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The Post-Foundation Training Break ("F3"): Evaluating its Impact on Postgraduate Medical Training

A report of independent research funded by the General Medical Council (GMC) and Association for the Study of Medical Education (ASME)

Dr Helen Church
Clinical Assistant Professor of Medical Education

Dr Steven Agius
Associate Professor of Medical Education

Liam Jenkins
Research Assistant in Medical Education

University of Nottingham

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Executive Summary

Background

In the UK, since 2017 more than half of the doctors who complete their Foundation Training Programme (FP) do not enter immediately into a Core/Specialty Training Programme (C/STP) following completion of their Foundation Training (FP). This 'Post-Foundation Training Break' (PFTB), often unofficially referred to as the 'Foundation 3 (F3) Year', has become the most popular training break for UK doctors, yet, despite the impact on current and future workforce, there is little evidence to aid our understanding of this trend.

Research Questions

Based on our previous scoping review,[1] we aimed to address three research questions:

1. How does taking a PFTB affect subsequent career progression?
2. What are Medical Educators' perceptions of doctors undertaking a PFTB?
3. Is the increasing number of doctors undertaking a PFTB affecting subsequent training post applications?

Methods

This mixed-methods study was organised into three workstreams (WS):

- WS1: A national survey of doctors who had undertaken, or were currently undertaking, their PFTB
- WS2: Semi-structured interviews of FP Directors/Heads of Foundation Schools.
- WS3: Semi-structured interviews of C/STP recruiters.

The survey was analysed mainly using quantitative statistical methods, with thematic coding for qualitative responses. The UKMED database [2] was utilised to add further data and context to our findings. Semi-structured interviews were transcribed and thematically analysed.

Key Findings

The survey was completed by 4,046 participants. Workstreams 2 and 3 included 16 and 21 interviews, respectively.

Research Question 1: How does taking a PFTB affect subsequent career progression?

- Career exploration was the fourth strongest motivator for taking a PFTB, behind 'personal fulfilment', 'taking a break from training' and 'improving health and wellbeing'.
- Career exploration was deemed necessary due to inadequate exposure to many of the different specialties during undergraduate and postgraduate training and the time-constraints of the C/STP applications which launch within the first few months of the

second FP year. Both doctors and medical educators regarded this as 'too soon' to commit to a specialty in the long-term.

- Of the 72% of doctors who agreed that the PFTB had influenced their career progression, 70% stated that it had confirmed their career choice (and almost 25% were deterred from certain specialties). In addition, approximately 60% reported that they had been able to enhance their CV for future C/STP application and over 60% improved their clinical competency.
- The majority of doctors reported positive effects of their PFTB on career progression, particularly pertaining to improved Professional Skills within the GMC Outcomes for Graduates [3] standards.
- Almost 90% of survey respondents *chose* to take a PFTB rather than apply for/enter a C/STP which clarifies that, for the majority, the PFTB is a *choice* and not a default position in the event of unsuccessful C/STP application.
- Of those continuing to work clinically post-PFTB, the majority have returned to the traditional training pathway despite their positive experiences outside of training.
- Only 10% of respondents subsequently began one C/STP post and then changed to a different specialty, which may indicate that the PFTB contributes to more long-term career certainty, given that a recent poll revealed that one-fifth of physicians have changed their specialty at least once. [4]
- One-quarter of respondents who were enrolled in a C/STP at the time of completing the survey work less than full time (LTFT) post-PFTB. This statistic exceeds the national average of 15% of trainees who work LTFT.[5]
- 95% of doctors who completed our survey would recommend the PFTB to their peers and colleagues.

Research Question 2: What are Medical Educators' perceptions of doctors undertaking a PFTB?

- Our research uncovered two potential challenges pertaining to this research question: (i) *how* educators can discuss the PFTB when the possibilities and range of activities that can be undertaken is so vast, and (ii) *whether* the PFTB should be discussed when there is concern about underfilled C/STP posts.
- Educators demonstrated a thorough understanding of both the PFTB movement and its trend over the past few years but, given the range of different clinical and non-clinical activities that can be undertaken during a PFTB, educators highlighted the challenge of providing advice when local and/or national guidance is lacking. They often discussed the PFTB option in more informal, opportunistic settings than in the formal context of mandatory FP careers sessions.
- 'Clinical Fellow Posts' during the PFTB were strongly favoured over locum posts due to their enhanced provision of supervision, guidance and revalidation arrangements.
- Educators acknowledged the benefit of PFTB doctors within their trusts, including both workforce stability through clinical service provision and added-value activities,

such as contributing to teaching. These value-added elements of PFTB posts mirrored the perspectives of the survey respondents, over 75% of whom felt that their leadership skills had been enhanced during their PFTB.

- Undertaking a PFTB in General Practice is particularly difficult given that Clinical Fellow and Locum-type posts do not exist in primary care in the same way as for secondary care-based specialties. As such, very few survey respondents worked within General Practice during their PFTB and this raises issues about how doctors might explore this career pathway prior to applying for a C/STP. Subsequently, our data demonstrated that doctors who had entered into General Practice training were less likely to have completed a PFTB (43% vs 57%).
- Educators drew comparisons between the PFTB and the re-creation of their own 'Senior House Officer' roles during the pre-Modernising Medical Careers (MMC) era in which they were able to enjoy the flexibility to explore different specialties on short-term contracts before committing to their long-term specialty. Similar messages about the PFTB as a more enjoyable working context (compared to training) were clear from the survey respondents, almost 70% of whom reported that the PFTB made a positive contribution to the way they viewed their work and over 50% considered it to have prevented burn out.
- Both educators and recruiters acknowledged that PFTB-focussed career advice usually came from peers, rather than supervisors. This correlated with the majority of survey respondents who decided to undertake their PFTB during their FTP and who failed to recall receiving advice about this career decision.
- FPDs justified not addressing the PFTB formally because the FP trainees received so much advice and information from their peers (especially those undertaking PFTBs). In agreement with this, just over half of survey participants felt that they had adequate information to make their decision about undertaking a PFTB from other sources.
- FPDs and recruiters alike shared the perception of 'generational' differences in which there is a trend for younger doctors to preference motivators connected with health and wellbeing, which our survey data supported. Furthermore, the NTS burnout scores demonstrated that educators were correct in their assertions that some doctors are motivated to take a PFTB due to 'burnout', with scores at the end of each FP year being higher in those going on to take a PFTB.
- Educators were acutely aware of the discontent amongst trainees who were unable to attend events in their personal lives due to rota organisational difficulties. Some educators considered this to be a manifestation of doctors not feeling valued in their role, compounded by a lack of belonging and collegiality which followed the departure from the traditional 'team' or 'firm' model.

Research Question 3: Is the increasing number of doctors undertaking a PFTB year affecting subsequent training post applications?

- A conflicting message exists about the relationship between competition at C/STP application and the PFTB: Doctors undertaking a PFTB can accumulate an impressive array of clinical experience, non-clinical activities, and qualifications. Whether this was a primary motivation for the PFTB or not, almost 60% of survey respondents stated that their PFTB influenced their career progression by enhancing their CV for subsequent job applications.
- Given the wide variations in recruitment systems for different C/STPs, the advantages afforded by the PFTB differ by speciality. Recruiters identified both direct and indirect advantages that PFTB doctors may have over their F2 counterparts:
    - Criteria within the Person Specification guidance may more easily be achieved or evidenced by PFTB doctors due to increased time and opportunity to undertake extra academic activities and/or qualifications.
    - PFTB doctors are more able to demonstrate specialty-specific insights and commitment to the speciality.
    - PFTB doctors were noted to generally demonstrate increased 'maturity' and breadth of clinical and non-clinical experience. This may in part be explained by the improvement in communication and interpersonal skills that over 75% of survey respondents felt was afforded them by their PFTB experience.
- The majority of recruiters explained that, if they were aware of the candidate having taken a PFTB, this was *not* taken into account – either to award them for taking a training break to demonstrate career commitment, nor to diminish any of their achievements due to them having had more time and/or opportunity to do so than their Foundation trainee counterparts. Some recruiters were more flexible in their interpretation of the interview assessment protocol, considering it more as 'guidance' when assigning scores to achievements completed within an FP or PFTB.
- Recruiters emphasised that whilst a PFTB is not mandatory to secure a C/STP post, they acknowledged why many doctors may perceive this to be the case.
- Educators and recruiters did not identify any specific demographics associated with those taking a PFTB. However, our data reinforce the findings from previous research from Cleland et al., [6] that those who are more likely to undertake a PFTB are:
    - male
    - privately educated
    - school-leavers on entering medical school
    - parents are educated to degree level.
- Our data also show that black doctors are more likely to undertake a PFTB than white doctors (OR=1.111, 95% CI=0.965-1.278) although this was not statistically significant. However, on recoding this variable into 'white' and 'non-white' to replicate the analysis undertaken by Cleland et al., [6] our results agreed with their findings that

overall non-white doctors were 32% less likely to undertake a PFTB than their white counterparts (OR=0.677, 95% CI=0.645-0.712, P<0.001).

