The State of Medical Education and Practice (SoMEP) Barometer 2023: **Deep dive into autonomy**

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Contents

Snapshot summary

Six in ten (60%) doctors agree that they have enough autonomy in their role. Views on autonomy were linked to doctors' roles and/or level of seniority, where more senior doctors generally felt greater autonomy than less senior doctors.

Doctors tended to define autonomy as the ability to make clinical decisions. This meant being trusted to making decisions that are in the best interest of the patient, according to their medical background, training and knowledge. **Doctors also valued autonomy in directing their own career and skills development.** While seen as important; having control over where, how and when they worked, and influence over change in the workplace, were felt to be comparatively less relevant aspects of autonomy.

A supportive environment is felt to be a key enabler of autonomy. Having approachable and available senior staff, who encourage learning and development, enables individuals to be more confident in their decision-making and to develop the necessary skills to act autonomously.

Essential to having the right level of autonomy was knowing when to seek support or input from others and being able to do so. Having systems in place for this collaboration to take place (for example, 'open door' approaches, regular team meetings, discussions focused on aspirations) were identified as important enablers of autonomy.

Restrictions on autonomy tended to relate to working with unsupportive, or unavailable, colleagues (more common among more junior staff), **and restrictions created by the wider system** (more common among senior staff). Doctors identified budget challenges, and resulting restrictions on resources, as systemic barriers to autonomy. Doctors who felt unsupported in their clinical decision-making felt isolated, and often stressed, as a result.

Doctors felt that having the right level of autonomy, and the resources available to exercise this autonomy, was very important in a number of ways. They felt this resulted in improved wellbeing and job satisfaction, stronger working relationships and, ultimately, better patient outcomes.

1 Introduction

Background and objectives

The General Medical Council (GMC) commissioned IFF Research to explore in depth doctors' expectations, experiences and perceptions of different aspects of workplace autonomy, perceived barriers and enablers to autonomy, and how autonomy impacts different aspects of their working life, such as wellbeing and patient care.

This qualitative research builds on questions in the 'The state of medical education and practice in the UK' (SoMEP) barometer survey 2023, an online annual survey exploring how doctors' experiences of practising in the UK are changing over time.

Research objectives

The research was designed to better understand:

- How doctors perceive workplace autonomy;
- What dimensions of autonomy are important and why for doctors in different roles
- The extent that doctors are able to work autonomously within their role;
- The barriers and enablers to working autonomously.
- The role of autonomy in relation to other aspects of doctors' workplace experiences and the care they provide.

Research approach

Fieldwork was conducted via telephone or video call, between 8th January – 15th February 2024, with a total of 40 doctors currently working in the UK. Each in-depth interview lasted around 45 minutes.

In the 2023 wave of the SoMEP barometer survey, doctors were asked if they would be willing to assist in follow-up qualitative research. Those that opted in were invited to participate in an interview.

Quotas were put in place to ensure that evidence was gathered from different types of doctors, with varying experiences of how autonomously they feel they can work (as indicated in the Barometer survey). Table 1.1 shows how the interviews break down by register group and training stage, and by current perceptions of their autonomy. Table 2.1 presents the profile of doctors by gender, nation of the UK, area in which they gained their Primary Medical Qualification (PMQ) and whether they are a trainer or not.

Table 1.1 Breakdown of interviews achieved, by registration type and sense of autonomy

Doctor Type		Agree enough Autonomy in the Workplace	Neutral/Disagree enough Autonomy in the Workplace	Total
GP		8	8	16
Specialist		2	4	6
Doctors in training	Foundation	1	1	2
	Core	1	1	2
	GP	1	1	2
	Specialty	1	1	2
SAS		2	3	5
LE doctors		2	3	5
Total		18	22	40

Table 1.2 Breakdown of interviews achieved, by country, gender, whether they are a trainer, and PMQ region

Quota		Total
Country	England	30
	Northern Ireland	3
	Scotland	4
	Wales	3
Gender	Female	18
	Male	22
Whether trainer	Yes	14
	No	26
PMQ	UK	21
	EEA	7
	Outside UK & EEA	12
Total		40

Topic guide

An understanding of the role and setting in which doctors worked, including how supported they felt in their role, was discussed at the start of the interview to understand the context in which doctors were working. This was then followed by a series of questions exploring doctors' definitions of autonomy in the workplace, how autonomously they feel they are able to work, how autonomy relates to other factors and perceived barriers and enablers of autonomy.

The topic guide used for the depth interviews was designed to be open, conversational and participant-led. This helped ensure that participants had the chance to convey what they felt were key messages or share examples of situations that they felt best illustrated their point. The topics and research questions in the topic guide were designed collaboratively with GMC colleagues.

Analysis and reporting

The current report collates the findings from these depth interviews following analysis and discussion between the researchers conducting the interviews. Emerging narratives were compared across the interviews, using a thematically structured analysis framework. The researchers then held analysis sessions to develop the narrative and subsequently create this report. Relevant results from the 2023 wave of the SoMEP barometer survey are also referenced throughout for context.

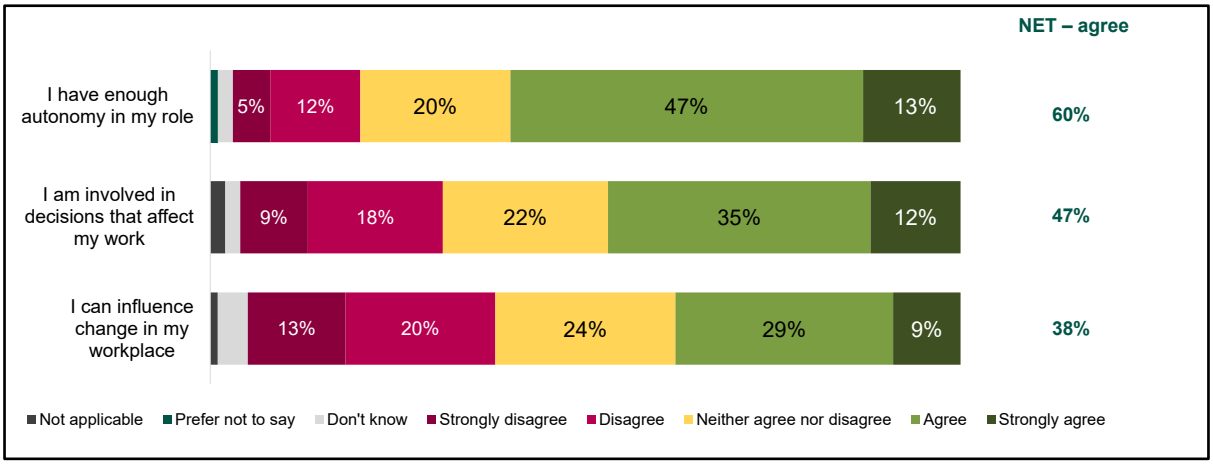
2 Key Barometer survey findings on autonomy

This chapter presents the headline findings on the theme of autonomy from the 2023 SoMEP barometer survey. Other survey findings are included throughout the report at relevant points.

Levels of autonomy experienced

The 2023 survey included a new set of statements designed to explore different aspects of workplace autonomy. For the most direct statement, 'I have enough autonomy in my role', only six in ten (60%) doctors agreed, as shown in Figure 2.1. Less than half (47%) doctors felt they were involved in decisions that affect their work and just over a third (38%) felt they can influence change in their workplace.

