



Adapting, Coping, Compromising research

Full Research Report for the GMC

October 2018

All interpretation and opinion in this report is that of the authors alone and does not necessarily reflect those of the General Medical Council.

The authors would like to thank all participating doctors for their frank and honest contributions to this research.

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1. Executive summary

1.1 Objectives and methodology

The aim of this research was to explore how doctors are practising in a system that is 'under pressure' and the extent to which they are making any adaptations or compromises in order to cope with working in such a system. The research findings have formed part of the evidence base for the GMC's 2018 State of Medical Education and Practice (SoMEP) report¹.

Community Research was commissioned by the GMC to conduct 40 interviews (a mix of face to face and telephone) with doctors across a wide range of locations, levels, specialisms and types of workplaces. A number of doctors who took part in an interview went on to complete an online follow up exercise to understand individual practice 'in the moment' at a more granular level.

1.2 Key findings

How doctors are experiencing pressure

Doctors experience both external pressures (over whether they'll be able to do their job with the limited time and resources available) and internal pressures (over whether they think they will be able to do that job well), with the former often exacerbating the latter.

The sources of pressure most commonly discussed included:

- A lack of / limited resources – particularly experienced doctors, but also beds.
- The increasing number of patients, particularly those with co-morbidities.
- Certain periods of time, particularly winter or weekends when demand is high and / or staffing is stretched.
- The overall system, including targets and administrative requirements.
- Cuts to other services, for example mental health services, leaving doctors to pick up the pieces.
- Their own feelings of responsibility leading them to take on more work than strictly manageable.
- Other doctors, for example, those making unnecessary referrals, or inexperienced locums adding to workloads.
- External factors, including the media and the GMC.

Whilst most doctors generally agreed that pressure levels had risen over the past few years, the extent to which they as individuals felt that they were working under a high level of pressure varied according to a number of factors, including their speciality; their seniority; their location; their mentality / emotional resilience; and the extent to which they felt they were supported or had control over their workloads or careers. Doctors

¹ SoMEP provides an annual summary of the medical workforce in the UK, including the challenges and pressures that doctors have encountered and the GMC's work to address these challenges

often discussed the vicious circles they found themselves in as a result of working in a system under pressure, for example doctors getting ill from the stress, leading to fewer doctors to manage the workload, leading to more doctors getting stressed and ill.

There was a sense amongst many that working under pressure had come to be accepted as the new 'normal'.

How doctors are dealing with the pressure

Doctors use a range of overlapping and interlinking ways to deal with the pressure they work under, that broadly fall under three main areas:

- Compromising – looking for ways to reduce their workload
- Adapting – trying to change the way they work
- Coping – learning how to live with the pressure

Compromising

Doctors tried to reduce their workload by either prioritising the most important tasks or by seeking help from others:

- Prioritisation
 - Prioritising their individual workload, for example by focussing on most urgently ill patients, or on their clinical work over their administrative tasks
 - Prioritising patient problems i.e. dealing with the first or main issue a patient presented with
 - Prioritising what the service can offer i.e. limiting their 'core' offer
- Seeking help
 - Delegating tasks to more junior doctors or healthcare professionals
 - Making referrals (even when not strictly necessary) in order to move patients on
 - Encouraging patients to take more responsibility for their own health

Adapting

Doctors also looked at ways in which they could change their approach to work or to find smarter ways of working to help manage their workloads:

- Greater reliance on individuals / effective teamworking
 - Working longer and harder (faster) in order to get everything done
 - Spreading the workload with colleagues
 - Relying on experience (rather than on protocols) to make quicker judgments
- Exploring smarter ways of working
 - Greater use of telephone and technology to save time
 - Delegating to others (as a proactive choice rather than as a compromise)
 - Developing more effective triage systems
 - More collaborative working with other practices or services
 - Reducing admin

Coping

Doctors employed a range of different strategies to help them cope physically and mentally with working under pressure:

- Inside of work they looked for reassurance that they had made the right clinical decisions, they tried to get some down time or breaks during the working day, or they tried to keep their role varied.
- Outside of work they tried to look after their emotional wellbeing and avoid burnout by making the most of their holiday time, taking exercise, spending time with family or friends, and by 'offloading' onto peers and colleagues.
- Some doctors also discussed the importance of training the mind to deal with the mental pressures, from informal approaches such as compartmentalising, to more formal strategies such as CBT and meditation.
- Some doctors felt able to push back when they felt the demands being made on them were unreasonable.

There was a broad consensus that many of the various strategies adopted were not sustainable in the longer term.

The impact that working under pressure has on doctors

Doctors who had worked under sustained pressure felt that it impacted on them both personally and professionally.

- At a personal level, most doctors felt that they were often (in some cases always) exhausted and emotionally drained, with some suffering from stress or anxiety. This had an impact on their health and on their personal relationships.
- At a professional level, pressure impacted on doctors in both short and long term ways.
 - Being tired and stressed day-to-day meant that they were irritable and nervous of making mistakes.
 - Many doctors felt that their professional development was impacted in that they had less time available for training or study, or got exposed to fewer clinical opportunities.
 - Many doctors had made changes to their longer term careers, from reducing their working hours to changing specialties to choosing to locum. A few individuals were planning to leave the profession (retiring early) or the country (practising abroad) altogether.

What this means for patients

Patient care

Most doctors acknowledged that the service and care patients received was reduced in quality as a result of the system and doctors being under pressure. They felt that patients' experiences would be poorer, for example, they would have to wait longer to be seen and when they did, doctors would spend less time with them. Doctors also discussed the fact that their 'bedside manner' and communication with patients and

families was adversely impacted when they were rushed, potentially leaving people less reassured.

Patient safety

A sizeable proportion of doctors felt that despite their best efforts, patient safety was being impacted. For some, it was seen as inevitable that tired and stressed doctors would make mistakes or miss things, and that delays could exacerbate issues. It was also felt that problems such as doctors having less opportunity to learn and develop would result in patient safety issues further down the line.

1.3 Conclusions

Many doctors feel that the so-called strategies they have adopted to deal with the pressure they are working under are not sustainable in the long term – they had often reached their limits in terms of the tactics they employed and / or some of these approaches brought negative repercussions or exacerbated vicious circles. Several of them felt that they as individuals were at risk of approaching burnout, and nearly all of them felt that the system itself was reaching breaking point. They were concerned about the safety and care provided to patients, and about the long term implications for the NHS as a whole.

2. Background, objectives and methodology

2.1 Background

The GMC is acutely aware of the increasing pressures that doctors face in trying to deliver high quality healthcare in a range of situations, from challenging and unexpected terror attacks to day-to-day care. They recognise that, as the situations in which healthcare is delivered change, the excellent care doctors deliver rarely does. The GMC outlined the mounting pressures that doctors face in its publication State of Medical Education and Practice (SoMEP) in its 2016, 2017 and 2018 reports.

The GMC further recognises that they, alongside other healthcare profession and system regulators, and NHS bodies need to adopt a position of flexibility and continuous development to adapt to the changes in the nature of healthcare in the UK, and to be careful to ensure that changes do not overwhelm doctors.

2.2 Research objectives

The aim of the research is to explore how doctors are practising in a system that is 'under pressure' and the extent to which they are making any adaptations or compromises in order to cope with working in such a system. The research findings formed part of the evidence base for the GMC's 2018 SoMEP report.

2.3 Methodology

Overall approach

Community Research was commissioned by the GMC to conduct 40 interviews (a mix of face to face and telephone) with doctors across a wide range of locations, levels, specialisms and types of workplaces.

Fifteen of the doctors who took part in an interview went on to complete an online follow up exercise, via a smartphone app, to understand individual practice 'in the moment' and at a more granular level.

An ethical advisor reviewed the overall methodology, as well as the materials shared with participants (the consent form and discussion guide), to ensure that these were appropriate from an ethical perspective.

Sampling and recruitment process

Participants for the interviews were recruited by Acumen Fieldwork to an agreed specification. Acumen specialises in medical market research recruitment and has extensive expertise in recruiting health professionals. The agreed recruitment specification covered a number of variables, including gender, geographic location, level of seniority, managerial responsibility. A profile of participants is provided in Table 1 below:

Table 1

Quotas	In-depth interviews	Online app participants
Total	40	15
<i>Care setting</i>		
Primary care	12	4
Acute care (of which, at least 5 in A&E)	22	11
Other setting (e.g. community care, mental health trust)	6	0
<i>Country</i>		
England	23	11
Scotland	7	3
Wales	6	1
Northern Ireland	4	0
<i>Remote</i>		
Remote	9	1
Very urban	18	7
Deprived	12	3
<i>Career stage / type</i>		
In training	11	4
Leading teams	7	3
Locums	4	2
Consultants / general GPs	25	7
<i>Gender</i>		
Male	23	7
Female	17	8
<i>Other</i>		
BAME	10	5
Qualified inside EU (not UK)	3	1
Qualified outside EU	6	3

Participants were given an incentive in cash, or an equivalent charitable donation, as a thank you for their participation in the interview and as a good will gesture to acknowledge the time taken to participate. Those who contributed to the follow up online task received an additional incentive.

Fieldwork process

In-depth interviews

All interviews were conducted during a period from the 6th August until 12th October 2018.

The interviews followed a semi-structured guide in order to allow participants to elaborate on and discuss their views and perceptions freely. All interviews were facilitated by Community Research, an independent research organisation, commissioned by the GMC. The groups were audio recorded and transcribed. The discussion guide used is provided in Appendix 2.

On line follow up

All interviewees were invited to take part in a follow up exercise designed to understand individual practice 'in the moment' and at a more granular level. The exercise involved participants downloading an app (www.indeemo.com) on their phones and completing a diary exercise for between 1-2 weeks. More details about this task can be found in Appendix 2.

Fifteen of the 40 participants took part in the online activity with their profiles outlined in Table 1 above.

By its nature, qualitative research generates a large volume of data. In this case, all of the discussions were audio-recorded (with the participants' knowledge and permission) and then transcribed in full. Several researchers then undertook analysis independently and simultaneously, and compared results to ensure consistent interpretation. Prior to writing this report the entire team of researchers met to develop the themes and structure for reporting.

Quantitative survey

Alongside this qualitative piece of work, the GMC also commissioned a quantitative survey of 700 doctors. The survey design was informed by some of the themes explored in these interviews and sought to quantify some of these emerging findings. The research findings have been used to inform the SoMEP 2018 report and the data tables will be published on the GMC website.

2.4 Notes on reading the report

There are a number of caveats to bear in mind when considering the research findings.

The context of the research should be borne in mind in that during the fieldwork period Dr Bawa-Garba won her appeal in relation to her right to continue to practise. As a result, the consequences of working under pressure may have been very top of mind for doctors.

It is worth noting that the doctors who participated in this research 'opted in' to the process and actively responded to communication about the research saying that they were willing to participate. It could be that those who opted into the process are different in some way (in terms of the level of pressure they work under) than the wider sample of doctors eligible to participate.

It is also important to note that qualitative research is not intended to be statistically reliable and, as such, does not permit conclusions to be drawn about the extent to which something is true for the wider population.

Throughout the report, quotes have been included to illustrate particular viewpoints. It is important to remember that the views expressed do not always represent the views of all doctors who participated. In general, however, quotes have been included to illustrate where there was particular strength of feeling about a topic across a range of doctors.

3. How doctors are experiencing pressure

Section summary

Doctors experience both external pressures (over whether they'll be able to do their job with the limited time and resources available) and internal pressures (over whether they think they will be able to do that job well), with the former often exacerbating the latter.

The sources of pressure most commonly discussed included:

- A lack of / limited resources – particularly experienced doctors, but also beds.
- The increasing number of patients, particularly those with co-morbidities.
- Certain periods of time, particularly winter or weekends when demand is high and / or staffing is stretched.
- The overall system, including targets and administrative requirements.
- Cuts to other services, for example mental health services, leaving doctors to deal with the aftermath.
- Their own feelings of responsibility leading them to take on more work than strictly manageable.
- Other doctors, for example, those making unnecessary referrals, or inexperienced locums adding to workloads.