- Geographical predictors of PFTB include those born in Scotland (less likely to undertake a PFTB than those born in England) and those completing their FP in Northern Ireland or Wales (more likely than those in England).
- Many recruiters recognised an increasing number of post-PFTB applicants. Statistically, specialties more heavily populated by doctors who have taken a PFTB than those who entered C/STP immediately post-FP include:
    - Anaesthetics
    - Acute Care Common Stem (ACCS)
    - Emergency Medicine
    - Public Health
    - Sexual and Reproductive Medicine

Implications for Practice

Overall, our research found the PFTB to be perceived as a positive career choice by medical educators, recruiters to C/STPs and the doctors undertaking the PFTB. The main future challenges highlighted by this report refer to the potential need for more support for doctors planning their PFTB, transparency around the perception that a PFTB is *necessary* to compete for the most popular C/STPs and the concern that certain specialties who inadvertently recruit heavily from either the PFTB or non-PFTB cohort are at risk of perpetuating a narrowing demographic profile into their specialty, which may not represent their patient population.

We would encourage all organisations and individuals involved in the education and training of our future medical workforce to consider how they might better support the PFTB for those who choose this career journey.

Contents

List of Abbreviations

C/STP – Core/Specialty Training Programme

CV – Curriculum Vitae

FP – Foundation Training Programme

FPD – Foundation Training Programme Director

LTFT – Less Than Full Time

MMC – Modernising Medical Careers

PFTB – Post-Foundation Training Break

Main report

1 Background

An increasing number of doctors both in the UK and internationally are taking a break along their training pathway. In the UK, the most popular point at which this occurs is after completion of the Foundation Training Programme (FP) (two years post-graduation) and before commencing a Core/Specialty Training Programme (C/STP) [7]; this Post-Foundation Training Break (PFTB) is often unofficially referred to as the 'Foundation 3 (F3) Year'. The popularity of the PFTB has been steadily increasing over the past 10 years to become the most popular post-graduate training break in the UK [7]. Since 2017, over 50% of doctors in each year group undertake a PFTB [8], thereby making this the 'new normal'. Despite the effect on the current and future workforce and healthcare economy, there is little evidence to aid our understanding of the drivers for, and impact of, this trend.

The PFTB has previously impacted the fill-rates for C/STP posts [7], which subsequently affects healthcare provision through rota-gaps. Longer-term, training breaks affect doctors' progression through higher training, thereby delaying doctors' completion of training. These issues have financial implications both locally, for Hospital Trusts who need to ensure patient safety through minimum staffing levels, and nationally, pertaining to how much of the country's healthcare budget can be justified to staff underfilled training posts. The long-term career pathways of doctors who complete a PFTB is also not known; and given that a major motivation for the career choice is 'career specialism uncertainty',[9, 10] whether this is resolved by the end of the PFTB is yet to be explored.[11]

Prior to undertaking this study, we conducted a scoping review [1] to map out the current literature on the PFTB phenomenon. Our review found that the most common perspective of PFTB presented was that of doctors who were *considering* an F3 year, rather than those who are either undertaking or have completed their PFTB. Also, there was very little representation of key careers influencers (clinical supervisors, foundation training coordinators, etc.) pertaining to how this career pathway is approached with trainees. This limits our understanding of how doctors make informed career decisions and supports the assertion from numerous articles that there is little support for doctors considering non-training career options [9, 12].

Given the ever-increasing popularity of the PFTB, our review alluded to the potential that the PFTB was driving up competition at C/STP applications, therefore establishing the perception that the PFTB might be 'necessary' to secure a training post. One paper also highlighted the association between white, male doctors from high socio-economic backgrounds [6] and an increased likelihood to complete a PFTB; If true, there are wider-reaching implications on

equality, diversity and inclusion (EDI) aspects of medical recruitment both in the UK and other countries with similar training-break trends.

Following our scoping review, Health Education England (HEE) published their mixed methods study on the PFTB,[13] which included F2 doctors who were considering taking a PFTB, currently taking a PFTB and who had completed their PFTB. The study highlighted key motivators for doctors taking a PFTB and recommended considering the PFTB the 'new norm' and reflected this by recommending the discontinuation of the term 'F3'. They called for more planning and surveillance of the trends, including monitoring of key potential impacts of the PFTB year, such as retention in clinical practice, and approaching recruiters and educators to understand what is offered and how it is provided to trainees considering a PFTB.

Our study aims to build upon previous literature in the field, and address some of the information gaps of interest identified.

1.1 Research Study: Aim

The aim was to explore the medium- and long-term impacts of the PFTB on aspects of post-graduate training pertaining to career progression; how training programme leads at both regional and local (Trust) levels provide careers advice and the perception of the PFTB from specialty recruiters.

1.2 Research questions

Based on the gaps in the literature identified by our scoping review, [1] the research questions are:

1. **How does taking a PFTB affect subsequent career progression?**

The majority of studies published regarding PTFB included participants who had not yet completed their FP [14, 15], or were currently undertaking a PTFB [11], and therefore explored future career *intentions*, rather than establishing what doctors actually *did* during their time out of training and the subsequent effects on career progression. This question will address this lack of evidence by exploring the journeys of doctors who have taken a PTFB to identify initial motivations for PTFB and whether PTFB impacted subsequent career trajectories.

2. **What are Medical Educators' perceptions of doctors undertaking a PFTB?**

The literature suggests that the PFTB has recreated the 'lost tribe'[a] [16] of the pre-MMC era. Given this possibility, FP Directors might feel a responsibility to encourage trainees immediately into a C/STP following their FP, and therefore are likely to be challenged by their

[a] The 'lost tribe' refers to the cohort of Senior House Officers who, prior to the introduction of the MMC, were perceived to be undecided and reluctant to enter C/STPs. They would move between 6-12 month rotations in different specialties, often over a period of many years, before entering into formal training (or gaining accreditation from their accumulated clinical experience) to complete training in a specific specialty.

responsibility to supporting trainees. This research question aims to explore how these influential educators approach careers advice and to identify initiatives through which FP trainees may receive adequate careers advice to ensure long-term retention of the workforce.

3. **Is the increasing number of doctors undertaking a PFTB affecting subsequent training post applications?**

Doctors' dissatisfaction with the post-graduate training programmes have contributed to the rise in PTFB popularity. The C/STPs are sometimes viewed as binding, inflexible contracts [17], and the FP has been criticised regarding its ability to support career-decision making, [11, 18] the acquisition of sufficient skills, and provide enough opportunities to build a competitive application to secure a doctor's preferred C/STP job [18].

This research question addresses whether the experience gained during a PFTB affords an advantage at C/STP application, including whether processes exist which acknowledge and correct for any 'additional experience bias'. Given the increased likelihood of white, male, doctors from high socio-economic backgrounds [6] undertaking a PFTB, this question has wider-reaching implications on EDI aspects of medical recruitment.

1.3 Outline of Report

This report's Methodology and Results sections are organised into three data-collection workstreams. The Findings section will combine and synthesise the results across the three workstreams to answer each of the research questions in turn before Implications for Practice will offer specific suggestions for the consideration of the stakeholders with responsibility for medical education and training.

2 Methodology

2.1 Recruitment

Workstream 1: Survey of doctors who have undertaken a PFTB

To capture the experiences, motivations and career impact of the PFTB on doctors who had undertaken such a break, an online survey was developed and managed via JISC online software. Through utilisation of data held by the GMC, participants recruited based on the following inclusion criteria:

- registered (licenced or not) doctors (with or without an active licence to practice)
- identified as not having entered a C/STP immediately following their FP within the past 10 years.

Exclusion criteria included:

- doctors with temporary (visiting) registration
- doctors without known email addresses (given the online nature of the survey)
- doctors who had opted out of receiving emails from the GMC
- doctors who were included in the recent GMC tracking survey: The open/closing dates of the tracking survey directly overlapped with the F3 survey. Therefore, trainees in the tracking survey sample were excluded from our survey to reduce survey fatigue.

The survey was advertised through a GMC-disseminated email (Appendix 2) and contained unique identifiers with a digital link to the survey to secure the anonymity of the respondents. Following the initial invitation, two further reminder emails were sent. Participants could voluntarily consent to the researcher accessing the participant's anonymised data held within the UKMED database,[2] and reciprocally have their data inputted into the UKMED database for future research. Participants who completed the survey could opt-in to a raffle to win a £50 Amazon gift card as an incentive for participation.