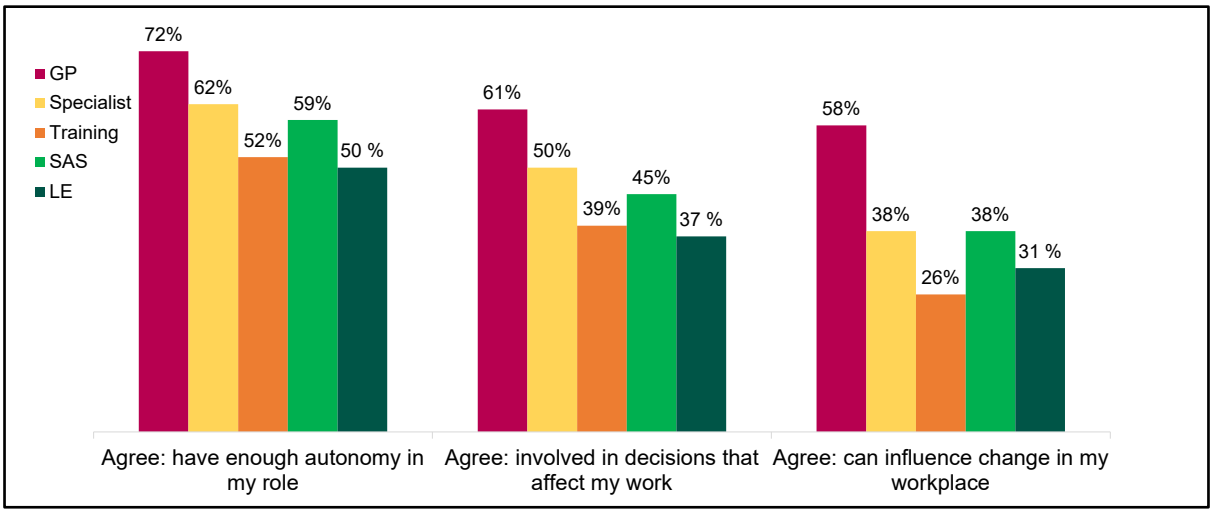
Figure 2.1 Agreement with autonomy statements



D3_X/a: To what extent do you agree with the following statement(s)? Base: All doctors (4288)

GPs were notably more likely to agree that they have enough autonomy in their roles (72%), while doctors in training (52%) and LE doctors (50%) were less likely. The same pattern can be seen for doctors agreeing that they are involved in decisions that affect their work or that they can influence change in their workplace, as shown in Figure 2.2.

Figure 2.2 Doctors' autonomy by register group



D3_X/a: To what extent do you agree with the following statement(s)? Base: All doctors (4288)

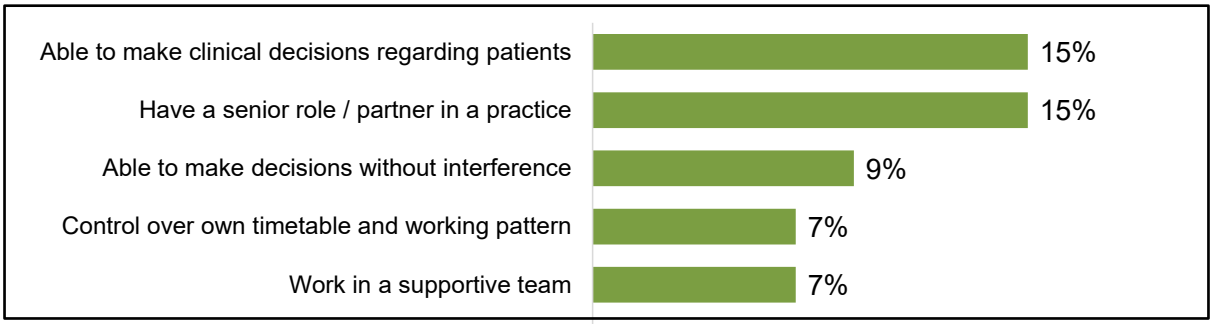
In general, views on autonomy seem to be linked to doctors' roles and/or level of seniority, where more senior doctors felt greater autonomy than less senior doctors. Indeed, among doctors in training, those in GP or specialty training were more likely to feel involved in decision making and able to influence change than those in core or foundation training.

Doctors with a PMQ from outside UK/EAA were less likely to feel they had enough autonomy in their role (53%) compared to UK PMQ doctors (64%) and EEA PMQ doctors (61%).

Experiences of autonomy

Doctors were asked (through an open question) the reasons why they agreed or disagreed they had enough autonomy in their role. Reasons given were most commonly focused on the decisions they were able to make – whether clinical decisions or about wider workplace issues. For example, the top reasons given by doctors agreeing they have enough autonomy in their role were that they were able to make clinical decisions regarding patients, that they have a senior role, or were able to make decisions without interference (see Figure 2.3).

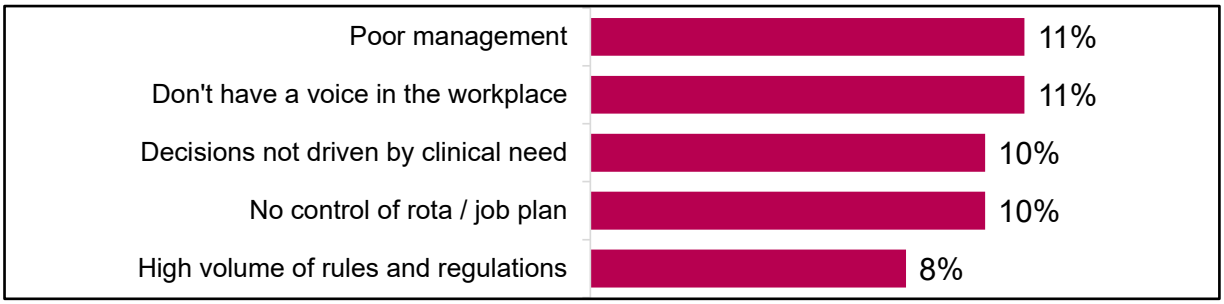
Figure 2.3 Top 5 reasons for agreeing doctors have enough autonomy in role



D3b. What makes you feel that you have autonomy in your role? Base: Those who feel they have enough autonomy in their role (2559)

Conversely, the most common reasons cited by doctors disagreeing they have enough autonomy in their role were poor management, feeling like they don't have a voice in the workplace and decisions not being driven by clinical need (see Figure 2.4).

Figure 2.4 Top 5 reasons for disagreeing doctors have enough autonomy in role



D3c. What makes you feel that you don't have autonomy in your role? Base: Those who feel they do not have enough autonomy in their role (741)

There was some variation in reasons given for having enough / not enough autonomy, by register group:

- **GPs** who agreed they had enough autonomy were likely to reference their senior role (27%), while those who disagreed tended to cite the high volume or rules and regulations (18%).
- **Specialists** felt autonomous due to control over their timetable and working pattern (10%), and felt their autonomy was hindered by poor management (20%), not having a voice in their workplace (19%), and decisions not being driven by clinical need (18%).
- **Doctors in training** who felt they had enough autonomy were more to say this was because they felt able to make clinical decisions regarding patients (19%). Those who lacked autonomy attributed this to a lack of control over their rota / job plan (14%).
- For **SAS doctors**, the most common reason for saying they had enough autonomy in their role was being able to make clinical decisions regarding patients (21%). Those who felt they did not have enough autonomy were more likely to mention not having a voice in the workplace (19%).
- **LE doctors** who felt they had enough autonomy were more likely to say this was due being able to make decisions without interference (12%).