Whilst most doctors generally agreed that pressure levels had risen over the past few years, the extent to which they as individuals felt that they were working under a high level of pressure varied according to a number of factors, including their speciality; their seniority; their location; their mentality / emotional resilience; and the extent to which they felt they were supported or had control over their workloads or careers.

Doctors often discussed the vicious circles they found themselves in as a result of working in a system under pressure, for example doctors getting ill from the stress, leading to fewer doctors to manage the workload, leading to more doctors getting stressed and ill.

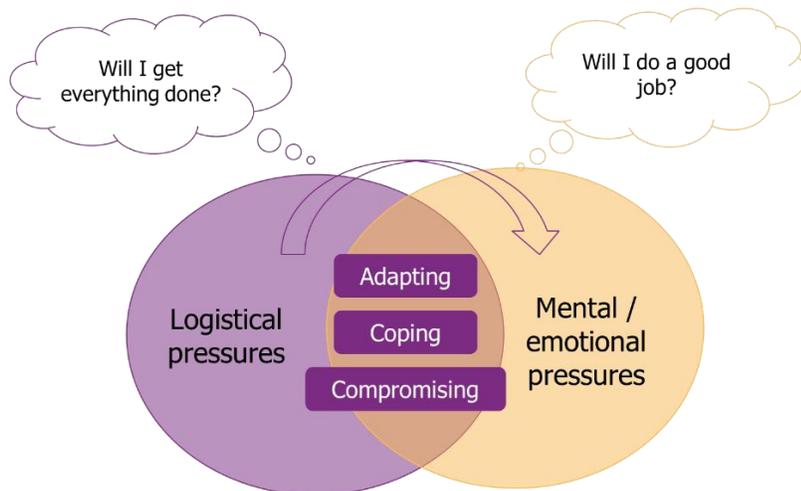
There was a sense amongst many that working under pressure had come to be accepted as the new 'normal'.

3.1 Sources of pressure

When discussing the pressures they find themselves under, doctors talk about both external and internal pressures:

- External pressures ("will I get the job done?") – these were the logistical pressures that impacted on doctors' ability to carry out their roles within various time and resource constraints.
- Internal pressures ("will I do a good job?") – these were the mental and emotional pressures that doctors felt under to deliver high quality care and make appropriate clinical decisions.

Unsurprisingly there was a great deal of crossover, with external pressures often exacerbating the internal pressures felt by doctors.



"I felt pressured about whether I was making the right decisions, whether all the patients were safe."
(Registrar)

The sources of pressure discussed by doctors were often interrelated or had a knock-on effect. We outline those most commonly mentioned here (but as these are well documented elsewhere, and the focus of the interviews was on the impact of these pressures, we have kept this relatively brief):

- **A lack of / limited resources**

- By far and away the source of pressure most cited by doctors was a lack of experienced staff. Sometimes this was simply a case of too few doctors (or other healthcare professionals) overall, but often the issue was the insufficient number of doctors with the right level of experience and skills.

"Our rota is chronically understaffed. We are short of one or two doctors at the moment so there's a lot of locum shifts." (Consultant)

- For many hospital doctors, a lack of beds was a significant cause of pressure, with a huge amount of time and energy spent trying to source more beds.

"That's the worst part of the job, not knowing where you're going to put your next patient. Because you know what you have to deliver and what you want to deliver but not being able to do that is incredibly frustrating and really stressful." (Consultant)

- A number of doctors spoke about issues with computer systems, either not working or being inefficient – or being prohibitively complicated.

- **The number of / types of patients**

- Many doctors felt that there were more patients to see than was possible and / or that the amount of time in which to see patients was much more limited.
- Related to this, the patients often had co-morbidities that required more time to treat.
- Many felt that patients' own demands and expectations were adding to the pressure. Some doctors were very anxious about patient complaints, litigation and the possible repercussions for their career.

"Even though it's NHS, it's free at the point of delivery service, people still have an expectation that what they see on TV, or what they've come across, I want this... That can be very difficult to manage people's expectations." (GP)

"A change in attitude of patients who now feel they don't want to wait a week for a GP appointment, you can do your shopping at midnight, why can't you come and see a doctor at midnight, kind of thing." (Consultant)

- **Specific periods of time**

- There were certain times of the year or week where doctors found the pressure levels particularly raised, either because it meant demand was high (for example, winter, or on Monday mornings) or because there were fewer experienced doctors (for example, August rotation, or over weekends).

- **The system as a whole**

- For some doctors, having to meet certain targets, most notably, the four hour waiting time in A&E, added to the pressure considerably.

"You would be having several people barking down your ear telling you that the patient is breaching but you've only been able to start seeing them at 3 hours anyway. Because there are so many patients to see and not enough people to see them. And yes, you feel like the priority is the four hours and it can be easy therefore that you miss something." (Registrar)

- The administrative requirements placed on some doctors were also an added burden.

"You're asked to take all the responsibility to sort out all the business side, to campaign, and plan the business cases, and at the same time, providing a superb service to your patients." (Consultant)

- Some doctors discussed the additional pressures of dealing with rotas, for example having to swap with other doctors when they were supposed to be working at the same time as being on annual leave or at relatives' weddings.

- **Cuts to other services**

- It was felt that doctors were having to see patients who might have been seen by other service providers previously but because of cuts, such provision no longer existed, for example, mental health services.

"These children previously they would have got a lot more support from their schools, from their educational psychologist, they would have got a lot more support from social services." (Consultant)

- **Themselves**

- Many doctors recognised that they themselves were taking on more than they strictly needed to, but they felt obligated to go above and beyond in order to do their best for their patients and / or to make sure they weren't letting their colleagues down.

"You don't necessarily want to [take on extra], but if you don't, you're leaving an open shift." (Registrar)

"You feel obliged to give up weekends and that has an impact on family life and work/life balance. So, yes, we're all doing extra locum shifts that a lot of people don't actually want to do but are taking them on because they know what it would be like for colleagues, those shifts would be unfilled." (Consultant)

- Some of the doctors we spoke to had taken on other roles in addition to their 'day jobs'. This was often done as a way of dealing with the pressure (this is explored in Section 4.6), but these additional responsibilities, in turn, did add to doctors' workloads, further exacerbating the pressure.

- **Other doctors**

- GPs in particular felt that other doctors added to their workloads by referring patients to them. They recognised that these doctors were under time pressures of their own, but felt that this needed to change.

"Saw a patient today in a busy surgery. He had been to A&E and needed follow up for orthopaedics and urology – neither was done by the A&E doctor, instead actioned for me to do it. There was an unnecessary delay in the referrals which were normal. Another patient was seen by neurology for a blackout and had investigations which were normal. Action for me to refer to cardiology. These actions should have been done by the hospital"

doctors and not delegated to the GP hence creating extra workload and delay in referral.” (GP, online app)

- Whilst doctors often relied on locums in times of high pressure, there was a general sense that they were usually not as ‘helpful’ as an employed doctor because they were less able or committed to providing high quality care.

“You always felt that they were just ticking over the hours, just doing what they can but because they are not going to come back the next day, they weren’t too bothered about the wait and department as a whole.” (Registrar)

“You go to a practice and, if you can sign 10 prescriptions, they’re eternally grateful for you because half the locums won’t do that, locums turn up to a practice and say, “I’m not going to do this, I’m not going to do that, not going to do that.” (GP)

- **External factors**

- Some doctors mentioned the media as being responsible for additional pressure (either from negativity about GPs generally or by reporting spurious health issues causing increased numbers of patients to book appointments). Some also felt that the GMC itself increased pressure on doctors, citing the introduction of revalidation and also its handling of the Bawa-Garba case.

“On the days when they’re not abusing us and telling us how we’re all earning a quarter of a million pounds a year, they’re just putting out stupid scare stories which just increase our workload because people walk in and go “oh, doc, I’ve just seen on the front of the Daily Mail this thing about statins”.” (GP)

There was broad consensus that the pressures had worsened in recent years. Even those who remembered having worked exceptionally long hours as house officers earlier in their careers felt that the degree of pressure had intensified in terms of the sheer volume of patients and the responsibility doctors took on.

3.2 The extent to which doctors experience pressure and influencing factors

The degree of pressure felt by doctors varied considerably; however, it was extremely rare for a doctor to feel under minimal pressure. When asked on a scale of 1 to 10 how pressured a typical working day was, and most said it was towards the higher end of the scale, around the 6 to 7 mark. A few doctors felt that they consistently worked at the high end of the scale, while others only did so during particularly busy periods. Some of the sample had experienced extended high pressure periods in their careers previously, but had since changed work patterns, partly in response to this.

*"You can have a day where it's not as frenetic but, you never get to the point where you sit down and have time to have conversation with somebody, or to actually have a lunch hour, or anything like that. You never have a moment in the day when there's not work in front of you."
(GP)*

Aside from the general areas discussed above, there were a number of factors that influenced the degree of pressure felt by doctors:

- **Specialism**

- The doctors that described feeling most pressure in our sample tended to be those from general practice, A&E and general medicine in hospitals.

"I just saw the stresses and the environment of general practice. It is not at all nice." (Registrar)

- **Seniority**

- While many of the doctors in the early years of their careers experienced stress because of their relative lack of experience, it was often doctors who were further advanced in their careers (e.g. consultants, or senior registrars, GP partners, but still a way off retirement) who were under most pressure in relation to both volume of work and doing their jobs well. They usually received less support than doctors who were still training, felt a real sense of responsibility to their colleagues, and had established careers (and more personal / familial commitments), and therefore fewer opportunities to change roles or reduce hours. And whereas in the past, more senior doctors would be less hands-on, it was felt that the role had changed and that consultants were now more accountable and more 'present'. This was acknowledged by more junior doctors who were often only too aware that their workload would not necessarily reduce as their career progressed.

"The partners stay a lot longer. Because they have a lot more admin than we do." (GP trainee)

"I would have loved to do that [move around] as well, but my husband works in the area, and I've got kids here established in school, so it's not that easy for me to move around. And also, I've taken up this lead consultant job, management type job. So, I feel like I shouldn't abandon the ship and go." (Consultant)

- **Location**

- As discussed in the methodology section, there was an expectation that doctors working in particularly urban, remote or deprived areas would be practising under higher levels of pressure, and this hypothesis was borne out by the research in relation to remote and rural areas.