Workstream 2: Semi-structured interviews of Foundation Training Programme Directors/Heads of Foundation School

Named FP Directors and FP administrators at hospitals across the UK were emailed using freely available information on the UK Foundation Programme webpages.[19] Snowball sampling was also employed to increase recruitment by encouraging enrolled participants to contact colleagues with similar responsibilities. In exchange for participants' time, a book voucher/donation was offered to the hospital education library.

Workstream 3: Semi-structured interviews of Core/Specialty Training Programme Recruiters

Doctors from all four UK nations apply to C/STPs through the same national recruitment system. Therefore, although primarily coordinated by Health Education England (HEE), it was appropriate for the Medical and Dental Recruitment and Selection (MDRS) Programme to disseminate the invitation email to multiple C/STP recruitment leads across the UK. In

addition, the Deaneries with C/STP responsibility and Royal Colleges were also contacted and asked to disseminate the same email. Snowball sampling was also employed.

Table 1 lists the location of the documents relating to each workstream.

Table 1: Index for research documents, found in separate 'Appendices' Document

Document	Workstream 1	Workstream 2	Workstream 3
Invitation	Appendix 1	Appendix 4	Appendix 8
Participant Information Sheet	Appendix 2	Appendix 5	Appendix 9
Consent Form	Appendix 3	Appendix 6	Appendix 10
Questionnaire/Interview Protocol		Appendix 7	Appendix 11

2.2 Data Collection and Analysis

2.2.1 Workstream 1

Participants completed the online survey between 07/06/2022 and 13/07/2022.

Two sets of data were analysed:

1. Survey data – included all participants who completed the survey.
2. UKMED data – included data pertaining to specific variables of interest for this study for all doctors held on the database apart from the survey respondents who declined to consent to use/access their UKMED data (n=564, 14%).

Descriptive and interferential statistics were applied to the quantitative data using Microsoft Excel (V.16) and SPSS software V.28 (IBM). UKMED data was accessed via a Safe Haven. Qualitative data from free-text boxes was either re-coded into quantitative data or sampled and presented as qualitative findings.

An additional metric was used to measure health and wellbeing as a motivator for PFTBs. Since 2018 the GMC National Training Survey (NTS) [20] has asked trainees seven work-related questions taken from the Copenhagen Burnout Inventory. Within the UKMED database, these are collated and averaged within-specialty to calculate a 'z score'. This metric will be used to explore the relationship between burnout during FP and taking a subsequent PFTB.

In 2019 Cleland et al [6] published their findings from the UKMED database about the PFTB. As part of our investigation, we will replicate some of their analyses to investigate whether their findings, particularly those pertaining to demographic and specialty choices associated with undertaking a PFTB, are still reflected in the current database.

2.2.2 Workstreams 2 and 3

Each participant underwent a one-to-one semi-structured interview hosted via Microsoft Teams. During Workstream 3 interviews, the participant was provided with Person Specification documentation relating to their specialty. Participants were asked questions relating to this document, to specifically generate data pertaining to the *Essential* and *Desirable* criteria in relation to PFTB applicants.

Each interview was recorded and auto-transcribed using Microsoft Teams before being proof-read and anonymised by the interviewer. Transcripts were thematically analysed using NVivo software (V.12, QSR) independently by the researchers before being discussed between members of the research group and organised into themes once consensus was reached. HRC led the organisation of themes and wrote the Results chapter pertaining to Workstream 2, whilst SJA performed the same role for Workstream 3. Chapters were then exchanged and edited based on feedback from the other researcher to ensure comprehensiveness and clarity of themes.

2.3 Ethical approval

All Participant Information Sheets and consent forms were designed and agreed upon by the GMC. Ethical approval was granted from the University of Nottingham (FMHS 258-0521). Research governance approval from HEE was granted.

As part of the agreement to access the UKMED database, all data (including any statistical analysis conducted within the database Safe Haven) was reviewed at the point of export and the contents of this report (under the stipulations for dissemination of data originating from the UKMED database) was also reviewed prior to publication.

3 Results

3.1 Workstream 1

4,046 of 34,924 potential respondents completed the survey, resulting in an 11% response rate. As not all questions in the survey were mandatory, non-responses, missing data from the database or those who responded 'prefer not to say', were excluded from the analysis. Therefore tables/figures should be assumed to contain 100% of the responses unless otherwise stated.

3.1.1 Demographics

This section contains the demographic information for survey respondents which can be used to explore which groups of doctors were more likely to take a PFTB. Table 2 shows the demographic variables both for our survey participants and for the cohort identified in the UKMED database, which represents the whole population of doctors who completed or were currently undertaking a PFTB within the last 10 years.

Table 2: Demographics of survey respondents and those identified as having taken a PFTB within the UKMED database

Demographic Variable	**Survey Respondents** (data acquired from Survey and UKMED Database*)		**UKMED*** (doctors identified as those who have taken PFTB)	
Age				
20-29	1395	35%	11130	27%
30-39	2520	62%	28120	69%
40-49	105	3%	1550	4%
50-59	15	0%	150	0%
60-69	0	0%	15	0%
70-79	0	0%	0	0%
Total	*4041*	100%	*40970*	*100%*
Gender				
Female	2425	60%	22615	55%
Male	1605	40%	18350	45%
Total	*4030*	*100%*	*40970*	*100%*
Ethnic Group				
Asian or Asian British	440	11%	7880	20%
Black or Black British	100	3%	1330	3%
Mixed	165	4%	1670	4%
Other Ethnic Groups	65	2%	1070	3%
White	3135	80%	27575	70%
Total	*3905*	*100%*	*39525*	*100%*
Disability				
Yes	415	11%	3510	9%
No	3365	89%	34490	91%
Total	*3780*	*100%*	*38005*	*100%*
**Data supressed and rounded in accordance with HESA (REF) rules due to inclusion of UKMED data*				

Viewing the different demographic variables in Table 2, our survey cohort generally resembles the total population of doctors who took a PFTB in this period, as per the UKMED database. The exception to this is the Asian or Asian British ethnic group, for which the proportion of respondents in this ethnic group is lower than the UKMED-identified population.

Following the work undertaken by Cleland et al., [6] we analysed the association between certain demographic factors and whether doctors took a PFTB using UKMED data. This was performed as a two-stage analysis.

Firstly, X^2 Tests of Independence were performed for each demographic variable to explore whether they were independently related to whether doctors continued straight through to C/STP following FP or took a PFTB (Table 3).

Table 3: Demographic variables and their relationship to proceeding immediately into C/STP after FP, or taking a PFTB

Demographic Variable	Proceeded directly into core or specialty training		Currently on, or took a PFTB		P value
	n	%	n	%	
Gender					
Male	11540	42%	16275	59%	<0.001
Female	16160	45%	19830	55%	
Age on Entry to Medical School					
School Leaver	20065	41%	29320	59%	<0.001
Mature	7635	53%	6790	47%	
Ethnicity					
Asian or Asian British	6305	51%	5950	49%	<0.001
Black or Black British	650	39%	1025	61%	
Mixed	995	41%	1460	59%	
Not stated	1045	47%	1200	54%	
Other Ethnic Groups	705	51%	690	50%	
White	18005	41%	25785	59%	
Income Support					
No	13235	60%	8950	40%	0.038
Yes	2240	58%	1630	42%	
Free School Meals					
No	14715	59%	10140	41%	0.077
Yes	1465	61%	935	39%	
Parents Educated to Degree Level					
No	3795	40%	5675	60%	<0.001
Yes	10875	36%	19710	64%	
POLAR [b]					
Q1 and Q2	4045	48%	4410	52%	<0.001
Q3-Q5	23590	43%	31615	57%	
UK Country of Origin					

[b] POLAR measures the proportion of young people within a given area who enter higher education. Quintiles 1 and 2 (Q1 and Q2) signify areas where the fewest young people participate in higher education.

Continued… Demographic Variable	Proceeded directly into core or specialty training		Currently on, or took a PFTB		P value
	n	%	n	%	
UK Country of Origin					
England	22760	44%	29170	56%	<0.001
Northern Ireland	1405	39%	2205	61%	
Scotland	2385	44%	3040	56%	
Wales	1155	41%	1695	60%	
Medical programme type					
Standard Entry Medicine (5 years)	22850	42%	31085	58%	<0.001
Graduate Entry Programme (4 years)	3605	52%	3390	48%	
6-Year Degree Programmes (Including Medicine with Gateway/Foundation Programmes and mandatory intercalating)	1090	41%	1560	59%	
High School (Secondary School) Type					
State-funded high school or college	18625	44%	24085	56%	<0.001
Privately funded/ independent/ fee paying	6505	40%	9585	60%	
UK Foundation Training Programme (FP) Region					
England	22760	44%	29170	56%	<0.001
Northern Ireland	1405	39%	2205	61%	
Scotland	2385	44%	3040	56%	
Wales	1155	41%	1695	60%	
**Data supressed and rounded in accordance with HESA (REF) rules due to inclusion of UKMED data*					

These initial X^2 Tests of Independence identified that, apart from free school meals, all of the demographics listed in Table 3 were found to be statistically significantly different between doctors who take a PFTB and those who enter C/STP following completion of the FP when analysed individually.

