we prefer to be paid for that aspect of the job.” (Holly, 25, Foundation Trainee Yr2)

This response to doctors’ working conditions was compounded when doctors made comparisons to those in other professions, who they perceived as enjoying better terms and conditions despite being less skilled. The freedom to move between employers within the private sector was contrasted with the feeling of being confined to the NHS and whatever terms of employment are eventually imposed:

“Essentially the NHS is a monopoly employer, if I say no, where else would I go apart from abroad? It’s not like if you were at a private company and someone offered you a rubbish contract, you would just say, right, I’ll go elsewhere then. If I’m an accountant, there’s loads of other firms, I’ll go and work elsewhere. We haven’t got that luxury.” (Scott, 28, Foundation Trainee Yr2)

Once again, the broader theme of feeling undervalued was intensified by the industrial dispute. Some interviewees specifically linked the intensity of their feelings to the way in which their position had been characterised by the Secretary of State for Health and associated media reporting:

“So the juniors are people that have thousands of hours that they’re not paid for and work really hard and you know, lead really disruptive lives because of shift patterns, then to have someone say that you don’t know what a vocational job is…..” (Tabitha, 26, Foundation Trainee Yr2)

“the entire media spin on it is absolute bullshit. So I’m sure you’ve heard this no end but offering an 11% pay rise, no one’s asking for more money, the 11% rise is in banded hours, so you lose all the money from the un-banded, which is what pays the majority of our wage. We’d lose 15% to 18% of our income under the new thing. And then he (the health secretary) spins it and spins it and spins it.” (Tabitha, 26, Foundation Trainee Yr2)
Dissatisfaction with managerial practice

“We had this chap who was essentially very unwell and I wasn’t sure what to do with him, and all the senior people cared about was where he was going next, rather than the here and now. Which I suppose is two different priorities for them, because they are looking at the overall flow through the system, but at the expense of what actually matters, which is the patient at the end of the day” (Adam, 28, Foundation Trainee Yr2)

The concerns of non-clinical management; waiting lists, triage times, patient turnover and financial balancing amongst others, were deemed important by junior doctors, however it was a commonly reported view that such priorities amongst managers conflicted with patient care. This conflict was attributed to a lack of clinical understanding among non-clinical managers as to how patient care and medical practices work, combined with the increasing pressure to achieve centrally imposed targets within the climate of funding constraints and rising demand. The effects of centralisation of managerial practice are portrayed below:

“Services are underfunded, so who is to blame? Blame the government? Well I guess I probably blame the managers as well because they share the view that is being imposed upon them by higher up, and so they only care about meeting targets and about saving money in the short term, and this basically affects staff morale.” (Ali, 31, Specialist Trainee Yr5)

Drilling down to how managerial practice actually impacts on the work of junior doctors and the care they provide, doctors perceived that notions of bureaucratic targets were detached from clinical reality. For example, one participant described working on an elderly care ward and being offered overtime by a manager to write discharge letters for a group of patients who were medically fit for release. However the letters had already been written and the patients were waiting for places in care homes:
“I said to him (the manager), ‘I’m happy for you to pay me an extra two hours to sit and drink tea, but you really don’t understand the problem.’” (Holly, 25, Foundation Trainee Yr2)

This sort of form filling was also resented because it was seen as a poor use of doctors’ skills and training.

“You’re doing a job you could have done when you were fifteen years old. I’m not joking. You do discharge summaries mostly, then you get grief for not doing them fast enough, even though you’re going as fast as possible.” (Tabitha, 26, Foundation Trainee Yr2)

Finally participants felt that managers abused their goodwill. As a result of perceived understaffing and underfunding, doctors felt that their hospitals and departments were only able to function because they gave more to the job than they were formally contracted to do, for example by working unpaid overtime and working without taking breaks:

“I think a lot of the NHS was run on junior doctor morale and all of us working really really hard, working more hours than we should, working through your breaks, because ultimately people who are doctors care; that’s what keeps the NHS going, even though it’s understaffed and crap, everyone works a bit harder.” (Holly, 25, Foundation Trainee Yr2)

Tensions between professional values and work requirements

...you go back to thinking, actually no it’s the right sort of thing that we’re doing, I am valued, I make a difference to patients and all that sort of stuff and that’s why I’m doing it. And you know at the end of the day, me being stressed about something or upset about something, actually all just links back to the main point which is that patients come first