Relationships between autonomy and other factors

The survey highlighted the relationship between having enough autonomy and other positive outcomes in work.

Doctors who agreed they had enough autonomy in their role were more likely to be satisfied in their day-to-day work (64% compared to 27% of those who disagreed), less likely to work

beyond rostered hours on at least a weekly basis (63% vs. 74%) and less likely to be at high risk of burnout (13% vs. 41%).

This is in direct contrast to doctors who disagreed they had enough autonomy. This cohort were more likely to have made adjustments, such as refusing additional workload or reducing their hours, as a result of workload pressure. They were also more likely to have acted outside of their role in the last month than those that felt they had enough autonomy, whether that was undertaking tasks usually completed by doctors in a more senior role (34% vs. 17%), a more junior role (70% vs. 49%), or a nurse or non-medical role (75% vs. 54%).

Feelings of autonomy were also related to both support and development opportunities. Doctors who said they had enough autonomy in their role were more likely to agree that:

- They felt supported by immediate colleagues (91% compared to 69% who disagreed they had enough autonomy);
- They felt supported by senior medical staff (69% compared to 39%);
- They felt supported by non-clinical management (53% compared to 16%);
- They had access to sufficient development or learning opportunities (65%)

Given these relationships– and definitions of autonomy given by doctors – it is evident that being able to act autonomously is closely related to having a supportive environment, including the culture around learning and development.

3 Feeling supported

The 2023 barometer survey clearly highlighted how a supportive working environment was an important context for doctors working autonomously (see 'relationships between autonomy and other factors' in Chapter 2). This chapter first presents findings from the barometer survey on how supported doctors feel in their role. It then explores the qualitative findings on how supported doctors felt and characteristics they attributed to supportive and unsupportive working environments.

How supported do doctors feel?

In the 2023 barometer survey, just under three quarters of doctors (72%) agreed that they were part of a supportive team, and the vast majority (85%) agreed that they were supported by immediate colleagues.

The survey highlighted how doctors felt relatively less supported by more senior staff and management than their immediate colleagues: just over half (54%) agreed that clinical leaders were readily available, 61% agreed they felt supported by senior medical staff and 41% by non-clinical management.

Qualitative findings were in line with this – on the whole, doctors felt supported by their teams to do their job well. Barriers to feeling supported usually related to clinical leaders, management or systemic factors. These themes are explored below.

Characteristics of a supportive working environment

How supported doctors felt to do their job well was highly dependent on the **characteristics of colleagues and working relationships**.

Those who felt very supported in their role described **working in collaborative and friendly teams**, which had a positive impact on how they felt about work.

> *"I feel enormously supported by the department...I think that's probably what keeps us in our jobs – the people that we work with on a day-to-day basis, immediate nursing and medical colleagues, are fantastically supportive."*
>
> **Female, Specialist, UK PMQ, Disagreed that they have enough autonomy**

> *"My practice is a very friendly practice. Everyone talks to each other (possibly too much). I've worked other places that are not as nice. One partner has been there 20 years – I can ask him anything clinical, and he's very laid back."*
>
> **Female, GP, UK PMQ, Agreed that they have enough autonomy**

An enabler of this was having **systems in place** – both formal and informal – which created opportunities, and carved out time specifically, for doctors and other medical staff to provide support for each other. Examples included clear line management systems (where staff are dedicated to dealing with complaints, working hours and annual leave and doctors can call these staff directly when necessary), scheduled team meetings, and social activities.

> *"My colleagues are pretty supportive... There is the opportunity to seek advice... We have a wonderful local faculty meeting where we review monthly what we have experience and where we are with supervisees."*
>
> **Male, Specialist, UK PMQ, Disgreed that they have enough autonomy**

> *"But we all kind of supervise each other, which sounds a bit strange, but I think in the team, you know we we kind of give feedback to each other. It works out quite well. We have a WhatsApp group and we have coffee mornings sometimes in the evening..."*
>
> **Female, GP, UK PMQ, Disagreed that they have enough autonomy**

Doctors attributed how supported they felt to **how open and approachable senior staff** were. This was particularly important for doctors in training andearly career doctors.

Those who felt supported by senior staff placed emphasis on **how comfortable they felt raising queries and concerns** with supervisors and other senior colleagues.

> *"...After every session, I have a debrief with either my clinical supervisor, but sometimes it can be one of the other qualified GPs in the practice or one of the partners...I can pop in and just knock on the door and ask a quick question if I need to... I don't feel scared to ask questions or anything like that..."*
>
> **Male, GP trainee, UK PMQ, Disgreed that they have enough autonomy**

Some doctors described working with senior staff who were not approachable or supportive. Sometimes, **senior colleagues had unrealistic expectations** in the extent to which those they support / oversee should work autonomously. This resulted in doctors in training and early career doctors being criticised for asking 'too many' questions, or feeling overwhelmed by how much responsibility they had.

Doctors explained how, in some medical settings, the **hierarchical structures** made it difficult to approach senior staff, and also reduce the sense of control doctors had over decisions.

"There's always a sense that if a consultant says do it, it needs to be done."

Male, Trainee, UK PMQ, Neutral on autonomy

Doctors also felt **senior staff not being present or being too busy** was a key contributor to feeling unsupported. Doctors felt this tended to be an outcome of **systemic issues in the UK health systems**, resulting resourcing constraints and the fact consultants and partners were often overstretched.

It depends on the registrar you have got covering you. They spend most time in the theatre and then they are on call all day and most of the time some of them go home. You can speak to them on the phone and ask them to look at X-rays, but not everyone is happy for you to ring them up, and they think it is something you could have managed"

Female, Trainee, Non-UK PMQ , Agreed they have enough autonomy

"The people I expect support from are overworked, so there's a limit to how much they can do. They see an even higher number of patients than I do, so there's nowhere for the work I'd like taken off to go to."

Female, GP trainee, Non-UK PMQ, Neutral on autonomy

The experience of a trainee doctor, who worked across different settings, highlighted the impact having approachable and available senior staff can have on how confident and comfortable doctors feel to do their job well, and how resourcing constraints can be a barrier to this.

"I feel well supported in community posts. I work in quite close quarters with a consultant and I have the opportunity to discuss cases. I tend to make a plan and then discuss to see if he [the consultant] recommends anything … that increases confidence … [it works] because we work in such close quarters with them. Inpatients can be tricky in terms of getting hold of someone. There is a structure, everybody on call as a junior doctor is expected to be supervised by a middle grade on call…there should be one on call in each locality and each of those could have several wards they are covering, so they are not always available. It tends to be a manpower thing."

Male, Trainee, Non-UK PMQ, Neutral on autonomy

The above also highlights the importance of support in the form of **receiving feedback**. Some doctors explained how receiving feedback and being able to discuss their treatment decision process with more senior doctors enabled them to feel more confident in making clinical decisions, and act autonomously when doing so.