The second stage in this analysis focused on determining whether the individually statistically significant demographic factors in Table 3 might *predict* the likelihood of a doctor taking a PFTB, whilst taking into account all of the other variables simultaneously. A binary logistic regression model was undertaken and resulted in an odds ratio being calculated for each demographic (

Table 4). An odds ratio expresses how much more likely an event is to happen than not to happen – here how likely a doctor with that demographic characteristic is to take a PFTB all else being equal. Where this value is less than 1, the doctor is less likely to take a PFTB than to take one.

Table 4: Results of Multivariate Analysis showing odds ratios for demographic variables in relation to taking a PFTB

Demographic Variable	Odds Ratio	Odds Ratio C.I (95%)		P value
		Lower	Upper	
Gender				
Female	0.826	0.791	0.863	<0.001
Age on Entry to Medical School				
Mature	0.517	0.481	0.556	<0.001
Ethnicity				
White				<0.001
Asian	0.595	0.563	0.630	<0.001
Black	1.111	0.965	1.278	0.142
Mixed	1.029	0.914	1.158	0.636
Not stated	0.824	0.718	0.946	0.006
Other ethnicity	0.597	0.517	0.688	<0.001
POLAR				
Low Participation	1.202	1.128	1.282	<0.001
Parental Education				
Yes	1.080	1.026	1.138	0.004
UK Country of Origin				
England				<0.001
Northern Ireland	1.062	0.927	1.216	0.386
Scotland	0.803	0.715	0.901	<0.001
Wales	1.101	0.98	1.236	0.105
Medical Programme				
Standard Entry Medicine				0.016
Graduate Entry Programme	0.872	0.792	0.959	0.005
6 Year Degree Programmes	1.020	0.917	1.134	0.721
High School Type				
Privately funded/independent/fee paying	1.084	1.028	1.142	0.003
UK Foundation Training Programme (FP) Region				
England				<0.001
Northern Ireland	1.202	1.007	1.436	0.042
Scotland	1.101	0.991	1.223	0.073
Wales	1.508	1.339	1.699	<0.001
Constant	1.985			<0.001
N= 37101 (Total number of cases included in model)				

Table 4 demonstrates that the odds of taking a PFTB lower if the trainee was female (17% less likely than males), mature (48% less likely than school leavers), from Asian backgrounds (40% less likely than white doctors), born in Scotland (20% less likely than doctors from England) or were graduate entrants to medical school (13% less likely that standard 5-year entrants).

The odds of taking a PFTB were higher for trainees who came from families where at least one parent was educated to a degree level (8% more likely), attended a privately funded/independent/fee-paying school (8% more likely than state-funded school) and completed their FP in Northern Ireland or Wales (20% and 51% more likely compared to those completing their FP in England, respectively). Perhaps contrary to some of the other variables in this group, those from low POLAR (Participation of Local Areas) scores were also more likely to take a PFTB (by 20%).

From

Table 4, the ethnicity statistics demonstrate that black doctors are more likely to undertake a PFTB than white doctors (OR=1.111, 95% CI=0.965-1.278) although this is not statistically significant. Recoding this variable into 'white' and 'non-white' to replicate the analysis undertaken by Cleland et al., [6] demonstrated that overall non-white doctors were 32% less likely to undertake a PFTB than their white counterparts (OR=0.677, 95% CI=0.645-0.712, P<0.001). (Cleland et al., found a similar result - non-white doctors were 23% less likely to undertake a PFTB than white doctors).

Table 5 shows the number and percentage of doctors who did or did not take a PFTB before entering each specialty at C/ST1 level as per the UKMED database. Specialties highlighted in green signify those where 50% or more of the doctors recruited to that specialty had taken an PFTB before entering the C/STP, whereas the orange rows identify specialties where more than 50% of the recruited doctors entered immediately post-FP.

Table 5: Relationship between entering specialties and whether doctors have taken PFTB

Demographic Variable	Proceeded directly into core or specialty training		Took a PFTB		Specialty Total
	n	%	n	%	
Anaesthetics	1480	45%	1790	**55%**	3270
Acute Care Common Stem (ACCS)	2005	48%	2185	**52%**	4190
Emergency Medicine	335	28%	850	**72%**	1185
General Practice	11800	**57%**	8985	43%	20780
Medical Training (including CMT/IMT/Broad based training)	7455	**61%**	4700	39%	12155
Obstetrics and Gynaecology	1140	**55%**	950	46%	2090
Ophthalmology	415	**56%**	330	44%	750
Paediatrics and Child Health	2030	**58%**	1465	42%	3490
Pathology	365	**65%**	195	35%	560
Psychiatry	1905	**62%**	1190	39%	3095
Public Health	85	35%	155	**65%**	240
Radiology	995	**55%**	805	45%	1800
Sexual and Reproductive Health	20	42%	25	**58%**	45
Surgical Training	3765	**62%**	2355	39%	6120
Total	*33790*	*57%*	*25980*	*44%*	*59770*

A subsequent a Chi-Square Test of Independence demonstrated a significant relationship between taking a PFTB and choice of subsequent C/STP specialty, X^2 (13, N = 59770) = 964.807, p <0.001. Therefore, there is a statistically significant relationship between undertaking a PFTB (or not) and which specialty a doctor subsequently enters into.

3.1.2 Deciding to take a PFTB

This section contains the data collected from our survey to better understand when doctors made the decision to undertake a PFTB, and which information sources they used when deciding to undertake their PFTB.

3.1.2.1 Timing of the PFTB Decision

Figure 1 shows that the majority of doctors in our survey became aware of the PFTB option during medical school (before final year) (45.6%), whilst most made their decision to undertake a PFTB within their second FP year (48.2%).

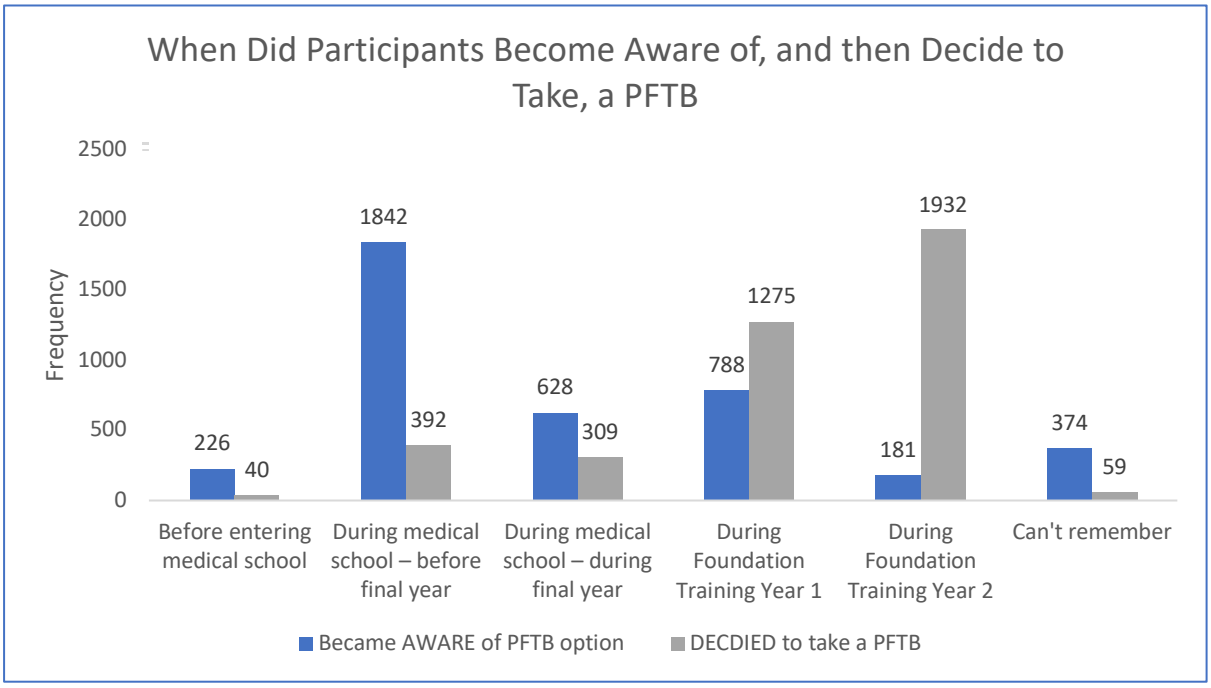

Figure 1: Timings of when participants became aware of, and chose to take, their PFTB

3.1.2.2 Sources of Advice

Figure 2 demonstrates that 43% of doctors in our survey [c] stated that the PFTB was not discussed with them during medical school nor FP. The data suggests that just under 20% of doctors recalled the PFTB being discussed during Medical School (either only in medical school, or in both medical school and FP training) whilst over 30% recalled the PFTB being discussed during their FP training.