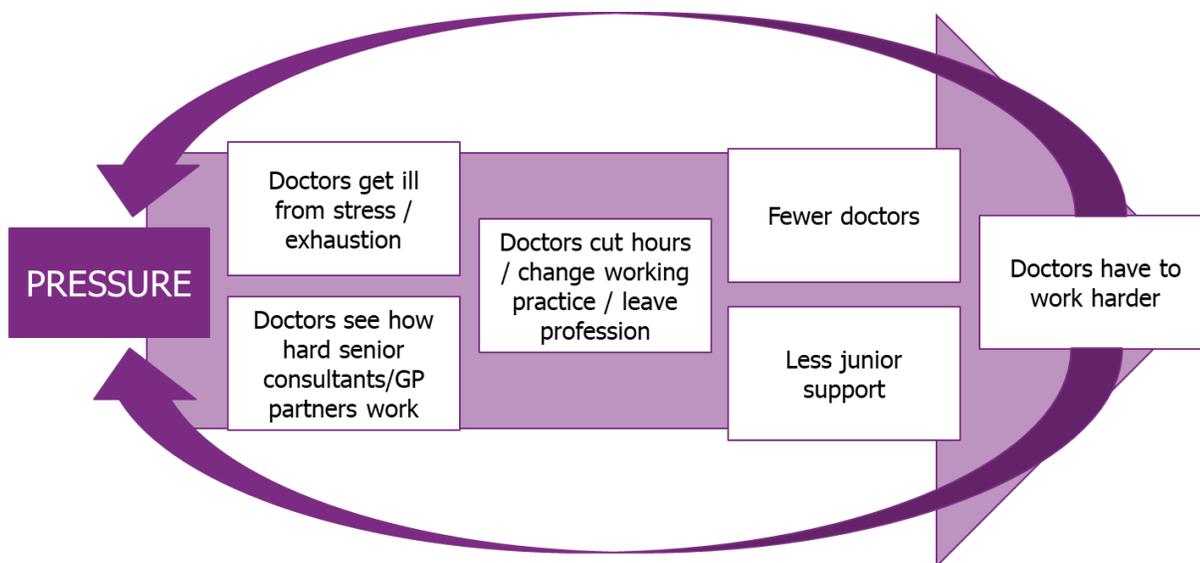
- Recruitment problems meant that there were often shortages of doctors in rural and remote areas, leaving doctors having to look after more patients as a result.
 - Doctors working in particularly rural or remote areas also found that pressure was exacerbated by the need to drive longer distances between sites or to patient homes.
 - Where hospitals were a long way from practices and / or the ambulance service was poor, this also put more pressure on GPs.
 - NB While a few doctors mentioned challenges in areas where patients had lower levels of English, broadly speaking it was rural/remote areas rather than urban where pressures seemed particularly high.
- **Individual mentality**
 - Different doctors responded differently to pressure – some felt far better able to cope (or indeed thrived under it) than others. Some of the doctors we spoke to considered themselves to be particularly resilient. Some had expected to be working long hours and it was only during exceptionally busy periods when they found the pressure take its toll.
 - **Support**
 - The degree to which doctors felt supported (by their colleagues and / or by their practice or Trust) made a difference to how much pressure they felt they were working under. Doctors who felt that they did not have people to ask if they needed help (for example, when they were the only doctor on call, or when they were working as an individual in a clinic as opposed to part of a team in a hospital) often felt under more pressure as a result. Doctors who felt that they were supported by management (for example, to pay for locums in busy periods) felt that they at least had some recourse when the pressures got too bad.
 - **Control – over workloads or careers**
 - Whether or not doctors were able to plan ahead also impacted on how pressured they felt. This could be on a day-to-day basis, for example, doctors who knew their patient list in advance could either prepare themselves mentally for a particularly busy day or try to make changes, whereas doctors who didn't know what to expect on a day-to-day basis had little opportunity to prepare. (Some doctors also felt at the mercy of rota coordinators, and when they struggled to get time off work well in advance also resented the additional pressure this put on them.)
 - Some doctors felt more in a position to reduce their overall hours to relieve the pressure than others (for example, some GPs could not reduce their clinics any more or they would be considered to be working part time which would impact on their pensions).

- Doctors in training also discussed the pressure of not knowing where they might be working in their upcoming placements and the stress of having to plan / uproot their lives accordingly.
- Finally, the amount of control doctors had over their long term career also impacted on their pressure levels. Doctors who were still in training were able to alter their career paths, whereas those with established careers in specific specialities felt that they were 'stuck' and that it was too late for them to change.

3.3 The vicious circle of pressure

A theme that occurred repeatedly was that many of the pressures experienced by doctors resulted in further pressures down the line and became vicious circles. For example:

- Doctors getting ill from the stress of the pressure cutting their hours, resulting in fewer doctors, resulting in doctors having to work harder, and so getting ill...
- Junior doctors seeing their seniors work at such a level that they are put off themselves and change career direction, resulting in less junior support for senior doctors resulting in senior doctors having to work harder...
- Doctors referring patients to other doctors to reduce their own workloads thereby adding to the workloads of those other doctors...
- Doctors being too busy to train more junior doctors who therefore don't develop skills as quickly and require more support from senior doctors adding to their workloads...



"The other thing which some trainees have mentioned is they look at us and see actually "you're here until ten o'clock at night on your evening weeks, you're on call and doing cannulas, I don't want to be doing them when I'm older", as it were. There's a bit of that, 'actually do I really want to be a consultant, is that what I want to end up doing' particularly now

we're doing much more hands on. It's a bit chicken and egg really because, if the rotas were filled and people weren't leaving, then the consultants could do more consultant roles." (Consultant)

"They go off sick and then it becomes a very skeleton staff. And then nobody joins because everybody thinks 'oh my god, why would I want to go there. There is so much less staff there?'" (Consultant)

The new normal

A number of doctors recognised that that they often accepted the conditions they were under as 'normal' and that it was only when viewed with a fresh pair of eyes (i.e. a new consultant joining; a foundation doctor moving to another rotation) that the extraordinary level of pressure came into focus.

"It's a common thing that people talk about that it's stressful, they don't get breaks, the rotas are awful. I think it kind of comes with the territory of working there. It is just the norm. So, perhaps yes, it's become so normalised that they are just accepting of it [in A&E]." (Registrar)

"I share a very small room with three other doctors, and another doctor comes in and will take my place and then I will have nowhere to work. We've just accepted that now, as you say, as the norm. A hot desk, and it's not good, it's really not good. But, we've accepted it." (Consultant)

"So we're aware of that but those compromises you make when you see patients, potentially delaying admission, having a patient for 12 hours in the emergency department, you're absolutely right, we are reminding ourselves that normalisation isn't right. We've been lucky enough to have a couple of colleagues in from elsewhere who are doing a couple of days a week with us and they're shocked by that sort of thing. So that's been quite a good reminder for us in the last few months." (Consultant)

4. How doctors are dealing with pressure

Section summary

Doctors use a range of overlapping and interlinking ways to deal with the pressure they work under, that broadly fall under three main areas:

- Compromising – looking for ways to reduce their workload
- Adapting – trying to change the way they work
- Coping – learning how to live with the pressure

Compromising

Doctors tried to reduce their workload by either prioritising the most important tasks or by seeking help from others:

- Prioritisation
 - Prioritising their individual workload, for example by focussing on most urgently ill patients, or on their clinical work over their administrative tasks
 - Prioritising patient problems i.e. dealing with the first or main issue a patient presented with
 - Prioritising what the service can offer i.e. limiting their 'core' offer
- Seeking help
 - Delegating tasks to more junior doctors or healthcare professionals
 - Making referrals (even when not strictly necessary) in order to move patients on
 - Encouraging patients to take more responsibility for their own health

Adapting

Doctors also looked at ways in which they could change their approach to work or to find smarter ways of working to help manage their workloads:

- Greater reliance on individuals / effective teamwork
 - Working longer and harder (faster) in order to get everything done
 - Spreading the workload with colleagues
 - Relying on experience (rather than on protocols) to make quicker judgments
- Exploring smarter ways of working
 - Greater use of telephone and technology to save time
 - Delegating to others (as a proactive choice rather than as a compromise)
 - Developing more effective triage systems
 - More collaborative working with other practices or services
 - Reducing admin

Coping

Doctors employed a range of different strategies to help them cope physically and mentally with working under pressure:

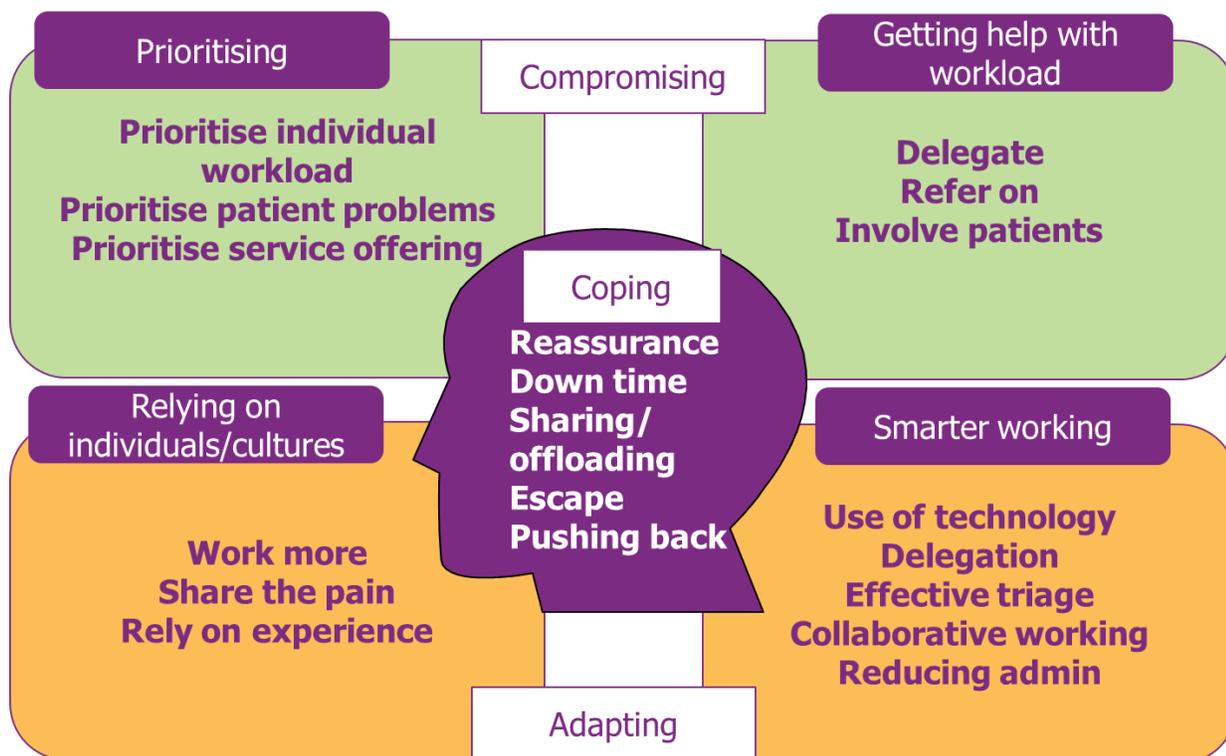
- Inside of work they looked for reassurance that they had made the right clinical decisions, they tried to get some down time or breaks during the working day, or they tried to keep their role varied.

- Outside of work they tried to look after their emotional wellbeing and avoid burnout by making the most of their holiday time, taking exercise, spending time with family or friends, and by 'offloading' onto peers and colleagues.
 - Some doctors also discussed the importance of training the mind to deal with the mental pressures, from informal approaches such as compartmentalising, to more formal strategies such as CBT and meditation.
 - Some doctors felt able to push back when they felt the demands being made on them were unreasonable.
- Many of these approaches were seen as unsustainable in the longer term.

4.1 Overview of strategies

Doctors employ a range of different strategies and coping mechanisms in order to deal with working under pressure, some of which are designed to reduce or minimise the pressure, while others are used to deal with its impact. Broadly speaking, these strategies fall into three main areas (although there is significant overlap between them):

- Compromising: looking for ways to **reduce their workload**
- Adapting: trying to **change the way they work**
- Coping: learning how to **live with the pressure**



It should be noted that many of these strategies were not proactive 'choices' that doctors made (for example, missing out on training, working during leave); rather they were often seen as the only options left available.

4.2 Compromising: Prioritisation

Many doctors felt that the sheer volume of work was adding to the overall pressure and they, therefore, needed to find ways to prioritise the most important tasks. They did this in a number of different ways:

- Prioritising individual workloads
- Prioritising patient problems
- Prioritising what the service can offer

Prioritising individual workloads

Doctors did this by deciding what tasks were most urgent and focussing on these, for example, dealing with the most ill patients first in A&E, reducing in-person follow up appointments, or focussing on clinical work over and above administrative duties or training.

"We get the DVLA [Driver & Vehicle Licensing Agency] forms ... and the GMC will say, these forms must be returned within 10 days. Now, to me, yes, it's important for people to get their licence back etc. but it is nowhere near as important as looking after my acute neurology patients." (Consultant)

"Most of my colleagues still see significant number of patients back in the clinic to see how they are, I would love to do that but I can't afford to do that anymore. So many of the times I will usually send a questionnaire or ring the patient rather than have them coming to the clinic because the clinic slot is then taken up by somebody who needs it more." (Consultant [in a management role])

Ultimately, this resulted in some aspects of their work getting dropped entirely, for example, one GP no longer attended child protection board meetings and one child psychiatrist no longer visited schools to speak with teachers and assess children in their educational environment or had the time to meet with educational psychologists. The psychiatrist felt that both of the latter were important preventative steps and the lack of this activity meant that problem cases were sometimes not identified or addressed at an early stage.