One factor that cuts across all three of the causes of low SWB discussed above (working time and intensity; under-valuing of junior doctors’ work; dissatisfaction with non-clinical management practice) was a sense of fundamental tensions between the values of ‘being a doctor’ - an ethic of care and responsibility towards patients – and the day to day requirements of the job imposed by the structures and practices of work in NHS England, as the following quote illustrates:
“The only reason that we get things like that done to us is because of the fact that we’re so moral and we get taken advantage of as a consequence of that because at the end of the day, I care more about someone not dying than me getting paid more, which is you know, it’s just a question of morality, but management take advantage of that fact and they make us work long hours that we don’t deserve, and they don’t care what happens to us, they don’t care about our life… they have no connection with the reality of what it’s like to be a junior doctor” (Nathan, 26, Foundation Trainee Yr2)

These tensions appear to have been exacerbated by the industrial dispute over the new contract. The vast majority of junior doctors did not expect to ever be participating in extended strike action. Many interviewees relayed anxieties surrounding the Hippocratic Oath as a complicating factor in their decisions to withdraw labour.

“in terms of hours, stress of work, poor training provision in certain areas and when you’ve basically got a Government that is turning round to say that they want to make it even harder for you, and completely ignore, quite frankly, the experts who understand it all, which are the doctors, and we all know that the remainder of the workforce will come next, all our colleagues, so when you have that bad day or you’ve done that extra mile, you’ve missed, I don’t know, you’re working long hours and you’ve missed a friend’s birthday or something like that, or anything else, you come back and you’re like, why do I do this? That question pops into my head and … that question’s never popped in my head before because I’m normally so positive about the job” (Nathan, 26, Foundation Trainee Yr2)

Nonetheless, the junior doctors who were interviewed for this research project displayed resoluteness in their decisions to take part in strike action. Whilst anxieties about a reduction in public support as the dispute went on were expressed, interviewees determinately related their decisions to take strike action back to their inability to provide safe levels of care should the new contract be implemented:

“…you go back to thinking, actually no it’s the right sort of thing that we’re doing, I am valued, I make a difference to patients and all that sort of stuff and that’s why I’m doing it. And you know at the end of the day, me being stressed about something or upset about something, actually all just links back to the main point which is that patients come first.” (Nathan, 26, Foundation Trainee Yr2)

For many of our interviewees, the net effect of all of this seemed to be an openness or willingness to consider practicing medicine outside of NHS England. One interviewee, who is moving to Australia to practice emergency medicine on an initial 12-month contract, typified the thought processes behind a decision to withdraw from training within NHS England:

“It was always on my radar. But then I think this situation’s just made it such a better option for all of us. And actually, I think all we want, all round, is to be appreciated. I don’t really want any more, I don’t want more money, I don’t want … I definitely don’t want them to change my hours! But I think just to be appreciated for what you do and the system in Australia just appears to do that for us” (Holly, 25, Foundation Trainee Yr2)
Conclusion

Our original decision to interview junior doctors as part of a wider project into happiness at work was based on the expectation that as an occupational group their SWB would be high. In fact this was not the case. This may reflect the vagaries of our sampling method; foundation stage doctors may be less happy and satisfied with their work than their more experienced colleagues, because as our data shows, they face greater levels of insecurity because they have often not settled on a clear career path. However, low SWB was also evident among specialist registrars we interviewed. We think therefore that it is likely that the industrial dispute has been responsible for falling SWB and morale more generally. Before the dispute, junior doctors were most likely feeling a degree of underlying dissatisfaction and unhappiness with many of the issues raised in this report, but the dispute then bought these aspects of the job into sharper focus, provoking an emotional response which has intensified dissatisfaction.

This could be an issue of concern for the immediate future of the NHS in England if it results in an increase in the number of junior doctors looking to pursue medical careers outside of it (Scotland, Wales, New Zealand and Australia were all mentioned as desirable alternatives to working in NHS England, with 6/20 interviewees mentioning without prompt from us, some sort of plan to move away from England). It is difficult to quantify how big a problem this is likely to be given our data. Many foundation stage doctors take a pause in their careers, sometimes working abroad for a year or two, after completing the second year of training anyway. Intentions to quit NHS England expressed in the heat of the dispute may change as anger cools. Nevertheless, we predict that the problems of poor morale exacerbated by the industrial dispute are likely to cause recruitment and retention problems in the future.