[c] [c] Excluded responses to this question included both '*Contradictory*: *responses'* – e.g., "Yes- in Medical School" and "No- not discussed in either Medical School or Foundation Training"; and '*Unclear responses'* – whereby a participant responded either "Yes…" or "No…" and also "Can't remember".

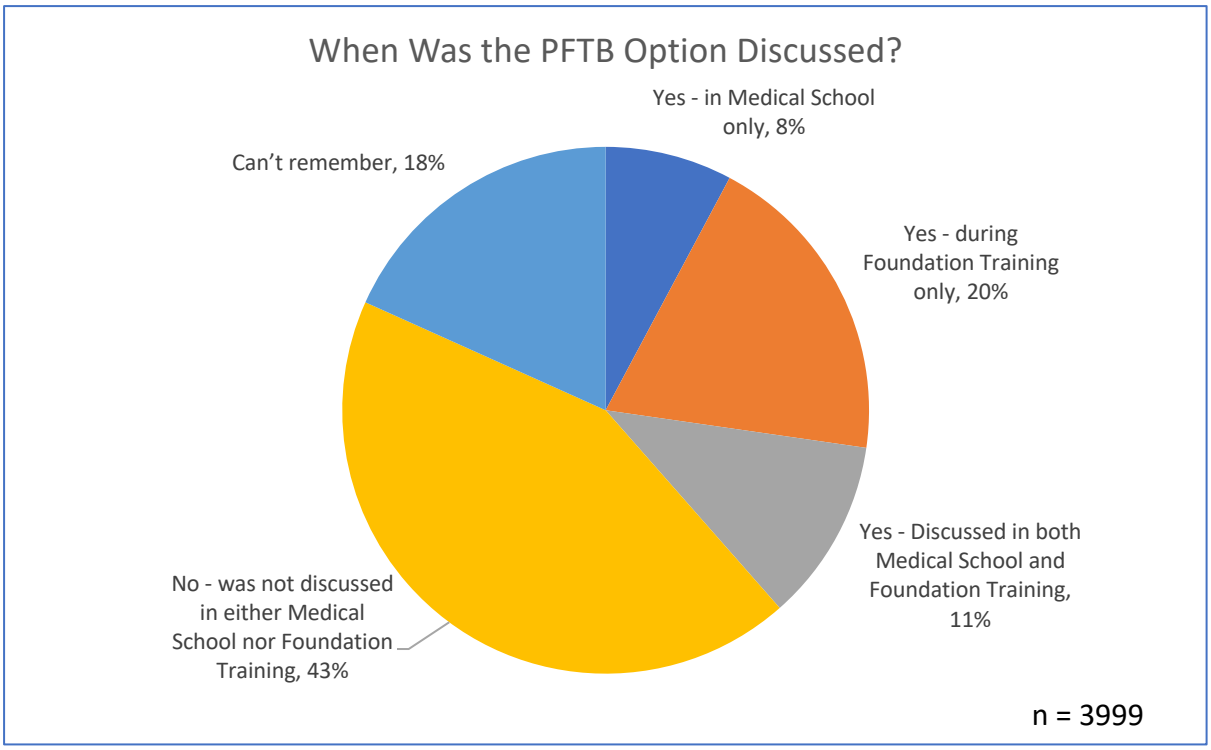

Figure 2: Pie chart showing when participants recalled discussing PFTB option

Participants were asked to identify the source(s) of any PFTB discussion within their under/post-graduate training. Figure 3 demonstrates that in both Medical School and FP, respondents most frequently cited their peers and senior healthcare professionals, as opposed to representatives of the training schemes, medical schools or during careers events.

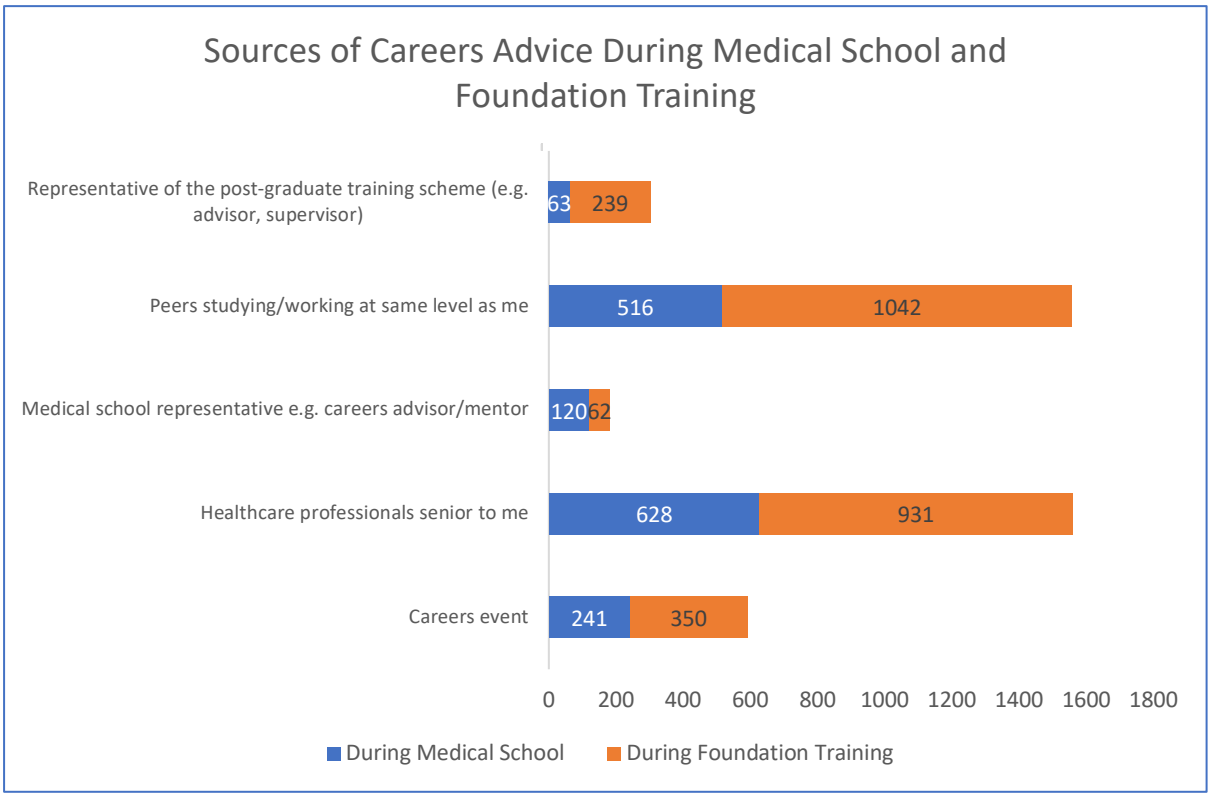

Figure 3: Sources of Careers Advice

In addition to the above information sources, over half of respondents (56%) did not seek any further advice before undertaking their PFTB and 4% could not remember whether they sought additional sources of advice. Figure 4 shows the range of sources utilised by the 40% of respondents who did seek additional advice prior to undertaking their PFTB, where each respondent (n= 1599) was able to select multiple sources (5348 responses in total).