"Yes, definitely, you have to make compromises and trade-offs. Often we might say we can't do that, or we can't attend this meeting, because we just don't have the time. So, a good example is, we get invited to attend for example, safe-guarding meetings on a regular basis. 10 years ago, there would always have been a doctor attending that meeting. Whereas now, it's extremely uncommon." (GP)

"Previously, I would have gone to the school and attended a meeting with them and try to explain the child's difficulties and what the school could do

to help. And that could have also made a difference. It is not direct mental health, but it is indirectly. You know the school is offering more support to reduce the child's stress. That was something we would routinely do before, but now there is not the time. So, I try my best and I will put it in a letter and send it off. But it is not as effective as face-to-face like before we used to do....So, before I used to meet regularly with Educational Psychologists in the area. Which are the kids that you are working with, that we are also aware of? How can we work together? Like that, planning. That used to help prevent problems." (Consultant)

Many doctors (both those still in training as well as fully qualified doctors trying to fulfil their CPD requirements) prioritised their clinical work over their training needs, which meant that they had to do the latter in their spare time.

Prioritising patient problems

When patients presented with multiple issues, some doctors felt they only had time to deal with the main or first issue being presented. This was particularly the case for GPs who often explained that patients came in with a 'shopping list'. However, they recognised that not having the time to explore the full list had potential consequences as patients sometimes needed time to 'build up' to the main problem.

"But when you are busy you don't listen to some of these other things, which maybe the actual prime reason that they came, but they come with like, oh doctor I've got a bit of an itch and then while I'm here, I've got a big growth." (GP)

"The patients will always appear with one or more problems, it's never just one thing...so on a normal clinic day you might address, if the patient is just about to walk out the door, and the patient will be like oh you know, I've had this lump in my breast, then I wouldn't say 'oh book another appointment and come back', on a normal clinic. When it is in session. But if this on the on-call and they have come in because they have had a chest infection and they really need to be seen with something or other, then as they walk out the door they mention something like this to me, I would just ask them to arrange, give them a little note and say next day, on a following day appointment." (GP)

It was not only GPs who felt they had to prioritise patient problems – several experienced consultants also described how they made decisions based on results sheets rather than went looking for problems by fully exploring patient histories

"If there is not enough time, you will look quickly, see what appears on the face and make decision because, if you keep going through every

single note, you are going to be spending hours and you haven't got time."
(Consultant)

"You make decision based on what you see in the results sheet without looking into the whole case history and notes." (Consultant)

Prioritising what the service can offer

Prioritising is not just happening at an individual level. Several doctors reported that they had been, or were going through, the process of establishing what their service could and could no longer deliver.

One consultant psychiatrist explained how his service had made the decision to be more ruthless about the number of patients they saw out of a sense of duty rather than medical necessity.

"But after three years of seeing her every four to six months and there'd been no change, and she's not unwell in terms of needing to see a consultant psychiatrist, I explained to her that we would follow-up now with the GP. Understandably, she took this very hard, she actually became quite unpleasant and aggressive about it, I anticipated she might put in a complaint and she had the point of view that 'it's only once every six months for her for half an hour, I'm sure that's not too much to ask me to provide". But the reality is, if I do that for the hundreds of people who want it from me, I've no space to see people when they're ill. So that's the difficulty, it's not a GMC thing, it's not medical practice or safety or any of those things, some people would argue why on earth were you seeing her in the first place, why are you seeing lots of people like that, the reality is psychiatrists, GPs, other specialists too, for a proportion of our outpatients there is no identifiable medical authority that can treat but we see people because the act of being a doctor and seeing someone is the treatment and it keeps them going. And that's what's being lost because we're having to pare things back down to what we need to do and not what we would like to do." (Consultant)

A GP described pushing back to the secondary care team and a consultant to community care:

"I feel comfortable being able to say look, I cannot possible do all that's required of me today, therefore these things that are going to happen and not happen. Or, someone else is going to have to do them, or for example if the hospital team are saying, please can you provide this to somebody, if they can do it themselves then we will say no, please can you ask them to do it" (GP)

"We can't afford to give the most luxurious or liberal type of care but really that we have to provide essential basic care. For example, I would say that I would like to discharge a patient and see that patient within a week in our inpatient clinic by myself but, because of the pressure and other things, I may not be able to see that patient within that short period, I have to ask junior doctors to see the patient or the home treatment team to see that patient....I keep still all the essential things, providing the right time and reviewing the patient on the ward or if there is anything urgent, to provide that care as much as we can" (Consultant)

Sustainability / limitations of approaches

While some of the different ways in which doctors prioritised to deal with pressure were working for now, it was clear that many of them were not sustainable in the longer term. Doctors described such actions as prioritisation as opposed to making compromises, but acknowledged that by choosing certain tasks to do first, other tasks simply didn't happen, or were not done as well. For example:

- Many doctors felt that because they had to focus on what patients *told* them was the problem (because they didn't have the time to probe around potential underlying problems), they might miss other issues.
- Doctors often talked about having to sacrifice spending time getting to know patients and building rapport with them. They felt that losing the opportunity to build a relationship meant that at the very least patients would have a lower quality experience, but the worst outcome would be that something could be missed.
- While it was usually clear which patients to prioritise, there were times when this was not so straightforward, and potentially ill people could miss out on treatment.

"But who do you say is more needy? If you've only been given one resource." (Consultant)

- Putting off or trying to reduce the amount of paperwork could mean that less detail would be provided on patients' notes, potentially compromising their treatment further down the line.
- Having to forgo training was mentioned by a number of doctors in training who found themselves unable to take up opportunities due to their workloads.

"On several occasions during my night shifts this week, there were people with fractures/dislocations in ED – very keen to learn how to manage this, both as it's an essential ED skill, and as I have an orthopaedics job this year. Unfortunately, I wasn't able to learn from these cases as the department was full, so I saw other patients whilst my reg managed the dislocations alone." (Trainee doctor, online app)

Overall, it was felt that a key consequence of having to prioritise was that the bigger picture would be lost. Doctors were having to be reactive, achieving quick fixes and just

doing what was needed, rather than working proactively. While the urgent task might be accomplished in the short term, in the long term they might be setting themselves up for more problems further down the line.

"You see it happening in secondary care. Where you send people along and they are on a conveyer belt. And you can see the clinicians have given no thought to the individual. They get referred with certain symptoms, which leads to a certain set of investigations and then discharged, with no thought for the individual. And the same happens in general practice, where if you start creating a conveyer belt. You stop constantly focusing on why are they on this drug? Why are they going to this? Why are they being referred to this?...If they are diabetic, why are you considering upping their medication? Would you be better bringing them in and having a chat with them and focusing on what they are doing wrong, rather than just penning another drug run? It all just goes downhill because you are not focusing on the person as an individual. Instead, you're just thinking well the next easiest thing to do is to take the step that involves little impact on my time." (GP)

4.3 Compromising: Seeking help with workload

Another way in which some doctors compromised was by finding ways to pass on parts of their workload to others. They did this via a number of different routes:

- Delegating tasks
- Making referrals
- Involving patients

Delegating tasks

One of the main ways doctors were able to manage to complete their work was by delegating aspects of it to colleagues – to more junior doctors or by upskilling nursing staff for clinical tasks, or by training administrative staff to carry out certain tasks. This was sometimes seen as a positive approach, in that it freed doctors up to focus on more important tasks (Section 4.5), but in some instances, delegation was more of a last resort than an active choice.

"We have a scheme where pharmacists... are taking some of the prescribing, the issuing of repeat medicines and so on. They are taking away some of the queries about medication and they are reconciling discharge letters with patients' current medication. If I had a choice, if you gave me the funding for the pharmacist and if there was a GP available, I would far rather have half-time GP and a full-time pharmacist. The value that you would get out of a half-time GP would far exceed a full-time pharmacist. However, beggars can't be choosers." (GP)

An unintended consequence of upskilling nurses?

Whilst doctors appreciated the role of the nurse practitioner, there was concern that they had a negative impact on the training of junior doctors, for example, inexperienced doctors may not be given opportunities to provide treatment because these experienced nurses are more able to do so.

"I think sometimes in some situations jobs get taken away from us and normally in most places I've worked there's a really good working relationship between the advanced nurse practitioners and the other health professionals and us junior doctors but in some places I can feel that often we're given the sort of paperwork jobs and they're given the actual clinical skills jobs." (trainee doctor)

"So because my juniors aren't exposed to unwell people anymore, because the nurse practitioners with 40 years' experience absolutely deal with them and call me, the junior never gets involved but the problem is that the junior is not a junior forever. So now what's happening is our middle grade doctors are completely deskilled and then they don't know what to do at all when someone's even moderately unwell and that's putting a huge pressure on medicine." (Locum, secondary care)

Making referrals

Doctors stated that they sometimes referred patients to other doctors even when not strictly necessary to avoid dealing with their issues themselves. Please note: doctors also identified this practice as being a source of pressure (as discussed in Section 3.1)

"Yes. And there may be some referrals as well. Somebody would come in, and other days you might say actually, you don't really need a referral there. But on bad days you will give them one just to shut them up to get rid of them." (GP)

"When we have time we can decide to investigate and trial treatments and so on, but I know certainly some of my colleagues, when they are more stressed they'd be, it's absolutely not worth my time doing this, I'll just refer on to someone else to deal with it." (GP)

Patient and family involvement

Some doctors encouraged patients to take on more responsibility for their own health, for example, by monitoring their conditions and putting the onus of them to report any changes.

"We just try and find ways of saying well look, you call us if there's a problem and then we'll try and address it." (Consultant)

One consultant psychiatrist raised the point that, because of the pressure on resources, increased burden can be placed on the family of people with mental health issues.

"So, I think the patient might feel it's better that I am being treated at home, but at the expense of the family. They are monitoring, they are providing a lot of responsive care which never gets highlighted at all." (Consultant)

One doctor also used patients to report concerns as she recognised that management responded quicker to patients than clinicians.

"And then the other thing I sometimes get the patients to do if something's not right, I encourage them to go the Patient Liaison Officer and make a formal complaint or raise a concern because actually hospitals listen to patients. So, if the patient complains about something, it then gets fixed much more efficiently than if a clinician complains about it." (Consultant)

Sustainability / limitations of approaches

Again, many of the ways in which doctors were trying to minimise their workload were not seen as sustainable in the longer term. For example, staff shortages across the NHS meant that doctors were running out of other doctors or HCPs to delegate to.

"So you need to do all extra work because you can't shift your work to anyone else. So this is the main crucial crux of work pressure, you're squeezed and there is nowhere else to go." (Consultant)

Even locums weren't always a solution, either because there weren't enough available, or because they simply weren't as helpful as doctors who were familiar with the way the hospital or practice worked.

It was also acknowledged that referring patients on would store up problems further down the line for other doctors.

4.4 Adapting: Greater reliance on individuals/effective teamwork

In addition to finding ways to try to reduce their workloads, doctors also looked at ways in which they could change the way they worked or their approach to their duties.

Doctors working longer hours

Across the piece the 'strategy' most likely to be adopted by doctors as a way of dealing with working in a system under pressure was to simply work more – longer (i.e. beyond their official workhours) and harder (i.e. trying to get through more in the time they had available). Most doctors we interviewed were working beyond their contracted hours, and many were missing out on breaks during their shifts. Doctors also found themselves catching up on work or training in their free time or on annual leave.