Other factors conducive to a supportive working environment included:

- Being **encouraged and given opportunities to progress and develop**. For example, some described being encouraged to undertake training that they were interested in, or being given experiences in the workplace to help build their portfolio.
- Being **supported through difficult times**. Some examples included doctors expericing poor mental health, going through an ADHD diagnosis, family bereavement, and on moving to UK and being alone.

4 What does autonomy mean to doctors?

This chapter explores doctors' views on what autonomy in the workplace *means to them*, and what aspects of autonomy they feel are most important.

How do doctors define autonomy?

Doctors were asked how they define autonomy in relation to their work. Most commonly, doctors defined autonomy as the **ability to make clinical decisions** that are in the best interest of the patient, according to their medical background, training and knowledge.

Generally, doctors felt all aspects of autonomy explored were important, however some aspects resonated more than others, and the relative importance of each aspect also differed. Figure 4.1 below illustrates the order of relevance that doctors placed on the aspects of autonomy mentioned.

Figure 4.1 The comparative relevance of different aspects of autonomy

Most doctors felt that the ability to act autonomously in **clinical decision-making** was vital to their profession and providing optimal patient care. References to clinical decision-making were usually part of doctors' spontaneous, top-of-mind thoughts on what workplace autonomy meant to them. Having the capacity and time to sit down with a patient and work out what's best for them, being able to work to the limits of their role, and not *having* to check with senior colleagues when they are confident, were essential parts of this aspect of autonomy.

> *"I have the ability to see a patient and assess and make decisions based on what I know."*
>
> **Female, GP, Non-UK PMQ, Neutral on autonomy**

Doctors also felt that **control over the focus and direction of their professional development** was important; for example, deciding on where to focus skill development, and then pursuing training provision that enables this and enabled progression, was especially valued. This aspect of autonomy came out both spontaneously and after being prompted. Skills development was also much discussed as an enabler of autonomy more broadly (giving doctors the skills and confidence they need to make decisions within their scope of practice). Although the importance of having control over professional development was mentioned by doctors at all levels, it was more prevalent among early career doctors.

Doctors valued **having control over their workload**, but this aspect of autonomy was usually only discussed after being prompted on. Doctors defined having control over workload as determining the number of patients they dealt with and the time frame for managing this.

Similarly, doctors also agreed that **when, where and how they work** were important aspects of autonomy, but was largely and appropriately predetermined by the nature of their work and area of medicine they worked in. These aspects of autonomy came out both spontaneously and after being prompted. Flexible working hours usually involved working according to one's own schedule, rather than this being dictated by others. Doctors acknowledged that having control over when you worked was a desirable aspect of autonomy but the appropriateness of this depended on your workplace setting and the area of medicine you worked in.

The final aspect of autonomy which doctors were prompted on was having **influence over change in the workplace**, which usually included having an influence over recruitment and internal processes. This was mentioned less frequently than other aspects and doctors had mixed views on how important it was. For example, more senior doctors usually placed greater importance on being able to influence change. Some doctors were happy to forego this aspect of autonomy if it meant they had more time and freedom in other aspects of their work e.g. clinical decision-making.

> *"But I'm happy not to be involved in the management and the financial decision-making of the practice, I have been there, and I've chosen the bits that I like."*
>
> **Female, GP, Non-UK PMQ, Agreed that they have enough autonomy**

5 How autonomously do doctors feel they can work?

This chapter looks at how autonomously doctors feel they can work in relation to different aspects of autonomy they identified as being important. For each aspect of autonomy enablers and barriers to feeling autonomous are explored.

Making clinical decisions

As outlined in 'the previous chapter, many doctors felt the most important aspect of autonomy in their role was the ability to use their experience, knowledge and training to make clinical decisions. Generally, the doctors we interviewed felt they had enough autonomy in this regard. Relatedly, in the barometer survey findings, the most common reason given by doctors for feeling that they have enough autonomy was 'being able to make clinical decisions regarding patients' (15% gave this as a spontaneous response).

Many doctors attributed autonomy in clinical decision-making to the team that they were in. **Feeling trusted** to make the right decision, and liaise with colleagues appropriately, was a key characteristic underpinning this, as was having the **support available** for decisions to be sense-checked *if* needed.

In many instances, having a greater sense of autonomy in decision-making was linked to the **seniority of the doctor**. Doctors who indicated that they had worked in their role for many years, or were partners in their practice, felt they had the appropriate experience and trust of others to make clinical decisions autonomously. Others acknowledged that sometimes a lack of autonomy in clinical decision-making reflected their current grade; although there were some frustrations with this, they understood that supervision was there to protect patients.

Some (usually doctors in training) doctors explained that the **availability of consultants or other more senior colleagues** was a factor in how autonomously they could act in clinical decision-making, and how confident they felt to do so.

Having consultants available to sense-check clinical decisions often enabled junior doctors to practise and grow confident in making clinical decisions.

However, it was more common for junior doctors to describe senior colleagues as stretched and/or difficult to access. In some situations, this meant these senior colleagues 'took over' the decision and treatment to save themselves time overall. In others, where there had been little or no input from a consultant or more senior colleague, this lack of reassurance left doctors fearful over decisions they had made.

> *"I just wanted to reassure my own self as well that I'm doing the right thing or wrong thing because it was my first time ever working in a GP surgery."*
>
> **Male, GP trainee, Non-UK PMQ, Neutral on autonomy**

Some doctors identified this sense of isolation in decision-making as a contributing factor to stress and poor mental health.

> *"There is a fine line between empowering people and abandoning them. Autonomy is great, but if it actually means your line manager and seniors are expecting you to deliver but not supporting you when you reach a stumbling block, or not giving you enough resources to do the work, then that does not feel like autonomy, but an imposition. That is a risk for me, individually, because it can lead to stress and burnout and job dissatisfaction, and it can filter down and mean the workforce also feel not supported and become disengaged which can have knock-on effect on patients"*

Female, GP, UK PMQ, Agreed they had enough autonomy

Regardless of seniority and experience, many doctors acknowledged the restrictions imposed on clinical decision-making due to budgets and resources available.

Budget challenges in the NHS, and a resulting **scarcity of resources**, was the most common frustration relating to autonomy in clinical decision-making. Some doctors recalled times that they had not been able to provide the treatment they would like because the equipment, facilities or drugs they would like to prescribe were not available. Some described needing to refer patients to other hospitals (usually in bigger cities) to access necessary testing facilities or care, which patients were sometimes resistant to. The result of this, some doctors explained, was providing inadequate patient care.

> *"[We don't have access to] simple things, like local anaesthetic agents. So, we're not being given the tools to do the simple things. And the frustration that it leads and sometimes you have to settle for providing what you know is substandard care simply because you don't have the tools and the patient needs the operation."*

Female, Specialist, Non-UK PMQ, Disagreed they had enough autonomy

Relatedly, some doctors felt **hospital managers** were obtrusive to autonomy in clinical decision-making and duties and, in some instances, blocked suggested treatment pathways due to **financial considerations**. This could leave doctors fatigued by the system and concerned for the level of patient care available.

> *"The fatigue of the hospital doctors and the low morale is because of over intrusion and obstruction from managers…they just make life harder. The role of managers is to help doctors, not to be obstructive, not to be outright bossy, aggressive, and almost dismissive of the concerns from doctors. It's the support structures above you that are, kind of, affecting how well you're able to do things."*

Females, GP, Non-UK PMQ, Agreed they had enough autonomy

Taken together, these findings align with the barometer survey, where doctors commonly reported that they felt a lack of autonomy as 'decisions are not driven by clinical need' (10% gave this reason spontaneously).