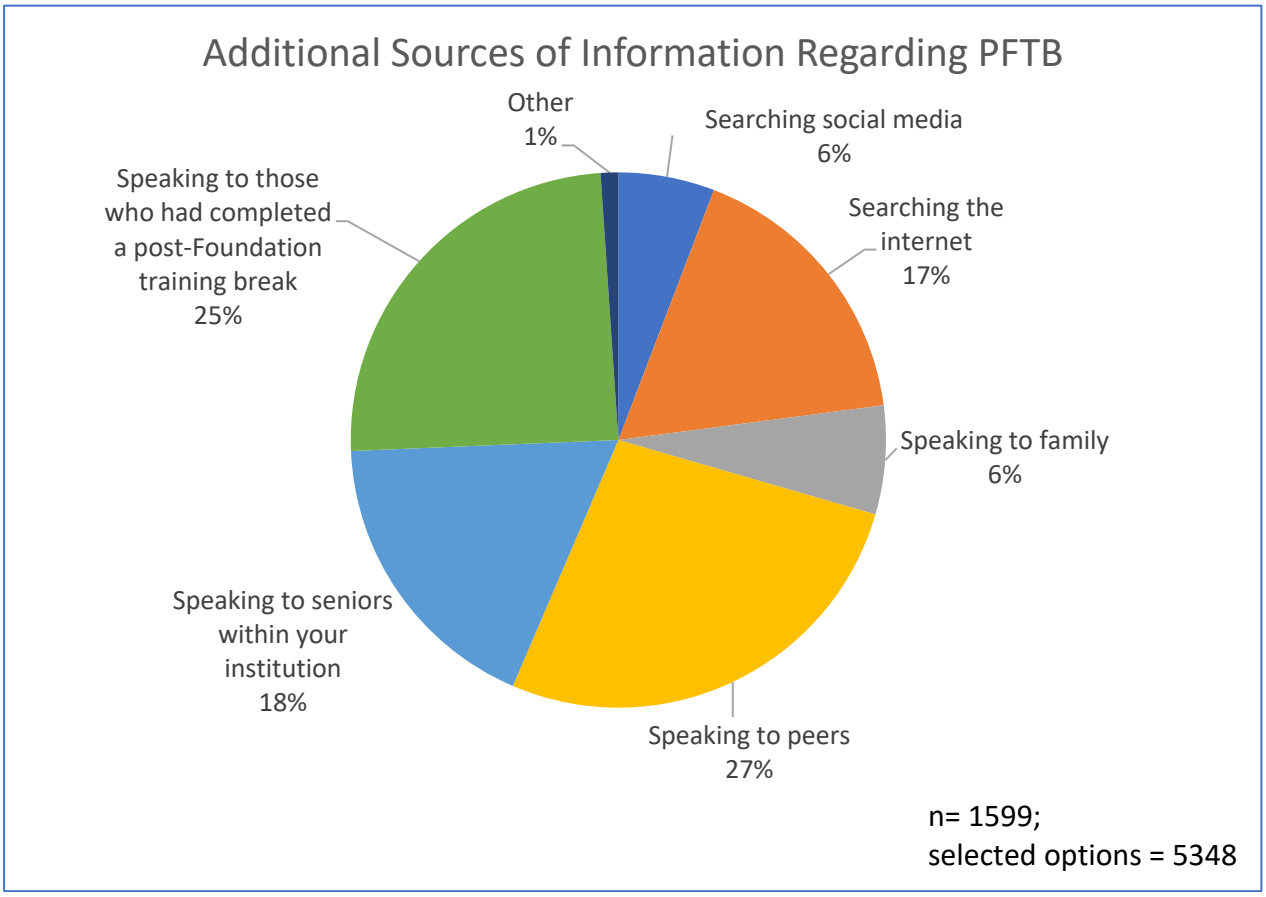

Figure 4: Additional Sources of Information

As a result, just over half of the respondents (51%) felt that they had adequate information to make their decision to take a PTFB. 36% said that they did not have enough information, whilst 13% were unsure.

All participants were asked *'What additional information or advice would have further assisted your decision making?'*. 1883 participants responded to this free-text question. Common items included requests for *"Formal teaching from foundation school on option of out of training year(s)"* including *"Range of options available"* and practical advice on *"how to re-enter a training programme at another time"* and the *"flexibility in training programmes e.g., deferral of entry".* Many participants requested *"financial advice"*, particularly including "*impact on NHS pension",* and information pertaining to *"GMC registration"* and "*revalidation*".

3.1.3 Motivations for taking a PFTB

Survey respondents were asked to select options from pre-populated categories (based on previously conducted research) which best aligned with their motivations to undertake a PTFB. These options and the illustrative examples offered to survey respondents are provided in Table 6 They were able to select as many options as they wished, including an "Other" category for those whose motivations did not fit into the available category options.

Table 6: PFTB Motivation Categories and Examples

Category to Describe Motivation for PFTB	**Example**
Personal fulfilment	Pursue non-clinical interests, travel, enjoy time away from medicine)
Career exploration	Work in different specialty/place, time to consider work options including those outside clinical medicine, gain professional qualifications)
Improve health and wellbeing	Improve mental and/or physical health, including burnout
Break from training or work environment	Break from assessment, portfolio, exams
Personal circumstances	Family, geographical reasons, life event such as a wedding/ buying a house etc.)
Logistical/ practical reasons	Did not secure training post, visa issue, earn more money)

Figure 5 illustrates respondent's motivations for their PFTB. Personal fulfilment and Taking a Break from Training/Work Environment were the strongest motivators, whereas Personal Circumstances (e.g., family, geographical reasons, life event such as a wedding/buying a house) and Logistical/Practical Reasons (e.g., did not secure training post, visa issue, earn more money) were less strong drivers for the PFTB.

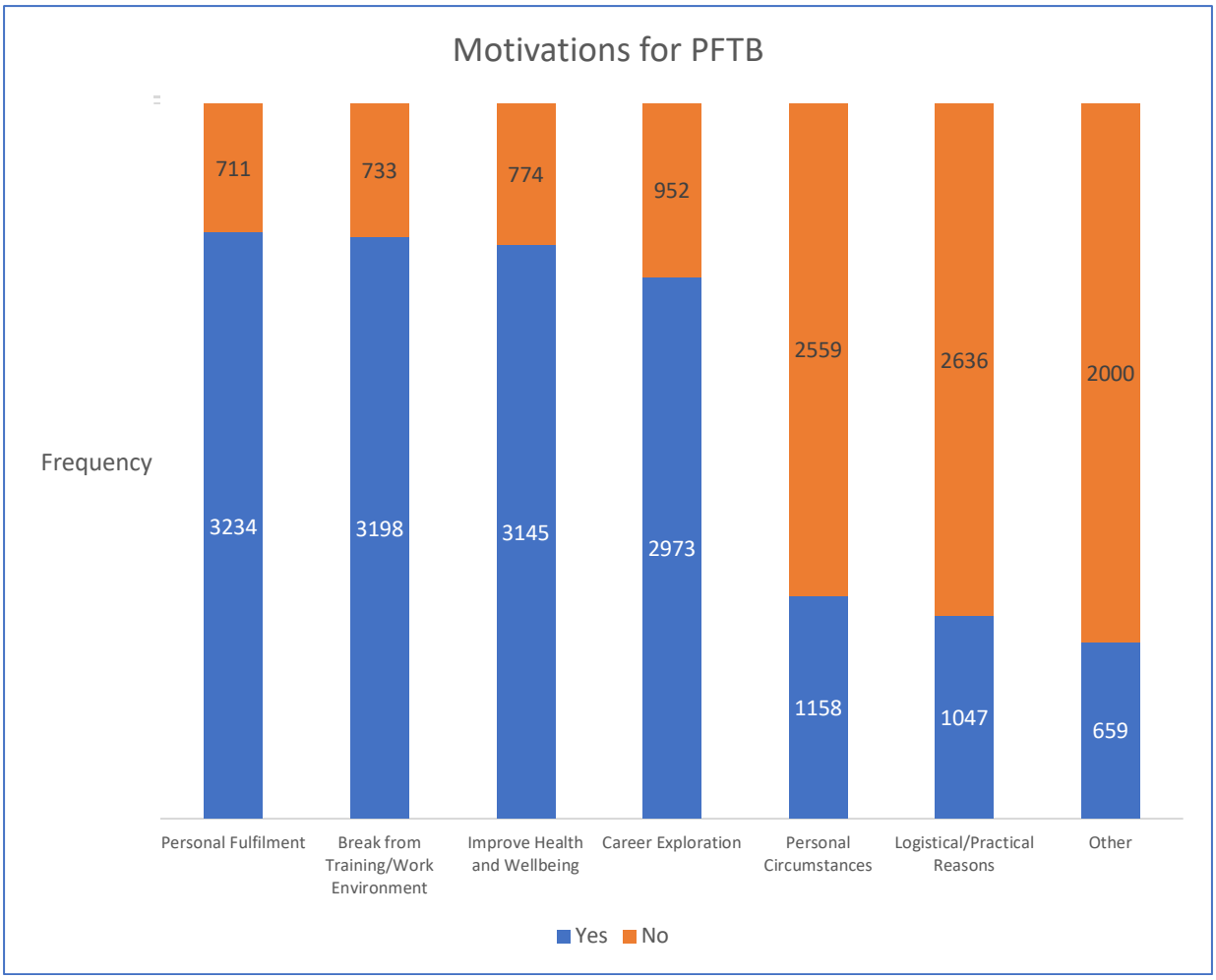

Figure 5: Bar chart showing motivations for PFTB

Participants who selected 'Other' were invited to add free comments to explain this option. 757 respondents left comments, which ranged from one-word responses to longer, more detailed explanations of their PFTB motivations. Common themes were identified, some of which related to the categories offered in the survey (but offered further context) and some of which fell outside of the given categories.