"Came to work early today, by an hour, as I didn't get a chance to go through Docman [software used to manage clinical correspondence]"

letters yesterday, so had to either stay late yesterday or come in early today – wasn't possible with full clinics to do this during the 9-5 day." (GP, online app)

"I spent most of our family holiday doing e-mails, doing stuff like that. Because it was just a mess back here, the practice, so I felt I just couldn't not deal with it while I was away." (GP)

"I had to go in for a meeting on my day off. This was the only opportunity to meet with the deputy medical director that week and the meeting was important and couldn't be postponed." (Consultant, online app)

Although it was not a strategy that doctors made willingly, they recognised that sometimes working extra hours was the only option available. Sacrificing their free time was made more palatable when doctors felt that it was recognised and valued. This could be financial recognition e.g. paying more for overtime, or even simple things like paying for taxis home.

"If it's after 11pm they will pay for a cab for you to go home. Which takes the sting out [it]." (Registrar)

Doctors working together

Some doctors felt that pressure was somewhat relieved when they could 'share the pain' i.e. spread the workload a bit. They would, therefore, rotate more onerous roles or tasks (for example, safeguarding role, duty doctor etc.) and be meticulous about planning these fairly.

"With regards to the rota, I have designed a spreadsheet, with a number of formulae, to make the rota more fair, and optimised the time we will need to spend with it when we can sit down this week. It is much more dynamic and flexible to change." (Registrar, online app)

"I think that's been revolutionary for us really because we've all mapped out what we're going to do for the next few years. Some people have said "I'm going to be retiring in a couple of years" then we can look at recruitment, and planning so that people don't just stack up their job plan and then get stuck with roles. The safeguarding doctor's role is quite a stressful job, we've said "right, you take it on and you do it for two years and then you pass it on to somebody else". (Consultant)

Doctors also found it helpful to feel part of a team that looked out for one another.

"The team pulled through – the trainees helped each other and tried to still have a laugh. This is what makes medicine work. The older nurses

tried to give us drinks of tea while we worked when we didn't get breaks. It is an excellent team. When nights are busy but the team works well, it makes everything better" (Locum, online app)

A number of doctors worked in practices or hospitals that had initiated regular meetings in which colleagues could talk through some of the recent experiences that they had had, particularly those that might be more emotionally difficult in order to help build resilience.

"So, one of my colleagues in our area started Schwartz rounds, I think they have them once every month or two, where one of the medical team, be that doctor or nurse or specialist nurse, or whoever, will discuss something that challenged them emotionally. Caused them stress. It's actually been quite insightful to listen. Because you realise that you're not on your own with things that have caused you upset." (Consultant)

Teamwork

Many doctors talked about the importance of feeling part of a team as being instrumental in helping doctors to cope with the pressures of work, both at a practical but also an emotional level.

"One of the good things about working in a team, is that you can say to your team "guys, I've got this going on" and everyone's able to take a patient for me... And you help each other out so, if someone's having a better day then they'll do that for you and you'll help somebody else out another day." (GP)

"We are trying to instigate socials maybe once every couple of months. We are encouraged to basically help each other out and to be a team and to feel like the organisation values you." (Registrar)

There was a feeling amongst some doctors that it was becoming less easy to build a sense of teamship for a variety of reasons, for example, an increasing number of locum staff meaning that personnel changed more often, less 'down time' to build up rapport with colleagues, and changing shift patterns meaning that doctors work with different people each time.

"I think in the past, definitely talking to people ten, fifteen years ago, there was much more teamworking and you worked with ... the same consultant and the same registrar and they felt like they had a bit more ownership and a bit more input in your training." (Trainee doctor)

Doctors relying on experience

Some doctors felt that the only way they could get through their workload was by relying on their experience (often at the expense of set guidelines and protocols) – for example, by having the confidence to discharge or admit a patient based on their knowledge or expertise. As those who made the comments tended to be more senior, they appeared to feel confident in their decisions based on experience:

"So you're going "with experience, you know what, I think we can get away without doing anything here, I've taken the story, it doesn't sound right, I think we can let you go home". But the protocol if anything was to happen, somebody would scrutinise what I'd done and they'd say, "you didn't follow protocol". (Consultant)

"And I think that's a shortcut. You don't really do it deliberately, I can't be bothered to, it's more, right okay it looks like a straightforward earache. I don't need to do the respiratory rate and heart rate. I've seen the ear, it looks red, I've looked at the temperature. Oh right. Whereas, you know, in another situation you would follow full clinical good practice guidelines. Clinical good practice guidelines aren't for people who have 5 minutes." (GP)

One consultant explained that there was a danger that more early career doctors, 'armed with a protocol' could prevent more experienced doctors from being able to rely on their experience.

"The problem is once you protocolise things it becomes a way and you continuously are administering these protocols because, let's face it, out of hours it's usually medical juniors that mention these protocols, there's no leeway for them, it ends up being a fight. Last week a lady came in with quite marked sensory loss down her side and I said to my medical junior that "I want her admitted, her CT is normal but she needs an MR because she could well have had a sensory stroke", he turned round and said, "never heard of it, can strokes just give you sensory loss" and I said "yes, I'm telling you", "never heard of that". So they don't have the knowledge base but they'll be happy to fight with the consultant." (Consultant)

On occasion, doctors (particularly GPs) also relied on their experience and knowledge of their patients themselves, to help them to save time when it came to treatment decisions or prescription admin.

"It's not so much a gut reaction, it's more having that knowledge about the patient. And a particular example would be, a mental health patient will come in and say, 'oh doctor, I'm suicidal I don't want to live'. Now a locum or whatever, would say well I don't want to find myself in front of a

Coroner because this person has committed suicide so would admit them... Whereas, I've dealt with them before, I can talk to them and I know I've seen them, they will cope, they are not suicidal." (GP)

"Your repeat prescriptions, you're meant to check everything. If they've got azathioprine, for instance, then you have to check they've had things like liver function tests and full blood count and kidney function test done, and one would like to say that you do definitely check that all the time but you just rush it sometimes. You think "right, I think I know this patient, yes, I'm pretty sure he or she's had it done" and you just sign it without actually physically checking it." (GP)

However, it was acknowledged that as doctors' workloads increased, they had less time to spend with patients and so had less opportunity to get to know them well enough to be able to rely on this prior knowledge.

Acting up/Acting down²

At all levels, doctors found themselves acting down during busy periods to make up for a short fall of staff. It was a particular concern for junior doctors who felt that they were not getting sufficient exposure to patients. This concern was often echoed by their superiors.

Consultants covering the role of registrars

"I've had it where I was actually on-call one night, and we didn't have a Registrar for the whole night. And a Consultant had to act down to act as a Registrar. It wasn't that we were asked to act up, so, it was more the Consultant had to more act down, stay the night, and act as a Registrar rather than one of us juniors acting up as the registrar" (Trainee)

Consultants covering the role of critical care nurses

"So those doctors are having to sit by the end of the beds for patients who are on ventilators and look after them...but they obviously struggle to provide the nursing care, these patients need to be turned frequently...there's lots of nursing interventions that are needed for the high quality of care which our nurses are obviously trained to do and doctors aren't. So we're managing these patients in areas that they shouldn't be in without critical care nurses for quite prolonged periods of time and that's becoming more and more frequent" (Consultant)

Those in specialty training covering the role of foundation doctors (because of concerns about less experienced doctors no longer having the skill base to equip them to deal with issues)

"In the old days SHOs and middle grade doctors would have left the juniors on the wards, we can't do that anymore because our juniors aren't skilled enough, so we stay in the wards all day which means we don't get to clinics." (Trainee)

Foundation doctors covering the role of nurses, healthcare assistant and/or administrative staff.

"What I've experienced in A&E is that everyone kind of pitches in. So actually I find I end up doing more nursing jobs and healthcare assistant jobs than I've ever done before just in attempt to get things done quickly. There's not really time to wait for the nurse to be free to give them the drug, to wait for the healthcare assistant be free to change the bed, it's quicker if everyone just pitches in." (Trainee)

"I noticed it a lot in my last job, and I remember saying it would be cheaper to employ a secretary, than junior doctors, for the kind of work that they are doing. And it's a shame really, because that is affecting their training." (Registrar)

Acting up came across as less as an issue for doctors. Whilst doctors in training often felt exposed and ill equipped, especially when working in A&E, there were no specific examples of being required to work above what was required of their grade. Instead, more junior doctors gave examples of how they sought the opinion of their superiors before making a decision.

Sustainability / limitations of approaches

Again, many of these approaches were seen as unsustainable. When it came to simply working more, this was fast becoming no longer an option. Time was a finite resource and many doctors felt that they were already working overtime and through their breaks – there was no more time available to give. They also felt that if they worked any longer / harder they would be putting patients' safety at risk.

And whilst working together was a worthy ambition, given the stresses and high pressured working environment, some felt that it would be hard to create a caring and sharing culture. Regular meetings for doctors to discuss traumatic or emotional cases were the types of sessions that were deprioritised in place of clinical needs.

"We aim to do "hot debrief" after events such as this [as upsetting cardiac arrest case], in order for the whole team to learn, and to assist the staff in emotional processing. Unfortunately I have never seen this actually happen, due to time / work pressures" (Trainee, online app)

4.5 Adapting: Exploring smarter ways of working

For the most part smarter ways of working were a result of top down initiatives rather than individual ideas. Typically they were implemented at practice or departmental level and, in some instances, were part of a wider policy agenda. It was felt that it was important for there to be cultural buy-in if changes were going to make a real difference.

"There are health and wellbeing questionnaires, there are health and wellbeing sessions. I think there is an awareness across the organisation that work is difficult and people feel under pressure. But, occasionally it seems like they are paying lip service to it a little bit, and that actually, there's not this deep drive to change some of the cultures, and to change the way that we work in order to make things better for patients, but also for staff and that pressure." (Consultant)

These smarter ways of working fall into several categories:

- Telephone communication and consultation
- Use of technology
- More effective triage
- Increased delegation
- Greater collaboration
- Reducing admin

² The terms 'act up/act down' were used spontaneously by research participants, and are in frequent use within the profession, but are generally applied intra profession rather than inter profession.

Telephone communication and consultation

The increased reliance on telephone communication and consultation with patients was mentioned by doctors from a wide range of specialisms and recognised as part of everyday practice. Doctors explained that most patient follow up was done over the telephone in order to ease the pressure clinics and GPs were also conducting initial consultations over the phone when it was deemed appropriate.

"I would say in [named Trust] we're very good at thinking of working smarter, so we are looking at more in the way of telephone clinics and offloading the easy stuff." (Consultant)

Use of technology

Across the sample doctors gave examples of how they have used or are in the process of exploring technology to help them work more efficiently, for example:

- Accessing computer systems remotely.
- Programmes that allowed doctors to sign referral letters and sanction actions remotely.
- Digital dictation equipment for referral letters and notetaking.
- Electronic prescribing systems

"I think things like electronic prescribing probably do speed up things although it can be a hindrance at the front door because you have to fill their medications on the system but it definitely can be a benefit down the line" (Locum, secondary care)

- Electronic ordering system

"The way we order, our ordering system is electronic which is slightly easier from our point of view, it's more difficult from the nursing point of view, but from our point of view it is easier. It probably makes things slightly less stressful because you're not chasing after paper notes, which usually get lost somewhere." (Consultant)

- Several doctors referred to the use of remote consultation technologies such as the triage tool, askmygp.com³, the 'GP at hand' app⁴ and telemedicine as a means of reducing the pressure on face to face consultations and improving upon telephone consultation. Some doctors were more open than others to the idea of these tools – there was a degree of scepticism from those who had not used them as to how much difference they might make.

³ <https://askmygp.uk/>

⁴ <https://www.qpathand.nhs.uk/>

"We now use TeleMed for stroke assessments so we can actually cover two or three hospitals at once rather than just each consultant doing one" (Consultant)

"We've got something called 'Ask my GP', where a lot of it will be telephone and Internet stuff...the experience of other areas have been like it has changed the workload altogether there. And apparently, we will be twiddling our thumbs in the afternoon, allegedly." (GP)

- One doctor in training explained how she and her colleagues relied on mobile phone apps to overcome cumbersome hospital IT and filing systems.