In some instances, blocks in clinical decisions came from the department which treatment had been referred to, on capacity grounds - surgical departments were most commonly mentioned in this regard.

> *"The biggest issue in my working and clinical working world is exit block. There is very poor flow of patients out of the emergency department into wards, but there's no restriction on the number of patients that come into the emergency department. In addition, there is a big priority to catch up from the COVID pandemic in terms of surgical planned care and elective care ['which is creating blocks from emergency to those departments]. "*

Females, Specialist, UK PMQ, Disagreed they had enough autonomy

A 'high volume of rules and regulations' was another common reason mentioned in the survey by doctors who disagreed that they had enough autonomy (cited by 8%). This was also evident in qualitative interviews, where some doctors mentioned the increasing **reliance on algorithms and guidelines to determine patient care**. Although these are informed by what is likely to result in the best patient outcomes, some felt the pathways were restrictive and not always optimal. They expressed that, due to fear of litigation, any deviation from the guidelines was usually avoided, even in circumstances where they felt confident that the alternative could have a better patient outcome. Some doctors also expressed frustration that the protocols undermined their expertise and reduced their sense of autonomy.

> *"[In Germany], you feel like a doctor, you're drawing back to your knowledge of anatomy and physiology. I can't remember ever having to open up a website to look at a guideline. [In the UK] you have algorithms and protocols... It's all automated, a robot could do it. I don't need to use my knowledge as a doctor at all."*

Female, GP, Non-UK PMQ (practising <10 years), Neutral on autonomy

Career and skill development

All doctors, regardless of level, valued having autonomy in relation to their **career direction and professional development**.

For some doctors, having autonomy in this regard meant being able to focus training and development in areas that interested or felt important to them. Often, having the opportunity to direct their own career pathways in this way improved doctors' sense of motivation as well as giving them a sense of personal growth.

Working in a team and setting that supported development was an enabler of this. For some, this simply meant working cultures and approaches which encourage staff towards training and skill development. For others, this included practical support for training (for example, with funding or adjustments to work to create time for training).

> *"I was supported to do a masters, and to develop on the clinical side on courses the hospital paid for."*
>
> **Male, LE doctor, Non-UK PMQ, Agreed they had enough autonomy**

One doctor explained how they **lacked knowledge of what training opportunities were available** to them at work, and this restricted the sense of control they had over the direction of their career:

> *" It's just as you know, being able to control the direction of your career. You know where you would like to go in terms of training opportunities, things like that...I think there are many places to go within the organisation where I work. I mean there may be, but I don't know what they are..."*
>
> **Female, GP, Uk PMQ, Agreed they have enough autonomy**

Doctors in training had mixed views and experiences in regard to autonomy and career direction and skill development.

While some trainees felt they had a good level of choice in steering their career path, others felt **restricted by the opportunities and options available** to them.

> *“More choice in the postings you get. Postings are pre decided in terms of where the sites are so maybe having some input into which posting you get… it is a matter of job satisfaction and being able to choose how that might affect your career path in terms of what you are thinking of specialising in and what experience you feel you need.”*
>
> **Male, Trainee, Non-UK PMQ, Neutral on autonomy**

Related to the themes presented in ‘characteristics of a supportive working environment’ (Chapter 3) and ‘making clinical decisions’ (Chapter 5), some trainees commented that the extent to which they were able to practise the specific skills they wanted to was dependent on the **availability and characteristics of their consultant**.

Consultants not being available to provide feedback, or not being open to allowing those in training to practise certain skills, reduced the amount of control trainees had over their skill development. Personality was considered a factor here, with **more risk averse senior doctors less likely to give trainees new development experiences**. One trainee described how being easily able to raise queries and challenges with consultants would greatly help their development and could reduce the resource burden on others.

However, this culture would be dependent on consultants having more time available to spend with trainees.

Ultimately, doctors felt having more control over career and skills development would mean they could focus on areas which either they lacked experience and confidence in, or areas they felt more passionate about. In turn, this would improve their confidence acting autonomously when providing care, mean they would be better at providing this care, and feel a greater sense of job satisfaction.

Control over when, how and where they work

In the qualitative interviews, views on how much autonomy doctors had in terms of when, how and where they worked was relatively nuanced compared to other aspects of autonomy.

The barometer survey highlighted control over working patterns and rotas was a key factor in whether doctors felt they had enough autonomy: having control over their own timetable and working pattern was one of the top five most common reasons for doctors agreeing they had enough autonomy (7% gave this reasons in an open-text response), and, conversely, having no control of their rota or job plan was one of the top five most common reasons for disagreeing (mentioned by 10%).

In these qualitative interviews, experiences varied dependent on the type of doctor and level of experience:

- **Senior doctors and those with managerial responsibilities** tended to feel they had relatively good control over their working pattern and how they worked.
- Doctors who had shifted to working **part-time, locum** or had **returned to work after retirement** felt they had more autonomy in how they worked, compared to colleagues and compared to how they had worked previously.
- **GPs tended to have greater autonomy** in this regard, but size of practice was a factor, with those in smaller practices feeling they had more control over their working hours.
- **Doctors in training felt more restricted** due to the system being set up to specify where and when trainees should work.

> *"[the training experience was] infantilising - where to be, what to do. The system is being used as an excuse to not make reasonable adjustments [in regard to where placements take place]."*
>
> **Female, Trainee, UK PMQ, Agreed they have enough autonomy**

Contracts were seen in some cases to limit autonomy in ways of working, and make doctors feel trapped in terms of when, where and how much they worked. For example, one SAS doctor explained how their contract was with a specific site but referenced the possibility of cross-site transfers. They have found that, increasingly so, they are being moved around to *"different sites, on different days or multiple times"* causing frustration and limiting their sense of autonomy.

GPs shared frustrations in regard to having little influence of autonomy over **how many patients** they are expected to see in a day and the **time allocated for each patient** - usually 10 minutes - which some found quite pressurising. Some attributed this to GMS contracts making it difficult to cap the number of patients they see within a session. They felt having more control over their workload and greater flexibility in the length of appointments would support better outcomes for patients.

"It's a supportive environment, but there's no getting away from the fact that at the end of the day it feels all the time that there's not enough time, that there's not enough resources, that the demand outweighs what we can do, what we can offer."

Female, GP, UK PMQ, Neutral on autonomy

For some doctors, **work plans and structures were considered restrictive** (i.e., having to fulfil duties or certain roles on set days). Doctors felt that the plans in place, which dictated when they did clinical work around other duties and meetings, were not realistic in terms of fitting all required work in.

"[You have] time allocated to do certain things at certain times. [Meetings] can be problematic if others' schedules don't match…Making up for the tasks you have to finish…it's a constant problem."

Male, Specialist, Non-UK PMQ, Disagreed they had enough autonomy

Another common theme when discussing autonomy in ways of working was **working from home**. Some doctors expressed a desire for more flexibility to work from home but recognised that meeting service needs was the priority. Even where remote working was not possible or approved, doctors were appreciative if requests had been listened to and discussions took place. Those who had been given more freedom to work from home outlined the benefits in terms of being able to be more flexible with their time, and were sometimes happier to work evenings and weekends as a result.