The most common themes which overlapped with pre-existing categories included the concept of earning more money within the PFTB (n=144), reference to the term 'burnout' (n=61) and improving mental health (n=21). The phrase 'work-life balance' was mentioned 31 times. Life events, such attending weddings (including one's own), was mentioned by 21 respondents, alongside comments pertaining to the difficulty in acquiring annual leave more generally within training programmes (n=25). 23 doctors referenced taking a PFTB to facilitate having maternity leave or childcare.

Common themes which fell outside of the categories, or highlighted more general motivations which traversed multiple categories included the perceived need to boost one's CV or portfolio for C/STP applications (n=70):

- *"Did not have time during foundation time work on application sufficiently (had no SDT despite it being a requirement in contract)"*

- "*It was felt necessary to compete with other applicants in a competitive CT1 application*"

The lack of flexibility within training programmes (n=42):

- *"Flexibility as training offered no flexibility with hours/leave/time out. Also autonomous over my own life as training doesn't let you pick placements- could be 100mls away from friends and family! Not able to book days off for friends/ family weddings due to service requirements."*

33 doctors specifically referenced using their PFTB instead of, or to consider, leaving the profession after completing their FP (n=33):

- *"Was totally burnt out, option was either take a short break or leave medicine. Foundation training can be brutal to your physical and mental health."*

14 doctors explained that their PFTB aligned with their aspirations to work in the armed forces, for which they must leave the NHS post-FP to join the military training pathway:

- *"Military pathway for Army and Navy involves 3 years out of training job as a general duties medical officer*"

7 doctors specifically referenced bullying within the NHS, whilst 8 doctors referred to its 'toxic environment':

- *"Bullying, hierarchies, sexism within the NHS never gets addressed. Constant changing wards & teams so never belonging. It allows more senior nurses who are permanently based on the ward to bully newly rotated doctors.*
- *"Rethink career... experience as a foundation doctor pushed me away from medicine. Treatment of foundation doctors by senior doctors was very poor e.g. bullying and creating a toxic workplace environment. Unable to speak out for fear of being labelled a "difficult trainee"…"*

3.1.3.1 Motivators for PFTB by Demographics

In order to explore whether doctors with different demographic characteristics were motivated to undertake their PFTB for different reasons, the UKMED database was utilised and merged with our survey data to create a cross-tabulation of motivations (as per Figure 5) versus demographics Table 7.

Table 7: Agreement with Motivations for PFTB presented by Demographic Characteristic

Demographic	Motivator for PFTB											
	Personal Fulfilment		Career Exploration		Improve Health and Wellbeing		Break from Training		Personal Reasons		Logistical/Practical Reasons	
	Yes (%)	Total	Yes (%)	Total	Yes (%)	Total	Yes (%)	Total	Yes (%)	Total	Yes (%)	Total
Sex												
Female	1965 (84%)	2350	1795 (77%)	2340	1945 (83%)	2340	1950 (83%)	2345	690 (31%)	2190	485 (22%)	2155
Male	1260 (80%)	1580	1170 (74%)	1570	1190 (76%)	1565	1240 (79%)	1570	460 (30%)	1515	555 (37%)	1515
Total		3930		3910		3905		3915		3705		3670
Age												
20-29	1165 (85%)	1375	1065 (78%)	1365	1155 (84%)	1370	1155 (84%)	1375	405 (31%)	1305	380 (29%)	1295
30-39	2015 (82%)	2465	1845 (75%)	2450	1915 (79%)	2435	1980 (81%)	2445	700 (30%)	2295	615 (27%)	2280
40-49	20 (34%)	60	60 (65%)	90	60 (63%)	90	55 (59%)	90	40 (45%)	95	45 (50%)	90
50-59	5 (50%)	10	5 (33%)	10	10 (77%)	15	5 (58%)	10	10 (64%)	15	5 (33%)	10
60-69	-	0	-	0	-	0	-	0	-	0	-	0
Total		3910		3920		3915		3925		3710		3680
Disability												
Yes	310 (77%)	400	280 (69%)	400	335 (83%)	400	335 (83%)	405	135 (35%)	375	115 (31%)	380
No	2725 (83%)	3280	2505 (77%)	3260	2605 (80%)	3255	2645 (81%)	3265	945 (31%)	3090	850 (28%)	3055
Total		3685		3665		3655		3670		3470		3435
Ethnicity												
Asian/Asian British	330 (78%)	425	330 (77%)	430	340 (80%)	425	340 (80%)	425	130 (32%)	405	150 (37%)	400
Black/ African/ Caribbean/ Black British	65 (71%)	90	65 (74%)	85	75 (81%)	90	75 (83%)	90	40 (46%)	85	45 (53%)	85
Mixed/Multiple ethnic groups	130 (83%)	160	115 (73%)	155	130 (82%)	160	130 (81%)	160	150 (34%)	150	45 (32%)	150
White	2560 (83%)	3075	2325 (76%)	3050	2455 (81%)	3045	2500 (82%)	3055	870 (30%)	2880	725 (32%)	2855
Any other ethnic group	40 (63%)	65	40 (66%)	65	45 (70%)	65	45 (72%)	65	15 (28%)	60	35 (56%)	65
Total		3810		3785		3780		3790		3585		3550

Table 7 demonstrates that certain demographics are associated with specific motivations for undertaking a PFTB. Overall, the difference in motivations between male and female doctors is quite small, but a higher proportion of female doctors were motivated to undertake a PFTB to improve their health and wellbeing (83% vs 76%), whereas male doctors were more motivated by logistical/practical reasons (37% vs 22%). The data pertaining to age stated in the table refers to the respondents' age when they completed this survey. Therefore, this can cautiously be interpreted as a lens through which generational difference in motivations can be viewed – i.e., those at the lower end of the age range are more likely to have taken their PFTB more recently, whilst those within the older age categories are more likely to have undertaken their PFTB around 2011 (the first year of PFTB commencement captured by our survey). Doctors who were younger at the point of completing this survey seem more motivated by personal fulfilment, career exploration and taking a break from training than their older counterparts, who were more motivated by personal reasons (e.g., family, geographical reasons or life events such as a wedding/buying a house). The only major difference in motivations noted between doctors who were disabled and those who were not disabled was career exploration; where the latter had higher levels of agreement with career exploration as a PFTB motivator (77%) than their disabled peers (69%). Regarding ethnicity, Black/African/Caribbean/Black British doctors and those other ethnic groups (i.e., did not identify with the other listed categories) were noted to be less motivated by personal fulfilment than their Asian/Asian British, mixed ethic group and white counterparts, but more motivated by logistical/practical reasons.

3.1.3.2 Change in motivations for taking a PFTB over time

Figure 6 shows how motivations behind PFTB have changed in relation to the year that the PFTB was started. Over the last 10 years, career exploration has become a slightly less common motivating factor (although still over 70% of respondents identified this was a motivating factor), whilst the personal fulfilment, improving health and wellbeing, taking a break from training, personal circumstances and logistical/practical reasons have become more prominent motivators. The latter two appear to have increased the most over the past 10 years.