We make this prediction because it is well known that job dissatisfaction is associated with quitting. Furthermore, a key finding from our wider research project is that it is a specific form of job dissatisfaction that drives employees to seek alternative employment and to quit. That is dissatisfaction resulting from misfit between personal values and the values or behaviours required by the job. Workers frequently adapted to other forms of dissatisfaction, for example by becoming inured to high levels of required effort, but a feeling that a job was out of tune with personal values appeared to trigger prolonged periods of rumination on alternatives that often resulted in quitting. We saw evidence of this in a number of other occupational settings: gardeners quitting a large local authority because they placed greater value on autonomy and discretion in doing their job; school teachers quitting because their personal values of what it means to be a teacher were in conflict with the way in which they were being asked to behave as a result of government reforms to the education system. The same misfit between personal values, in this case about what it means to be a doctor and job requirements, was very evident among many of the doctors we interviewed.

If the Department for Health and NHS Employers want to address poor morale among junior doctors, what might they do? Before going further, it is important to add the caveat that we are not experts in hospital management or the structuring of medical careers, so we leave the details of how these suggestions might be developed for others to consider. Nevertheless, our data point to a number of key issues that NHS England would have to address to tackle issues of poor morale among junior doctors.
• Our data suggests that it is important to address and try to change the perception shared by many junior doctors that their work is undervalued by non-clinical managers, the NHS and Government as an employer. The feeling that they are undervalued by those at the top of the NHS seems to have become particularly strongly embedded as a result of the industrial dispute.

• One way of addressing this first point would be to focus on relatively mundane issues; ensuring that junior doctors are adequately supported in undertaking training and skill development; thinking about systems for drawing up rotas so that doctors do not feel that they are frequently subjected to arbitrary decisions about when they work, over which they have little control; asking questions related to job design, like how much routine clerical and administrative work is being done by junior doctors, and could that work be done more cost effectively by support staff? To focus on these questions and issues would be evidence of a willingness to take seriously junior doctors complaints and concerns. In this context it is worth noting that Dame Sue Bailey’s Inquiry was specifically set up to consider these issues. Our results suggest that there is a real need for her Inquiry.

• Perhaps most challengingly, more needs to be done to understand why so many junior doctors appear to feel that their personal values and identities around being a doctor, which are centred on an ethic of patient care, run into conflict with what they perceive as the reality of working as a doctor within NHS England. Why do so many doctors feel that time to care for patients and a priority on meeting patient needs is compromised by managerial practice? Are there unreasonable expectations on the part of junior doctors, or is the NHS failing to live up to the values and ethics of patient care coming first, which medical training develops?

Overall then, this report suggests there is good reason to think that the morale of junior doctors is a problem that the NHS must tackle; if it fails to do so problems of recruitment and retention seem highly likely to follow.


Appendix 1: The GHQ12 Caseness measure

The 12 questions of the GHQ are worded as follows and ask individuals:

“How have you been feeling in general over the past few weeks? Have you recently…..”

(a) “Been able to concentrate?”, with a scale running between 1-4, where 1 was “better than usual” and 4 “much less than usual”.

(b) “Lost much sleep over worry?” with a scale running between 1-4, where 1 was “not at all” and 4 “much more than usual”.

(c) “Felt you are playing a useful part in things?” with a scale running between 1-4, where 1 was “more so than usual” and 4 “much less than usual”.

(d) “Felt capable of making decisions about things?” with a scale running between 1-4, where 1 was “more so than usual” and 4 “much less than usual”.

(e) “Felt constantly under strain?” with a scale running between 1-4, where 1 was “not at all” and 4 “much more than usual”.

(f) “Felt you couldn’t overcome difficulties?” with a scale running between 1-4, where 1 was “not at all” and 4 “much more than usual”.

(g) “Been able to enjoy you’re your normal day-to-day activities?” with a scale running between 1-4, where 1 was “more so than usual” and 4 “much less than usual”.