Work cultures which allow staff to take ownership over their working pattern and approaches, and had policies in place to allow this, were appreciated.

"Flexible working, I push out as policy and a huge emphasis across the organisation. I encourage those I line manage, who line manage themselves, to do their upmost to provide an autonomous working

environment to allow people to have control over their hours, location, and place of work – hybrid and flexible working wherever that can work … it is received very well."

Female, GP, UK PMQ, Agreed they have enough autonomy

I have to work weekends and nights, but this comes with flexibility when I want to take days off. I feel very much in control."

Male, LE doctor, Non-UK PMQ, Agreed they have enough autonomy

Influencing change in the workplace

Barometer survey findings showed that doctors who felt they have influence within the workplace were in the minority: less than half (47%) of doctors agreed they were involved in decisions that affect their work and just over a third (38%) felt they can influence change in their workplace.

In these qualitative interviews, the extent to which doctors felt able influence change in the workplace was predominantly rooted in seniority and, to a lesser extent, setting.

Those in **more senior positions** (for example, GP partners and those with managerial responsibilities) **felt more able to influence change** in their workplaces. This echoed findings from the barometer survey, where having a senior role, or being a partner in a practice, was the second most common reason given by doctors agreeing they had enough autonomy in their role (15%).

For those in more senior roles, frustrations with their ability to influence change tended to come from **systemic barriers**. For example, some referred to '**macro politics**' and '**top-down structures**', where external forces (such as politicians, government, and Health Boards and Committees) impose systems and targets without consultation with the staff who will be delivering against them.

"Frontline people need have a real input into their workspace that is not dictated to by executives or even the Department of Health, or even the GMC."

Female, Specialist, Non-UK PMQ, Disagreed they have enough autonomy

More senior doctors also expressed that they wanted to be able to **influence wider service planning and delivery**.

There were a few instances where doctors held **an influential role / responsibility outside of their immediate care setting**, which allowed them to input at a more strategic level for planning and commissioning in their local area. For example, one of the doctors interviewed was a clinical lead for their Integrated Care Board (ICB) and explained

how they could use their knowledge from delivering 'on-the-ground' to challenge NHS England where necessary (usually where they felt something that worked elsewhere would not work in their locality).

Doctors recognised that 'top-down' decisions were borne out of other pressures within the system (for example, funding challenges, high workloads). However, they did not feel these decisions address the root issue and were not perceived as the best solution. Instead, doctors felt these decisions created greater pressure on the workforce, and friction between frontline staff and 'decision-makers'.

Some doctors did not feel a need to influence change in the workplace, as they felt it was outside of their grade or remit. Others - usually those frustrated with management of their workplace - described **internal barriers** when trying to elicit change.

One common frustration shared was among those who had experienced **resistance from 'long-standing' or 'strong characters'** when trying to voice something which could potentially result in a positive change. Often, this meant these ideas were blocked.

These findings align with the top two reasons doctors disagreed that they had enough autonomy in barometer survey: poor management / poor decisions made by management, and not having a voice in the workplace / concerns or that ideas are dismissed (both cited spontaneously by 11% of doctors who disagreed they have enough autonomy).

One doctor commented that, while strategic decisions will always be relatively difficult to influence (due to their top-down nature), doctors can have greater control over work cultures and how autonomous others feel to influence change within a team or immediate setting.

Indeed, doctors who described working in more **supportive work cultures** were more likely to feel that staff at all levels were given an opportunity to input into decisions that would affect their work, showing that autonomy in this regard can be nurtured.

Some doctors highlighted the **importance of giving junior staff a platform to influence change** in this way. They felt this was crucial in succession planning (i.e. identifying and developing future leaders, and securing the future workforce) from two perspectives:

1. It gave junior staff a greater sense of autonomy and control within the workplace, which, in turn, meant they were more fulfilled, less frustrated, and less likely to leave the profession; and,

2. It developed leadership and decision-making skills in the new generations of doctors coming through.

What should autonomy look like?

Doctors were asked what autonomy *should* look like in their role. Although responses varied, depending on the level and specific experiences of each doctor, all were able to talk about factors which were conducive to working with the right level of autonomy.

In general, doctors agreed that having **freedom and trust** to act autonomously was crucial, but first there needs to be **appropriate support to develop skills and confidence** to work autonomously.

Doctors felt a key part of working autonomously is **knowing when to ask for support** and having this **support readily available**. Doctors acknowledged the importance of knowing your own limitations to avoid risk and maintain patient safety.

Regardless of level, being in an environment which placed emphasis on **continued development** (for example, nurturing skills, allowing for professional development, opportunities to take on leadership roles) ensured doctors were able to constantly improve and work with the right level of autonomy. For trainees, this meant being encouraged and able to make clinical decisions independently and confidently.

Where a working environment had these qualities, there tended to be **strong leadership**, where senior staff led by example and in the best interests of the team. Characteristics of strong leadership included:

- Empowering others to make decisions;
- Not micro-managing;
- Being prepared to make difficult decisions to ease the workload of the team;
- Keeping morale up - not allowing their own stress to affect the team spirit; and,
- Creating an environment where staff felt able to raise concerns and feedback on what is and is not working, without fear of working relationships being damaged.

Factors which limited autonomy, or created environments where doctors were fearful of acting autonomously were also highlighted.

Most commonly, this related to a **fear of litigation**. Doctors explained how they did not feel cared for at system level and, as a result, tended to practise defensively and 'to the book'. They felt this was sometimes at odds with what was actually the best course of action for a patient.

> *"We practice defensively. Working that way means we have to follow the guidelines, because if anything should happen, you followed the guidelines so you're covered. If we remove the fear of litigation, it gives you the chance to actually use your brain. There is a lot of wasted knowledge that then doesn't benefit the patient... What this means is I'm not giving my whole self to the patient."*
>
> **Female, GP, Non-UK PMQ, Neutral on autonomy**

One doctor gave an example where they had gone against protocol when ordering blood tests, and although it ended up in the best interest of the patient, the reaction from colleagues deterred them from doing it again:

> *"Protocol was to check if temperature was over 38.5 then do blood tests. My patient was at 38.2…I ordered the blood culture...in the morning they were like 'why did you do the blood culture, the patient hasn't reached the threshold...' In the end I was justified because the patient was more sick; by that point everyone else became happy I did the blood culture. The impact of [their reaction to me ordering the blood culture] that is that in future, if a patient was at 38.2, I would just stick to the protocol I wouldn't do the blood culture...*
>
> **Male, LE doctor, Non-UK PMQ, Disagreed that they had enough autonomy**

Adding to the systemic context for limited autonomy, the **NHS system was described as "pressured and overstretched"**, creating an environment where doctors were constantly under pressure and living in fear of anything going wrong due to fear of litigation. One doctor felt that, in order to maintain patient safety, the GMC needed to consider care for doctors and working conditions too; they viewed the GMC and fear of complaints and litigation as a deterrent to acting autonomously in clinical decision-making.

> *"Quite frankly the purpose of the GMC should not just be to protect patients…It should also be to uphold the standards of care for doctors and working conditions... in order to protect patients that's what you need to do."*
>
> **Female, Specialist, Non-UK PMQ, Disagreed they have enough autonomy**

Supporting others to work autonomously

As highlighted throughout this report, doctors - particularly those working at lower grades - frequently identified working in a supportive environment as a key contributor to working autonomously. To explore this from a different angle, we asked doctors how they support others to work autonomously.