"I think the use of apps, we all use apps quite often now and we've all got guidelines on our phones that are just vastly quicker than having to load up an incredibly slow NHS computer to try and find something online, or to go to a physical set of guidelines which change quite often anyway. So I think everybody uses their phone for everything from calculating drug doses to looking up the guidelines for management of various things or which antibiotics to use in your Trust etc. I think that's the main thing that I would use that saves a huge amount of time." (Trainee)

- Some doctors felt that there was more that could be done to harness technology to make working practices more efficient, for example, make use of video conferencing or remote monitoring of patients.

"What I would be keen on looking at, I've read about myself, is remote monitoring. So, people have say smart phone enabled things to measure their pulse, their oxygen saturations, ECG." (Consultant)

Increased delegation

Delegation was often seen as a compromise; however, there were several instances when it was regarded as a smarter way of working.

"So we're going to try and get one of the nurses to do it. 10 years ago it would have been unheard of for a nurse to be putting in drains on a regular basis but I think we have to work smart and, if we haven't got doctors, then somebody else is going to have to fill the gap in terms of the nurses and the pharmacists." (Consultant)

- One hospital doctor highlighted that having a dedicated bed manager allowed doctors to delegate the thankless task of finding a bed for a patient.
- One GP highlighted how delegating the duty doctor's observations to a health care assistant had benefited patient safety.

"Two things actually we've found, it's helping the on-call doctor save some time. Secondly, remarkably I think it is helping patient safety as well... Because the healthcare assistant is doing full observations. So, for every sore throat for example, she would check the temperature and will do blood pressure and the doctor sometimes, when they are rushed, may take a shortcut and not do all the recommended checks. Like respiratory rate, heart rate, capillary oxygen, blood pressure." (GP)

- One GP has had funding to recruit pharmacy technicians who look at discharge summaries and change medication, freeing up the time of the doctors. Another had a designated nurse for weight management referrals.

"You will be surprised how long it takes. People just don't know anything about what they should be using or how much they should be exercising. It takes a long time to go through all the facts. So, it is nice to be able to refer them on." (Trainee)

- Finally, delegation had gone one step further with one GP practice who outsourced all home visits to an outside company.

It was felt by some that a shift in mindset was required if doctors were going to take advantage of the opportunity to delegate some of their tasks. In addition to doctors being prepared to give up that control, management also needed to be open to a different way of working.

"There are some doctors who don't feel that they're willing to give up looking at discharge and clinics letters and things like that to somebody else to put it on. There's some doctors who want to maintain absolute control over everything and as a result they end up with higher workloads but, once you've got appropriately trained people, you can take a lot of the mundane stuff away from you." (GP)

More effective triage

Several doctors gave examples of developing effective triage systems as a smarter way of working. For example triage nurses in A&E conducting and ordering initial test for patients to save time down the line; receptionists in general practice signposting patients to potentially more relevant services.

"In one of the practices I work at, the receptionists try to triage as much as possible. So, for example, if there's a medication query, oh you can speak to our practice pharmacist. If it's a joint problem, here's the number for the physiotherapist, you can see the physiotherapist. Rather than everyone having to see the doctor." (GP)

"Now, what we do is we're doing a lot of things in parallel now and I think most EDs are going this way. So everybody's getting blood tests just because I know the lab's turnaround time is meant to be 20 minutes. I can assure you that their turnaround time is an hour and a half so why would I wait, people are waiting three hours to get into my place for me to say you need bloods done. Well, if I can see them at three hours and have all the results to hand, whether they needed the bloods or not, is a question we leave very much up to the triage nurse." (Consultant)

One GP mentioned that his practice has won funding for a pilot introducing a triage system of nurses so that they have contact with patients in the first instance, meaning that doctors only see cases that they need to. This has allowed them to increase the appointment time per patient to 12.5 mins from 10 mins.

Greater collaboration

Several GPs mentioned collaborative working as a way of proving greater efficiencies.

- One GP partner working in a federation explained that three practices were now sharing IT and cleaning contracts, which freed up time for GP partners.
- One GP referred to working with other practices to create an out of hours hub that allowed them to meet government requests for extended opening hours.

"And they have very recently got the hub which are extended clinics provided by a number of practices in certain areas. Say for example, six practices team up and they will be providing between 6 [pm] and 8pm, Monday to Friday and they are doing some Saturday and Sunday sessions." (GP)

- One GP spoke of how they used social prescribing to try and address a range of underlying issues such as domestic violence, money and housing worries etc. They described an initiative that was funded by the voluntary sector and a housing association that enabled a voluntary sector representative to attend the practice twice a week to provide better signposting to what was available in the community to support potential patients.

Reducing admin

Doctors were always looking for ways to reduce or minimise paperwork, for example by passing on tasks to other staff as discussed above, or by finding ways to do things more quickly. Examples included writing patient notes in the format of referral letters rather than duplicating them; only noting down 'abnormal' results in notes pages; not ticking a box to say a task had been completed. Often these time savers only saved seconds, but these were seen to all add up.

Sustainability/limitation of approaches

Although some doctors were able to provide what they regarded as smarter ways of working there were others who felt that they had run out of avenues to explore, as one consultant put it 'there aren't any left really'. Several other doctors highlighted how smarter ways of working might be promising initially but that they had potential to backfire. This was particularly the case with telephone or electronic consultations in general practice, where for example it had led to increased demand or patients having a more cavalier attitude towards their appointments.

"We opened up the amount of telephone calls we were taking. Again, you could actually manage a certain amount of patient contact without patients coming in. Because the telephone call is quicker than a face-to-face consultation. Not much, but it is 5 minutes shorter. But, some people use it correctly then you get a significant number of people who just abuse, any service that is free gets abused. I'm not a proponent to charge it to the NHS. But if something is free, people use it without a thought." (GP)

"Some people are happy to deal with things over the phone, some people want to come in and be examined. I think safety as a doctor is important as well ... at the back of your mind you think, no I just want to listen to your chest, I want to bring you in anyway." (GP)

Some doctors also questioned whether a greater use of technology might have a detrimental effect on more vulnerable patients who were less able to access such tools.

"A lot of our patients are quite poor and they can't afford smart phones, things like that, as well and they're the ones that often have the most need. So often they're the most vulnerable ones and they're the ones that can't access the telephone and haven't got enough money to do it, so you end up providing an efficient service for the worried well."

4.6 Coping

Doctors had a number of different strategies they employed to help them cope with working under pressure, both in and out of work.

Coping on a day-to-day basis

In work, these strategies fell into three main categories:

- **Seeking reassurance**
 - In order to deal with the emotional pressure that came with the responsibility of the role, (usually less experienced) doctors looked for ways to reassure themselves that they were making the right clinical decisions. This might be at an individual level, for example, reviewing decisions at the end of the working day, or at a more collegiate level, for example, discussing decisions with peers or senior doctors.

"I don't think I've ever forgotten something or not done something or something's gone wrong but it's that thing of I've got to really focus and be really methodical and double check everything to make sure I'm not missing something. So that then almost adds to the stress of being busy."
(Consultant)

- **Down time**

- Doctors were often mindful that they ran the risk of exhaustion or burn out and so tried hard to take breaks during the working day or to ensure they finished on time; however, this was not always possible.

- **Escape / varying role**

- A number of doctors found relief in pursuing specific professional interests outside of their day-to-day roles. For example, they sat on Boards or did additional / separate clinical roles. They felt that doing something like this gave them the opportunity to escape from the pressures of their everyday, and reminded them of what they had liked about medicine in the first place. Similarly some doctors tried to keep a mixture of clinical duties and research to provide variety and avoid burning out from too much clinical work.

"So I do something which is of interest to me and that gives me a little bit of pleasure as opposed to loads of other things which are dumped on me."
(Consultant)

"Plus, I do the helicopter stuff [air ambulance work] as well which is interesting, it's a nice break working for an organisation in the NHS that really does work." (Consultant)

Some hospitals or practices provided emotional support for doctors to deal with the mental pressures of their roles.

"We're lucky here also, we've got a psychologist who's here for our wellbeing as well as the patients." (Consultant)

Outside of work, doctors cited a range of different ways in which they tried to ensure they looked after their emotional and physical wellbeing:

- **Rejuvenation**

- Holiday was seen by doctors as an extremely important way to give their bodies and brains a break from high pressure working periods. Many made sure that it was carefully spread out across the year. There was some discussion (Section 3.1) about the difficulty of actually keeping annual leave free of work, with many

doctors finding that they used their so-called holiday to catch up on admin or training.

"This morning I was looking at planning leave for next year so that it's strategically placed, my annual leave, I'm not going months and months without leave. So every couple of months I know I'm going to have a long weekend or a week off, something like that." (Consultant)

- Physical exercise was also seen as key in helping doctors to deal with the stresses of work, although again these pressures made it increasingly difficult for them to find the time to fit this in.
- Other ways of recharging, for example, listening to music or spending time outside were also mentioned.
- **Sharing / offloading**
 - Doctors talked about the importance of spending time with family and friends to help to deal with the emotional pressures of work (and again bemoaned the fact that their workloads often meant they had less time available to do this than they would like). Many of the doctors we spoke to were married to other medics which helped in that they could understand and support one another (although this could mean that it was even more difficult to juggle personal lives).
 - In addition to family and friends, being able to talk to peers and colleagues was really important to many doctors as these people were able to understand and empathise with the pressures. This could be face-to-face e.g. going out for drinks after work, or on social media.

"I'm very lucky to have some very close friends who are doctors, whether locally or further away, and so knowing that you've got people that you can debrief to if you need to debrief and people that can almost act as mentors that you can have a bit of a chat with. If you're still thinking about something you can go "I'll just ring my mate up, they'll be able to talk through", because I think that's something that isn't really provided, isn't really encouraged within our workforce, to have that. So I think there's lots set up for that and people have set up Facebook groups and things where you can talk about things, the patients anonymously, their cases, more about how you're feeling about it and the impact it's left with you rather than the specifics of the patients and that can be quite helpful sometimes. Even if it's just seeing a situation where you go "oh, I had that", "yes, I felt like that afterwards", "oh, that's normal, that's really reassuring" and things like that." (Trainee)

Several doctors discussed the importance of training the mind to help deal with the mental and emotional pressures of work:

- **Compartmentalising**

- At the most 'informal' end of the spectrum, doctors discussed clearly demarcating home and work time, for example by refusing to take work home, by not having email access at home, or by switching off the phone when on holiday.
- **'Formal' approaches**
 - A range of other more 'formal' techniques were mentioned by individual doctors as ways to help to develop the mental capacity to deal with the pressure: resilience training; neuro-linguistic programming coaching; Cognitive Behavioural Therapy; meditation.

Coping by refusing to take on more work

Some doctors felt able to push back when they felt that the demands being made of them were unreasonable. This could either be on a day-to-day basis, for example, refusing to see patients when too many have been scheduled in and asking for them to be rescheduled, or at an actual role level, for example, stipulating in contracts that they will not work beyond a certain time or that they have protected time in their rotas.

"The problem is that doctors generally expect to work a lot. When you get into the field you are expecting that you will be rinsed. And so, whilst it is put on you, you accept it. Because that is what you know and that is what you have dealt with in hospital medicine. So because I tend not to do that. I would negotiate working in hours and how many patients I am seeing."
(Registrar)

Some doctors would also push back to patients as well, for example, by explaining how busy it is and encouraging them to go home if they can.

"Sometimes it helps, I think when you're a bit more experienced as well, you know you have the confidence to make decisions, and you also have the confidence to stand up in Accident & Emergency and say, there's only two doctors from now until 9 o'clock in the morning. If you really feel like you need to stay, then definitely you will be seen, but there will be a wait. We are working as hard as we can.' And that diffuses the situation sometimes." (Registrar)

Having the confidence to 'push back' in this way depended on individuals' own attitudes and personalities, but there was a sense that more junior doctors felt more able to do this (from what they said in interviews or from what more senior doctors said about their junior colleagues).