(h) “Been able to face up to your problems?” with a scale running between 1-4, where 1 was “more so than usual” and 4 “much less than usual”.

(i) “Been feeling unhappy and depressed?” with a scale running between 1-4, where 1 was “not at all” and 4 “much more than usual”.

(j) “Been losing confidence in yourself?” with a scale running between 1-4, where 1 was “not at all” and 4 “much more than usual”.

(k) “Been thinking of yourself as a worthless person?” with a scale running between 1-4, where 1 was “not at all” and 4 “much more than usual”.

(l) “Been feeling reasonably happy, all things considered?” with a scale running between 1-4, where 1 was “more so than usual” and 4 “much less than usual”.

Any item score of 4 is deemed to indicate psychiatric caseness. A value of 1 is awarded for each item that displays caseness, meaning that the caseness scale runs from 0 – 11. A score of 4 or higher is seen as evidence of psychiatric morbidity.
Appendix 2: Interview schedule (key questions on SWB are highlighted in bold)

The interview began by collecting basic demographic information.

1. Why did you choose to work in your current job? (prompts about the role of family and school in the choice to become a doctor and about work-life history to date).

2. Job demands: how often does your job involve doing the following things:
   a. Working at very high speed
   b. Working to tight deadlines
   c. Working very hard
   d. Working extra time to get the job done

   Responses:
   Always | 3/4rs of time | ½ the time | ¼ of the time | Almost never | never

3. Job control: how much influence do you have over the following aspects of your job?
   a. Influence over how hard you work
   b. Influence over deciding tasks you do
   c. Influence over how you do tasks
   d. Influence over quality standards

   Responses:
   None | Not much | Fair amount | Large amount

   Interviewees were asked to explain their answers.

4. Measures of enthusiasm/depression and contentment/anxiety: thinking of the past few weeks, how much of the time has your job made you feel each of the following:
   a. Calm
   b. Tense
   c. Contented
   d. Relaxed
   e. Uneasy
   f. Worries
   g. Enthusiastic
   h. Cheerful
   i. Depressed
   j. Gloomy
   k. Miserable
   l. Optimistic

   Responses:
   Occasionally | Some of the time | Much of the time | Most of the time | All of the time

   Interviewees were asked to explain their answers.

5. Which number best describes how satisfied or dissatisfied you are with the following aspects of your job?
   a. Promotion prospects
   b. Pay
   c. Your supervisor
   d. Job security
   e. Opportunities to use your abilities
   f. Opportunities to use your initiative
   g. Abilities and efficiency of management
   h. The hours you work
   i. Fringe benefits
   j. Amount of work
   k. The work itself
   l. The variety of work
Note that interviews were semi-structured, this means that the questions set out above were the starting point in a more wide-ranging conversation in which the interviewers asked supplementary questions to tease out and develop interesting points.

**Qualitative data analysis**

Data were analysed using a method known as thematic analysis (Braun and Clark, 2006). All interviews were transcribed. The research team read through the transcripts making a note of interesting points. When the same or similar points appeared in multiple transcripts it was considered to be a theme. Researchers discussed between them themes that they had identified, and a template of themes was agreed. Transcripts were then read again, with different themes being highlighted, so that a body of quotes relating to each theme could be identified and the incidence of different themes in different interviews could be noted. Each transcript was read multiple times, with at least two of the research team reading each transcript to ensure that themes were applied consistently. This process was conducted using Nvivo software.

m. Training provision
n. Friendliness of people
o. Your job overall

**Responses:**

Completely satisfied | Mostly satisfied | Somewhat satisfied | Neither Somewhat dissatisfied | Mostly dissatisfied | Completely dissatisfied

Interviewees were asked to explain their answers. If the industrial dispute wasn’t mentioned, a prompt was used to ask if it had any impact on job satisfaction.

6. Would you change job if there were plenty available?

7. If a situation arose where you could manage financially without going to work, would you still want to work as in your current job? Or would you want to work somewhere else, perhaps doing something else?

8. How satisfied or dissatisfied are you with your life overall?

**Responses:**

completely satisfied | mostly satisfied | somewhat satisfied | neither satisfied nor dissatisfied | somewhat dissatisfied | mostly dissatisfied | completely dissatisfied.

9. What are the most important things for you in determining how you feel about your life overall, where does work fit into this