Many doctors felt that creating a supportive working environment was a key factor. This included providing a **safe space to encourage open communication** and share experiences, and for those supervising to be as **approachable** as possible. This fostered an environment where junior staff felt comfortable to raise any issues that they might be facing and resolve them collaboratively.

> *"Communication is key, being receptive and open, being supportive to colleagues, supporting each other through times of stress."*
>
> **Male, GP, UK PMQ, Disagreed that they have enough autonomy**

Within this supportive working environment, **developing confidence in junior doctors** was thought to be important in allowing autonomous working. More specifically around clinical decision-making, senior doctors emphasised the importance of allowing junior staff to share what they would plan on doing first, prior to any input from other staff, and then encourage them to review this by discussing alternate courses of action. This helped build their knowledge and confidence to push them towards working *more* autonomously.

> *"Obviously those who are more junior to yourself, that's from education and also progressively allowing them to take on more responsibility and encouraging them to get more involved with decision-making."*
>
> **Male, LE doctor, UK PMQ, Neutral on autonomy**

Doctors with supervising responsibilities highlighted the importance of **creating opportunities for junior doctors** to work autonomously and practise skills.

Sometimes a barrier to this was the patients themselves, who often want the most experienced doctor to complete their procedure.

To avoid this, doctors highlighted the importance of **how junior doctors were introduced**. If the introduction was framed in a reassuring and enthusiastic way (for example, saying, 'they're my best'), patients felt at ease with the junior doctor's competence, and comfortable with them doing the procedure. Furthermore, this praise increased the junior doctor's confidence.

When encouraging junior staff to be confident in their clinical decision-making and in undertaking procedures, doctors commented that their own **fear of litigation** could act as a barrier. They acknowledged that when supporting junior staff in making clinical decisions, senior doctors didn't always have the full picture of patients' health and were sometimes worried that they could miss something important and advise an incorrect course of action. If this happened, supervising clinicians felt that the blame and potential litigation would fall on them.

> *"Eventually you know if something goes wrong, the buck stops with you. If you've made a clinical judgment but you don't necessarily have all the facts in front of you."*
>
> **Female, GP, UK PMQ, Neutral on autonomy**

Doctors felt it was important to be **aware of the learning and development aspirations of those they supervised**. To support this, time needed to be carved out for conversations specifically focussed on learning and development. This enables doctors to proactively support junior staff to achieve these goals (for instance, through

encouraging them to undertake courses or training if they show interest). As a result, junior doctors would feel more autonomous and control of their own career development.

"In terms of the junior doctors I supervise, I make a point of trying to get to know them - what they want to get out of the department...how much supervision they want or not."

Female, Specialist, UK PMQ, Disagreed they have enough autonomy

Some doctors felt it was important to **bring more junior staff into strategic discussions** around protocols, budgets, management of shift patterns, and designing services. They felt that this contributes to a sense of control and job satisfaction. They also felt this could help broaden awareness of how services work operationally, allowing them to get more involved in workplace strategy or look into areas for improvement.

"In discussions and in teaching in general, you know sort of on a one-to-one basis, you can definitely influence, and then being aware of the different projects that are available or the different areas which could be improved in the hospital means that you can then be involved in things that could hopefully make a change."

Male, LE doctor, UK PMQ, Disagreed they have enough autonomy

Supporting more junior staff in these ways had the added benefit of these staff not having to rely on them as much in the long-term, freeing up time and headspace for some of their own tasks and workload.

In line with trainees and junior doctor views, more senior doctors felt a main barrier to being able to provide this level of coaching was **their time and capacity** to do so. One doctor explained how, in the context of high workloads and staffing constraints, poor coverage from supervisors sometimes created delays in care:

"Sometimes if it becomes unsafe, I just say you have to stop until I finish and then I can come across... but you know staffing levels of consultants, there are not enough of us."

Female, Specialist, Non-UK PMQ, Disagreed they have enough autonomy

6 How does autonomy relate to other aspects of doctor's work and patient care?

Being able to work autonomously could impact other aspects of a doctor's work and the care they are able to provide. This chapter explores the relationship between autonomy and other factors, such as patient outcomes, wellbeing and job satisfaction, and working relationships. It is important to note that a lot of these relationships feed into each other in a cyclical way.

Patient safety and outcomes

Doctors felt that having autonomy in clinical decision-making typically meant that the best patient outcomes could be achieved.

Being able to confidently decide on the course of action for a patient, without undue restrictions on what could be offered, and without bureaucracy acting as a barrier, meant that the patient could be offered treatment with their best interests in mind. Nevertheless, it was acknowledged that a balance is required here to avoid negative patient outcomes from incorrect decisions being made.

Furthermore, having the ability to discuss alternative treatment plans with the patient, where relevant, and consider their preferences was valuable in developing relationships with patients and ensuring that they felt involved in their treatment.

> *"If a clinician is able to speak to a patient about a specific problem and be flexible if they're resistant… It could be through discussion you can work on an outcome together."*
>
> **Female, GP, UK PMQ, Agreed they have enough autonomy**

As previously outlined, doctors understood that sometimes autonomy meant knowing when to collaborate and seek input from others. Doctors felt that this was a crucial part of ensuring patient safety.

> *"You should not have the final say – this is what should be done for the patient. It is important to get other people involved and let everyone come to a decision. It is a human life we are talking about."*
>
> **Female, Trainee, Non-UK PMQ, Agreed they have enough autonomy**

A potential threat to patient safety, expressed by one doctor, was doctors feeling **a sense of apathy due to having to deal with high workloads and a 'failing' system**, where doctors no longer felt motivated to try to change things for the better or go the extra mile for patients or colleagues. This means patient outcomes may be being affected by the current context doctors are working in.

"It comes down to apathy in healthcare. When you've been working in a system that's been failing for so long and you've seen so many adverse events, and you've seen many, many people try before, I feel like the only way you can carry on and go to work is to become apathetic. And that's where it's dangerous [for patient safety]."

Female, Trainee, UK PMQ, Agreed they have enough autonomy

Other risks to patient safety, already discussed in this report, include:

- **Budgetary restrictions** restricting resources and treatment options.

"You can feel sometimes that your autonomy is stunted in the clinical world because you can want to do something, but the resources aren't there."

Male, GP, UK PMQ, Agreed they have enough autonomy

- The **amount of time doctors can spend with each patient**.

Doctors felt that if they had more autonomy over their workload and the patients that they saw, these effects could be mitigated. For instance, if doctors could see patients they already have a relationship with, rather than being allocated patients according to availability, this would provide better continuity of care, which is an enabler of patient safety and outcomes as well as a driver of job satisfaction for doctors (see more under 'Job satisfaction' below).

Wellbeing

Most of the connections doctors made between autonomy and wellbeing highlighted that autonomy needs to be well-balanced with other factors and the importance of having *appropriate levels* of autonomy in this regard. Having the right level of autonomy was important for morale and to reduce feelings of isolation.