"I certainly get the impression now having worked with juniors, that it's very much I'll start at this time, I'm going to finish at this time, and if I don't finish on time then I'm going to put in an exception report."
(Consultant)

At the most extreme end, some doctors felt that the only long term coping solution was to reduce their workload by formally reducing their hours e.g. by working part time.

"I will probably try and work less than full-time as soon as I can. Or whatever consultancy I would pick, to only work 3 or 4 days a week."
(Registrar)

Sustainability / limitations of approaches

In terms of individual coping mechanisms, it was felt that these could also be difficult to maintain, for example:

- Seeking reassurance from more senior doctors increased the demands on consultants and added to their own pressures. Taking the time to reassure oneself was not always feasible given time pressures.

"I am to reflect regularly on interesting, educational, or upsetting cases/events – not only is this an essential part of our portfolio of evidence, but I find it helpful in my processing and personal development. During A&E there have been many cases I would like to reflect upon, but I have never had the chance to sit down and write one!" (Trainee, online app)

- Whilst sharing / offloading was an important recourse for many, some also acknowledged the danger of mentally taking work home.
- As much as doctors wanted to give themselves down time, allocated breaks and finish times were hard to protect and were often the first thing to go.
- Some doctors found it increasingly difficult to fit in their means of 'escape' given how squeezed their time was and how exhausted they were.
- In relation to pushing back, it was felt that while this made sense for individuals to protect themselves by refusing to take on more work or cutting back, as it stood, the system relied on doctors actually doing more than their fair share. If everyone pushed back, the system would therefore collapse.

Reporting concerns to managers

While most doctors in training felt able to report concerns to their managers, they often felt that there was little point in doing so because management was already aware and there was not much that could be done. There was also seen to be an element of concern about being blamed for making mistakes when raising a concern.

One doctor in training reported that management only took complaints about working hours seriously when faced with the prospect of a financial penalty. She explained how she and her colleagues had been supported by their union to report breaches to the contract.

"So I suppose they just say "yes, it's terrible", everyone's aware of the issues, there's no secrets here, we all know, it's black and white. Probably the only way to get the management to ever to listen or to change a rota is to monitor it and to get them to pay. So last year I should have been on a 30% salary as a trainee

and I was on an 80% salary, where you get your full salary and 80% again because the rota wasn't compliant with any laws." (Registrar)

A number of consultants had also raised issues with their immediate managers. Middle management was often criticised for being ineffective at dealing with the issues, largely due to budget constraints. Given that it was a time consuming exercise, some doctors felt that it was not worth the effort.

"It's quite an arduous form to complete, it takes quite a long period of time, but whenever I've filled these in, wherever I've worked within the NHS, I don't think I've ever really heard anything back. There's very little feedback, I think it goes to managers in various areas and they may well do things with them, they may well take them on board, but I don't think I'm alone in thinking amongst doctors and even nurses that it kind of feels pointless." (Trainee)

A number of consultants, although frustrated, had sympathy with management's position, for example they recognised that there was no more money available or that it had proved impossible to recruit certain posts. It was more effective to go to management with a solution; however, finding the time to put together a business case was another demand on time.

"There's no point in moaning about it. You can highlight a concern but you need to put figures behind it and think of solutions yourself and put them forward if you want to be taken seriously." (Consultant)

In several instances consultants had become so frustrated by middle management that they had 'gone to the top' to raise their issues, highlighting patient safety issues.

"If I tell them, my patients are extremely at risk, I tell my line manager that and I can tell them until I'm blue in the face, I did that for 10 years. They will take no action. The only time it is taken seriously is when I go above them." (Consultant)

5. The impact that working under pressure has on individual doctors

Section summary

Doctors who had worked under sustained pressure felt that it impacted on them both personally and professionally.

- At a personal level, most doctors felt that they were often (in some cases always) exhausted and emotionally drained, with some suffering from stress or anxiety. This had an impact on their health and on their personal relationships.
- At a professional level, pressure impacted on doctors in both short and long term ways.
 - Being tired and stressed day-to-day meant that they were irritable and nervous of making mistakes.
 - Many doctors felt that their professional development was impacted in that they had less time available for training or study, or got exposed to fewer clinical opportunities.
 - Many doctors had made changes to their longer term careers, from reducing their working hours to changing specialties to choosing to locum. A few individuals were planning to leave the profession (retiring early) or the country (practising abroad) altogether.

Given the nature of this research, discussions around the impact of working under pressure focussed on those periods where doctors had experienced the highest levels of pressure. Whilst some doctors in the sample were consistently working at this level, for others, these were less frequent experiences, but they were asked to think about the impact during such periods.

5.1 Personal impact

Working under pressure often had a physical and / or emotional impact on doctors. Working long hours in intense environments left doctors physically exhausted and lacking the time or inclination to focus on hobbies, relaxation or even personal relationships.

"I used to cycle, or I would go to a gym. I don't have any time to do that anymore. I feel that I don't have time to communicate with my family to the extent that I would have. My wife is a GP as well, she just wants to retire. And I'm encouraging her. It's just damaging my life and I can't perceive how I will continue on to retirement age. In fact, I know I won't. Even though my retirement age is probably only about 6 years away. I'll be gone completely by 60." (GP)

"Worked backshifts (6pm-2pm) last week, into long days (11am-10pm) over the weekend, into four night shifts Monday - Thursday. As a result, haven't seen my flatmate for a week. Booked three yoga classes this week,

all of which I had to cancel as was too exhausted from work" (Trainee, online app)

The mental pressures also took their toll, with some suffering from stress or anxiety.

"During handover, the FY1 doctor on for the weekend was in tears at the volume of jobs she had and embarrassed at handing them over. She had come in for an hour early, stayed over an hour late on a 12 hour shift and had a 15 minute lunch. I remember that feeling. She was not crying for her lack of breaks, she was crying as she felt she was letting her patients down." (Locum, secondary care, online app)

"I've had my own breakdown, I have had to ask for time off." (Trainee)

5.2 Professional impact

Day-to-day work

The physical and / or emotional repercussions of working under pressure also impacted on doctors professionally. Being tired and stressed during the working day meant that they were nervous of making mistakes or more irritable with colleagues.

Training and development

In the longer term, most doctors talked about the impact on their professional development. Those who were still training felt that there were numerous negative repercussions of working under pressure:

- They simply didn't have the **time to study** (and even so-called protected time often had to make way for clinical priorities), let alone the ability to concentrate.

"The tutorial won't happen and your protected teaching time for self-study won't happen because you will be called." (Trainee)

- They weren't able to get exposure to certain **clinical opportunities**.

"In the last day I have had to skip out my own training in order to meet GP practice needs. I was due to do a cervical smear which is needed as part of my training portfolio but instead of that I had to attend a home visit as the other GPs were already doing visits." (Trainee, online app)

"The hospital I worked at we were always in majors and if we had any interest in doing the minors stuff, like suturing and doing fractures and things like that, that opportunity was not given to us because they said essentially, you need to do the service provision and the bulk of the work is in majors. So only if majors is empty can you go into minors. But majors is never empty." (Registrar)

- Senior doctors didn't have the time to do **workplace assessments**.

"We have to be observed doing things, we have to get feedback for things and we have to show all of that and it's really difficult because sometimes we just don't get that because everyone's so busy." (Trainee)

Even more experienced doctors felt that they struggled to maintain their CPD.

"I don't have time to research, I don't have time to travel and to go to the conferences." (Consultant)

Career plans

As discussed above, several doctors had reduced their hours in order to cope with the pressure that they were working under.

"You will find most GP trainees as soon as they finish, they go down to working 3 or 4 days a week because they hate doing clinics." (Registrar)

A number of doctors in training talked about the ways in which the pressure they worked under had resulted in them re-evaluating their career plans, with some of them choosing different specialities as a result. Even more experienced doctors questioned their long term futures.

"I left medical school thinking I'll be an in-hospital medic. Like, do core medical training, maybe do acute medicine or something like that. And I finished the F1 year and said I'm never, ever going to work in medicine in a hospital. It was just so gruelling." (Registrar)

"It makes me question whether it's the right career. Especially I'm at the start of my career and for already to be having days like this, it makes you think well, is this really it?" (GP)

Similarly, some doctors were diversifying their careers in order to keep their options open.

"I want to be a full-time NHS consultant but I don't think it's possible to be a full-time clinical consultant physically on your mind or your body or anything else. So I probably want to diversify my career." (Registrar)

One doctor talked about the acronym RLE (Retire Locum Emigrate) as being shorthand that was commonly used on doctors' websites. These ways of escaping the pressures were all discussed in our interviews:

- **Retire**

- A number of doctors stated that they considered themselves unlikely to continue working for as long as they theoretically could. They felt that they would suffer from burnout if they tried to keep going.

"I think everybody my age, consultant level anyway, are now thinking there's no way we're doing this until we're 67, absolutely no chance. So we're all looking as early as we can at when our pension might be sufficient to take retirement at an age of 55 or shortly after." (Consultant)

- **Locum**

- Some doctors had considered locuming (and some of our sample were currently doing so) as a way to have more control over their workloads and be better remunerated.

"I see why people go for it. It's more money. You can pick your shifts. You're not tied to all the other stuff that comes with the job, so the portfolio and continue personal development and all the boxes you have to tick to keep moving up the years." (Registrar)

- **Emigrate**

- Many doctors knew friends or colleagues who had moved to practise abroad. Within our sample, one doctor was planning to move to the Middle East this year and another had worked in Australia and was considering returning. These moves weren't only motivated by a desire to escape the pressures of working in the NHS; these roles were also seen as better paid.

"A huge number of my colleagues are moving to work in Australia or New Zealand where the system is very, very similar but the pressures are far lower... Your work life balance is totally different and there's a general feeling of being much better supported, things like you're given time off to study or you get time off to take your exams, you get time off to study for your exams and your exams are paid for when you're in a training programme. That would never happen in the NHS and I think that has a huge impact on people, the fact that you can go somewhere else and be much better compensated, have a much better work life balance and generally feel much better supported and appreciated." (Trainee)

Commitment to the NHS

A number of doctors discussed the fact that they had explored the idea of leaving the profession, or leaving the UK to practise abroad, but they felt committed to the ideals of the NHS. They were, therefore, prepared to cope with a certain degree of pressure as a result.

"I'm a really strong believer in the NHS and I want the NHS to work..... So, for me, it's goodwill, it's goodwill, it is really, truly that." (Registrar)

However, there was a sense amongst some that this goodwill towards the NHS was not necessarily enough to sustain it in the longer term.

"One of the great things that makes the NHS is that people really believe in it and believe that people have a genuine right to universal healthcare but the fact is that GPs will end up putting their own lives on the line as a result and they'll keep working harder and harder and harder and they'll end up like frogs boiling in the water." (GP)

The health system

Many felt that the pressure faced by doctors would have a longer lasting impact on the NHS and the profession as a whole. They cited a number of concerns in relation to this:

- **Doctors having less rounded skills**
 - As a result of the need to prioritise, some doctors felt that their skills were too focussed and that they were lacking breadth of experience.
- **Innovation**
 - Because they were struggling to achieve all their daily tasks as it was, doctors were not able to step back and innovate at all – rather they were firefighting.

"You get very little opportunity to sit down and think are we doing this the best way? Should we introduce a new area of care into the practice? Should we develop a better system of doing this? That takes time." (GP)

- **Morale**
 - It was generally agreed that morale was low in the NHS and that this had a knock on effect.

"The nurses are tired, the nurses are grumpy, the doctors are grumpy. It sometimes creates not the best environment at times. ... When it gets busy you get quite irritable, unfortunately. Whether you want to be irritable or not. That has an effect on service and how quickly things are done and the relationship with the professionals." (Registrar)

- **Succession**

- There was some concern that because certain roles (for example, GP partners or hospital consultants) looked so unappealing to more early career doctors, there might be an issue further down the line when the current cohort retires.