More specifically, autonomy in terms of **flexibility in working patterns** (e.g control over when and where you work) was highlighted as crucial for maintaining mental health and preventing burnout. One doctor explained how this was the case for them:

"I have learnt over the years to be very careful about my selfcare … five years ago I had a period where I was off sick for three months with a mental health episode, which essentially was burn out … I have a high degree of autonomy over my working life so I work a compressed week with four long days … if I can protect my long weekend, then generally I have enough motivation and capacity to manage the weeks."

Female, GP, UK PMQ, Agreed they have enough autonomy

Knowing when to ask for help was important in preventing feelings of isolation and ensuring doctors accessed support when they needed it. Having the **time, and a conducive workplace environment, for doctors to interact with other doctors** was important in reducing feelings of isolation and creating opportunities to access support.

Having autonomy in decision making in the absence of the necessary support and input from others was seen as a threat to wellbeing. This was because doctors may feel more isolated in these circumstances, and lack the support necessary for more challenging situations, especially for junior doctors.

It was thought that having **dedicated time for psychological support** could be helpful here.

> *"Specialties need to be a little bit more like psychiatry and have dedicated time for psychological support of especially the trainees who are new to the system, as everybody goes home and internalises these things."*
>
> **Female, Specialist, Non-UK PMQ, Disagreed they have enough autonomy**

Another aspect of autonomy which related to wellbeing was the **extent senior staff micro-managed**. Micro-management obstructed the care doctors could provide which lowered staff morale as they didn't feel trusted or valued.

Teamwork and relationships with colleagues

Throughout, we have referenced how individual autonomy flourishes within supportive teams, which have an emphasis on collaboration and camaraderie. It is also the case that teamwork in clinical decision-making can contribute to positive patient outcomes.

However, for this to work well, there needs to be a **mutual understanding of expectations regarding autonomy and responsibilities,** which can be enabled by staff having an awareness of each other's competency and capabilities.

Some doctors explained how **tensions can arise when there is a perception that autonomy is not evenly distributed** within teams. For instance, some stronger personalities may naturally be more confident in eliciting more autonomy for themselves, while others are less so. One LE doctor working in surgery explained how they felt that doctors in training are often prioritised for time in theatre over them but that they still need to keep up their skills so as to be an effective team member (which could ultimately reduce pressure on more senior staff).

Short placements during foundation training were identified as a barrier to junior doctors being able to develop meaningful relationships with their team. It was highlighted that the quick turnaround times can mean trainees are less invested in ensuring they carry out their role effectively. This could also affect how well trainees are able to develop their skills, affecting job satisfaction and patient safety.

"The very short placements and turnaround of trainees makes things really difficult because people don't get to know each other well... to what extent, if it's not going to be your problem later, do you want to action anything?"

Male, Specialist, Non-UK PMQ, Disagreed they have enough autonomy

Job satisfaction

Having the right level of autonomy was seen as vital for job satisfaction.

Doctors explained how being able to work autonomously gave them a positive perspective on their impact and sense of making a difference. For instance, **involvement in decision-making for patients and increased responsibility,** such as safeguarding and participation in the management board, **meant that they felt trusted and valued** by their organisation which improved their job satisfaction.

"Definitely. Having a degree of autonomy makes me feel I'm making a difference, not just doing something a robot could do. It helps me learn as well."

Male, Trainee, UK PMQ, Neutral on autonomy

Another factor that could lead to increased job satisfaction for doctors was having **more control over the patients they see.** This could allow more instances of continuity of care (i.e. patients seeing the same doctor each time), allow relationships to develop and, as a result, be more fulfilling.

"Some of the satisfaction that I gained from my job when I when I was a GP partner, was having a long-term relationship with patients."

Female, GP, UK PMQ, Neutral on autonomy

In relation to career progression, having little autonomy over learning and development was linked to reduced job satisfaction.

This could be counteracted through **career pathway systems** that doctors can use to help guide them in their decision-making around choice of specialism.

Where autonomy was threatened, doctors sometimes felt job satisfaction was threatened too. For example, in the case of restrictions created by **protocols and guidelines** (as explored in 'making clinical decisions', Chapter 5):

"I think if you feel forced to make a decision that's not right for them because you have to follow a protocol or guideline. It's not going to be

good for your job satisfaction because at the end of the day, we're in this job because you want to do the right thing for the patient and to make their lives better."

Female, GP, UK PMQ, Neutral on autonomy

However, another doctor highlighted that working to set guidelines ensures everyone is focussed on a common goal and, in turn, this allows more effective working within a team.

"If everyone's working autonomously but not together, then it can be a problem because it leads to disjointed care. But if you're all working in the one practice towards the same goal, following same guidelines, practise standards but doing so autonomously, then you know I think that's ideal."

Male, GP, UK PMQ, Agreed that they have enough autonomy

A lack of autonomy could be a contributing factor to the migration of young doctors to other countries, which has implications for the future of the NHS.

"Many of my younger colleagues have moved already...money is spent to train them, and they are moving."

Male, GP, Non-UK PMQ, Neutral on autonomy

7 Conclusions

A consistent theme throughout this research has been the positive impact working in a supportive environment can have on a doctor's sense of autonomy (and, conversely, how unsupportive environments often restrict autonomy). Central to this, is the role senior staff have in supporting colleagues. Focusing on these staff members and expectations for them in their supervisory roles could have a positive impact on autonomy. For example, equipping senior doctors with coaching skills which would nurture confidence in clinical decisions (and resulting autonomy) in those they supervise, encouraging them to have conversations about career direction and aspirations, and putting systems in place (for example, regular meetings) for these kinds of discussions to happen.

Doctors understood that some of the current barriers to senior staff offering a good level of support were rooted in wider, systemic issues; low staffing levels and high workloads often meant consultants and other senior staff were 'too busy' to provide a good level of support. However, some doctors felt a shift in workplace *culture* could be more readily addressed. Having systems – both informal (for example, coffee breaks) and formal (for example, monthly meetings) – to create a collaborative working environment would mean doctors are engaging with and supported by other peers too. Another frustration some doctors had in regard to autonomy was not being able to influence change in the workplace. These systems could also act as pathways for voices at all levels to be heard and considered in managerial decisions.

For the doctors interviewed within this research, the most important aspect of autonomy in their role was the ability to use their experience, knowledge and training to make clinical decisions. Although the doctors we interviewed generally felt they had the right level of autonomy in this regard, some frustration came from the perception that 'algorithms and protocols' were restricting these decisions and did not always support the best possible treatment and resulting outcomes for patients. Engaging with doctors on how these systems have been created, their benefits and purpose, and how to work with them for the most effective care, could go some way to alleviating these frustrations.

Doctors also felt having autonomy in regard to the direction of their skill and professional development was important. Current barriers to this aspect of autonomy could be addressed by ensuring that doctors are aware of the development opportunities available to them, creating a culture of continuous learning, and ensuring senior staff understand and support the development goals of colleagues.

It's important to acknowledge that this research *required* doctors to think about their work and experiences 'through the lens' of autonomy. However, their accounts draw genuine connections between autonomy and doctors' wellbeing, working relationships and job satisfaction. These are aspects which we know (from the barometer survey) are currently at relatively low levels, contributing to the risk of doctors leaving the UK medical profession. What's more, doctors have reflected on how having the right level of autonomy contributes to delivering the best care to patients and achieving optimal patient outcomes. As such,

facilitating doctors to work autonomously is likely to have benefits for both doctors and the patients they care for.

“

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