Positive impacts

While the majority of discussions focussed on the negative impacts of working under pressure, there were some examples of positive consequences. However, these were few and far between and tended not to be top of mind – doctors had to think quite hard to provide any examples:

- Consultants being more hands-on on the wards

"Now – I think because of how medicine has become defensive, but also the pressures, but I think also a cultural change as well – it is expected that there is a Consultant on the shop floor as it were." (GP)

- A more supportive working environment

"Those softer skills, those caring for each other skills, which sounds a bit wishy washy, those are really important things which I think make working in a place much more enjoyable, and they've come about because of the stresses, bringing people together to recognise that." (Consultant)

- Doctors being more open about their working patterns and succession planning

6. What this means for patients

Section summary

Patient care

Most doctors acknowledged that the service and care patients received was reduced in quality as a result of the system and doctors being under pressure. They felt that patients' experiences would be poorer, for example, they would have to wait longer to be seen and when they did, doctors would spend less time with them. Doctors also discussed the fact that their 'bedside manner' and communication with patients and families was adversely impacted when they were rushed, potentially leaving people less reassured.

Patient safety

Across the sample, doctors in different care settings and at different levels expressed the view that despite their best efforts, the fact that they were working under pressure had resulted in patient safety being impacted. For some, it was seen as inevitable that tired and stressed doctors would make mistakes or miss things, and that delays could exacerbate issues. It was also felt that problems such as doctors having less opportunity to learn and develop would result in patient safety issues further down the line.

6.1 Patient care

While some doctors did not accept that there were likely to be any issues when it came to patient safety, most acknowledged that the quality of the 'service' received by patients was reduced as a result of the pressures doctors were working under. Simply having less time to spend with patients meant that doctors had to reduce any niceties and focus purely on the patients from a clinical perspective.

"So, the simpler ones you can cut down to 5 minutes. Because you are trying to save time. ... You don't chat with them about their lives anymore."
(GP trainee)

"I can recognise when I am coming close to what I call 'compassion failure' in A&E. When you have a patient who clearly hasn't got an emergency problem, but is anxious, or difficult, or having difficulty understanding. It's easy to get frustrated and short with them." (Registrar, online app)

"I would like to think that they [patients] wouldn't notice the difference. But certainly, when we are well staffed, and we are under much less pressure, we can give a heck of a lot more time... We can choose to go that little bit further, and ask them more personal questions, maybe things that aren't relevant to their consultation, but things that will make a difference. That extra stuff. And we, as a result, the job satisfaction is

much higher as well. They definitely go hand-in-hand. Because patients leave happy, or not just leaving happy because you've dealt with their problem, but you feel like you've related to them, you've asked them important questions. You feel like you've made a difference. Then you can go home thinking you know what, I did a good job today. Rather than just be, when you feel like you're chasing your tail around, at the same time you're thinking am I actually any good at this?" (GP)

6.2 The patient journey

Similarly, even if patients were correctly treated, it was felt that their overall experience was likely to be poorer as a result of doctors (and the system) being under pressure. This was the case at all stages of a patient journey:

- Before being seen
- Whilst being seen
- After being seen

Before being seen

As a result of pressures doctors acknowledged it was harder for patients to get appointments so there were often delays before being seen, and when they did get appointments or went to a walk in clinic or A&E, they had to wait longer to be seen. Doctors felt that this wasn't just an issue in terms of the hassle factor for patients; it also added to patients' stress and concerns, and potentially meant that treatment started later than it should do.

"People often wait more than four hours to be seen and there can also be a long, long wait in A&E before they've managed to get a bed somewhere else in the hospital. So people can spend a lot of time just sitting in an A&E cubicle which is obviously not ideal for anyone." (Trainee)

Whilst being seen

There were a number of different issues identified by doctors in relation to patient service and care when they were being seen or while they were in hospital, for example:

- **Shorter appointments or telephone appointments** (instead of face-to-face)
 - Some of doctors' strategies for dealing with workload pressures meant that patients got less quality time with their doctors – this could mean that things got missed if doctors weren't able to get to the bottom of patients' 'real' issues or underlying causes, especially if they couldn't get the non-verbal clues from face-to-face interaction.
- Doctors not having enough time to do **proper handovers or write full notes**
 - Doctors were often already working past their contracted hours, and the pressures meant that they were not always able to give comprehensive handovers at the end of their shifts, meaning that those doctors would not always have patients' full histories.

"A&E had long 'breaching' wait times so patients were sent through to medicine that had not been clerked in properly, bloods were not chased and they had not had time to ring me about unstable delirious patients. Therefore, I had no history...treating them without baseline knowledge about them is extremely difficult" (Locum, online app)

- **Haphazard / sub optimal communication** to patients / their families
 - Doctors found that during busy periods they often did not get the opportunity to talk through their diagnosis or treatment plans with patients.

"I've had no opportunity to explain what their diagnosis is or what I'm thinking about their care or how long I think they'll be in hospital etc. So people often end up going to a ward overnight with really no idea what's wrong or what's been going on." (Trainee)

- **Unnecessary procedures / defensive practice**
 - In order to 'cover their backs' or to save time further down the line, some doctors indicated that they sometimes gave patients unnecessary procedures, for example blood tests, or had them stay in longer than needed to be on the safe side.

"Overnight I definitely refer more often because I don't have the confidence or the support to back me up to say that someone could be safely discharged. If I don't feel that there's someone senior enough to make that decision then I will inevitably refer and sometimes that person could probably have avoided admission and frequently that ends up being a very short admission and they get out next morning and that creates a lot of work for everyone involved and is unpleasant for the patient and probably didn't add very much." (Trainee)

- **Lack of 'bedside care'**
 - As discussed above, because they were stressed and tired, doctors weren't always able to provide the 'bedside care' they would like.

After being seen

Again, because of workload pressures, some doctors found it harder to follow up on patients, than they would ideally like. For example, they spent less time carefully reviewing repeat prescriptions to check that they were still suitable or they did not chase patients who were supposed to make follow-up appointments so assiduously. At the other end of the scale, some patients were having to make unnecessary return visits (for example, coming back for test results because the system was too stretched to give them then and there) or being referred unnecessarily (for example, more inexperienced doctors referring patients to be on the safe side when there is no one more senior to ask).

"A&E also had several very junior inexperienced doctors sending through inappropriate referrals such as chest pain associated with GORD [Gastro-oesophageal reflux disease]. These patients did not need admission and I as someone with more experience could send them home. However by the time they came to medicine they had been waiting 8 hours to see me." (Locum, online app)

"In the last few weeks I have seen a lot of patients coming back, failed discharges coming back within a few days or a few hours even of being discharged from hospital." (Trainee)

For some doctors the pressure led them to be unnecessarily cautious and practise defensively, while the opposite was true for others whose workloads forced them to have more of a 'get them out ASAP' mentality.

6.3 Patient safety

A few doctors felt that no matter what, patient safety would come first, and even though they recognised that the quality of care may not be ideal, the patients would not be in harm.

"I would just stay until I know everyone is safe. That was my aim, it was I'll make sure everyone is safe and then I'll get decisions about their further management from the Consultant ward round... I thought I can do the safe bit and then they can do the bigger picture." (Registrar)

However, a sizeable proportion of doctors thought that the pressure had reached the point where it was inevitably compromising patient safety (not just care / service). Whilst they tried to minimise this, they felt it couldn't help but trickle through. Numerous examples and reasons were given for this including:

- **A lack of time** (for reflection / for consultation with other colleagues / spent with patients themselves) leading to things being missed.

"With the best will in the world, if you're constantly being interrupted or being asked to move rooms or jumping between patients you could see how things can be overlooked." (Registrar)

"I've seen cases of delayed HIV diagnosis missed because it's such a complicated thing and you have to sometimes scroll back through their history to piece everything together to work out what's going on and you don't have the time always to scroll back through the notes before every single person comes in." (GP)

- **Exhaustion / stress leading to mistakes** being made.

"On my last night shift, my reg and I didn't manage to keep up with any of our patients notes or discharge letters as it was too busy. Spent the hour between 7-8am trying to catch up. By this point we had seen so many patients that we were mixing all their details up and making mistakes" (Trainee, online app)

"People become exhausted from working extra shifts. Burdened, I guess, as well, they are obviously very diligent staff who feel they have to cover shifts and are coming in in their own time and not resting adequately as well... Certainly your risk of making mistakes increases." (Consultant)

"I think our attention can suffer sometimes through fatigue as well, you can often see people, they've just been to see a patient and they're like "I can't remember half of what that patient said to me, I'm going to have to go back and ask". It's just little things like that, everyone is running on empty a bit and it means that things are getting missed, things aren't getting done, aren't getting documented as well." (Trainee)

"Definitely – if you're working under pressure, then it will compromise safety. No doubt... Because anyone under pressure, we are not super human, we are human. And you are far more likely to make a mistake, a case of sepsis or whatever, if you are working under pressure." (GP)

"We are all aware of these risks and that makes us uncertain and we are not confident, and we think that if you work under this pressure the mistakes that are going to happen are much more likely." (Consultant)

- **Delays being seen leading to diagnosis or treatment being delayed** or smaller problems getting worse.

"If you're already overcapacity, the next patient you see who you might otherwise have admitted for perhaps a period of observation, who may have benefitted from that, their admission will be delayed or deferred... That probably means that the patients are very sick by the time they come to us." (Consultant)

- **Patients being delegated to more junior doctors** / junior doctors getting less exposure / experience leading to more mistakes or things being missed.

"I think the question inevitably comes 'does safety get compromised', and I'm sure you've heard doctors say in the past "it's very difficult to answer that question" because, of course, the automatic reaction would be no and,

if it was, we would stop doing it, we would do something differently". But I think it would be naïve for there to be a black and white, all or nothing response to the question because I think if it was just black and white, is it safe enough that it meets bottom standards. I don't think that's what most of us aspire to and I don't think that's what patients really want from the health service, I think they want a quality service that isn't just bargain basement safe, that's the very minimum they should be expecting. I think what we do find is that as pressures increase we end up aspiring to the baseline safety." (Consultant)

7. Conclusions

While there was considerable variability across the total sample, most doctors agreed that even if they personally were not working at the most extreme levels, the system was under considerable pressure. The situation is exacerbated by pressures from within the health system (for example, from other health professionals referring patients unnecessarily to move them off their own lists) and externally (for example, cuts to social and community services placing more pressure on primary and secondary care). Furthermore, shortcuts and trade-offs adopted by doctors often resulted in further pressure down the line.

Within the sample there were a few individuals who had found themselves better able to deal with the pressures than some of their peers. This was sometimes down to their own resilience and temperament, and sometimes due to the practical and emotional support they received. In areas where doctors had greater control, for example, GP practices, there seemed to be more willingness / opportunity to implement new or different ways of working. However, even here there seemed to be significant variability. Ensuring doctors felt valued and recognising the extent to which they were going above and beyond was also important in boosting morale.

Overall, however, there was a strong sense that the system is being stretched to breaking point. This was particularly the view of those doctors in the sample working in general practice, A&E and general medicine in hospitals. While doctors employed a number of different strategies (both proactively and reactively) to deal with these pressures and there was discussion about the 'normalisation' of the situation, there was general agreement that many of these were short term firefighting solutions and / or they were exhausting ways of coping i.e. they had reached their limits. Most doctors also agreed that at the very minimum, the quality of care patients received was being compromised, and many felt that in some cases patient safety was also at risk. Many also voiced their concerns about the profession itself if these issues were not addressed, thinking about low morale in the short term as well as the potential dearth of experienced doctors coming through the ranks (because of issues such as them moving abroad, them lacking clinical certain levels of expertise, or them avoiding certain specialties).

Appendix 1 - Research instruments



Final discussion
guide



Online follow up
task.docx