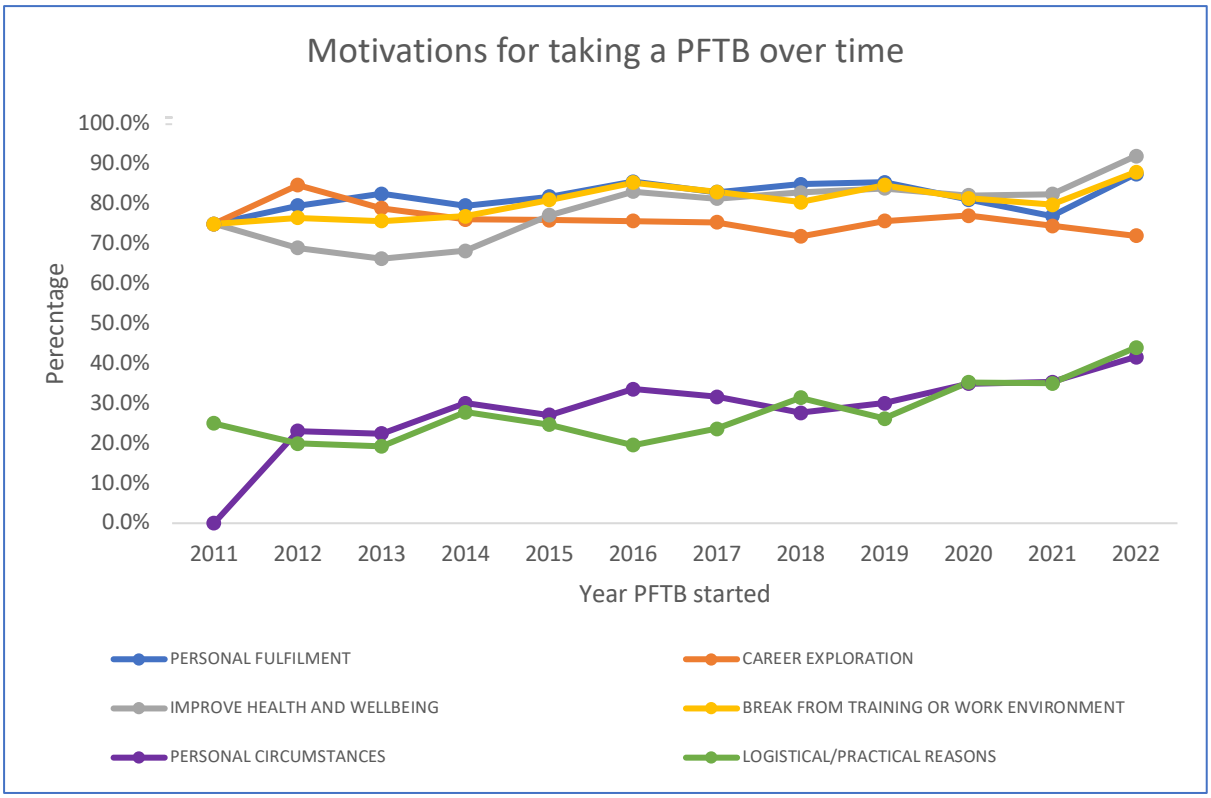

Figure 6: Motivations for PFTB over time

3.1.3.3 Strongest Single Motivator for PFTB

When asked to identify the single strongest motivator for taking a PFTB, the responses largely echoed the results seen in Figure 5, with the most popular choices relating to personal fulfilment (23%) taking a break from training (17%) and improving health and wellbeing (17%), and the weakest motivators being Logistical/Practical Reasons Personal (9%). Almost one-quarter (23%) of respondents selected 'Personal Fulfilment' as their single strongest motivator.

3.1.3.3.5 Motivations for taking a PFTB: Burnout

Two of the most popular motivations for the PFTB were 'Break from Training' and 'Health and Wellbeing'. Additionally, the specific referencing to 'burnout' in the free text comments reinforced this as a motivation for PFTB and therefore it seemed appropriate to explore whether self-reported burnout, as gathered through the National Training Survey (NTS), predicted likelihood to take a PFTB. Two independent T-tests were conducted using UKMED data to compare the burnout z score at the end of FP years 1 and 2 and whether trainees took a PFTB (Table 8).

Both mean z-scores for F1 and F2 were higher for doctors who subsequently took a PFTB, but this was only statistically significant for the F1 burnout score: M=0.04, SD=0.99, compared to M=0.0873, SD=0.96 ($t(7149)= 2.69$, p= 0.007). Therefore, doctors who reported higher levels of burnout in F1 were more likely to take a PFTB, but only accounted for a very small part of this decision because the effect size was so small (d=0.05). Whilst the same relationship was

also noted for the F2 burnout scores, the likelihood of taking a PFTB was not deemed statistically significant and therefore must be interpreted more cautiously.

Table 8: T-test results comparing means for NTS burnout z-scores at Foundation Years 1 and 2 between non-PFTB and PFTB doctors

Survey Completed at End of....[d]	Cohort	N	Burnout z score from NTS		T test score	P value
			Mean	Standard Deviation		
Foundation Year 1	Non-PFTB	3786	0.0354	0.99104	-2.693430	0.007
	PFTB	8267	0.0873	0.96231		
Foundation Year 2	Non-PFTB	5238	0.1410	1.03148	-1.098873	0.271
	PFTB	9842	0.1602	0.98994		

3.1.4 The PFTB Experience

3.1.3.1 Length of PFTB

This section contains data pertaining to the length of the PFTB, whether doctors also applied for C/STP immediately after completing their FP, and both where and how doctors spent their PFTB.

One third of respondents (1137, 34%) were currently on their PFTB when they completed the survey.

Of those who declared that they had completed their PFTB (2597, 66%), 53% stated that their PFTB lasted for 12 months or less, approximately one-third took between 1 and 2 years out of training and less than 10% took between 2 and 3 years [e] [f] (Figure 7).

[d] Survey takes place in April/May before the completion of F1 or F2 post in August.
[e] As only Month and Year were collected, the 1st of month was used for analysis purposes.
[f] 49 responses were excluded due to non-response or providing incomplete or inadequate (e.g., start date chronologically after end date) to complete analysis.

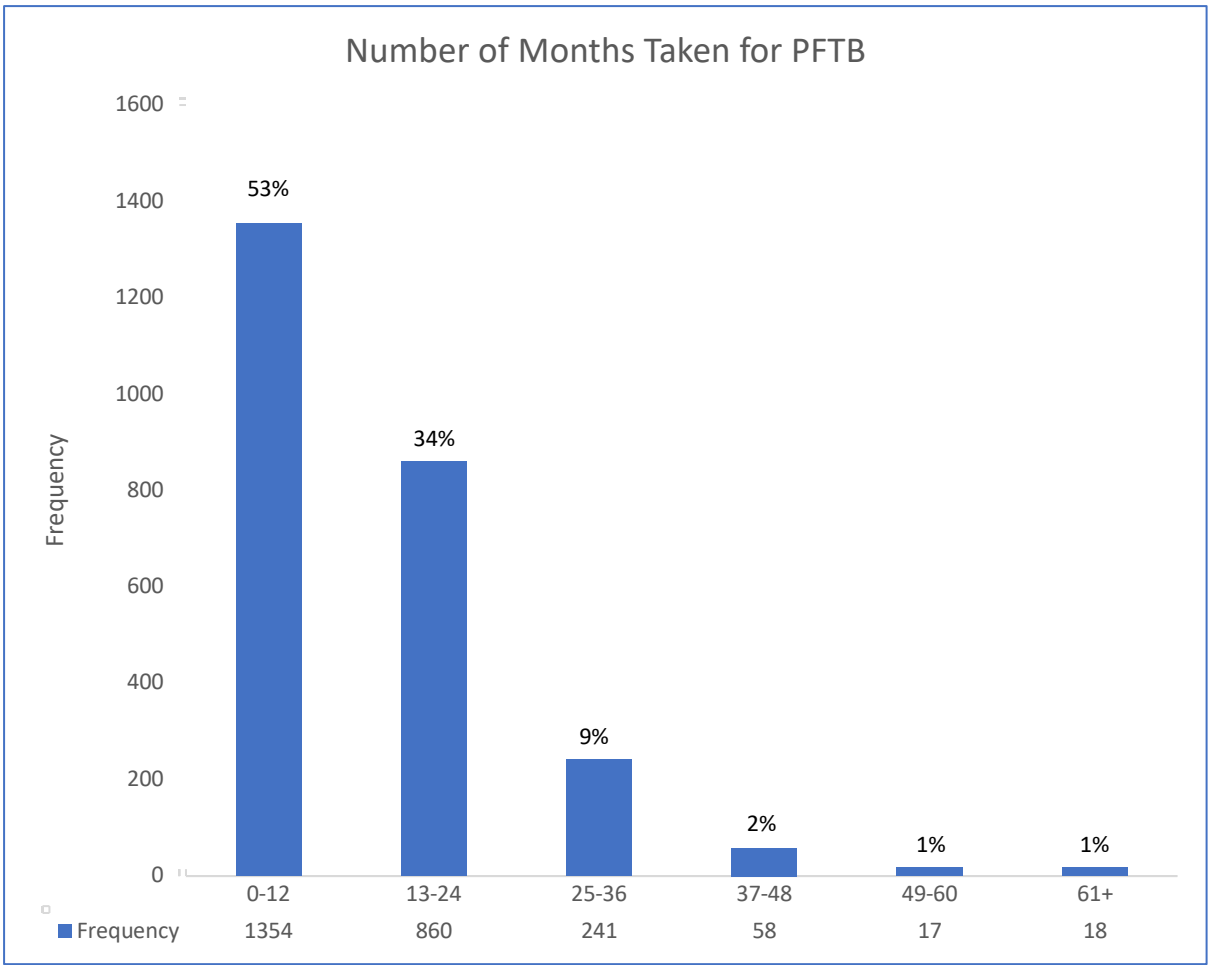

Figure 7: Duration of PFTB in months

To investigate whether the length of PFTBs over time has increased, decreased or remained the same, a scatterplot was used: For each respondent who declared that they had completed their PFTB, the year they commenced their PFTB was plotted against the duration of their PFTB (Figure 8). The scatterplot demonstrates a negatively inverse relationship between the year in which doctors took their PFTB, and its duration- hence over the past 10 years, there has been a trend towards taking a shorter PFTB.

To investigate the strength of this association, a simple linear regression and subsequent ANOVA were conducted. Whilst the relationship between the two variables was statistically significant, the model showed a low negative correlation, with only 2.6% of the variation in PFTB duration being accounted for using this model ($R= 0.162$, $R^2=0.026$, $p<0.001$).

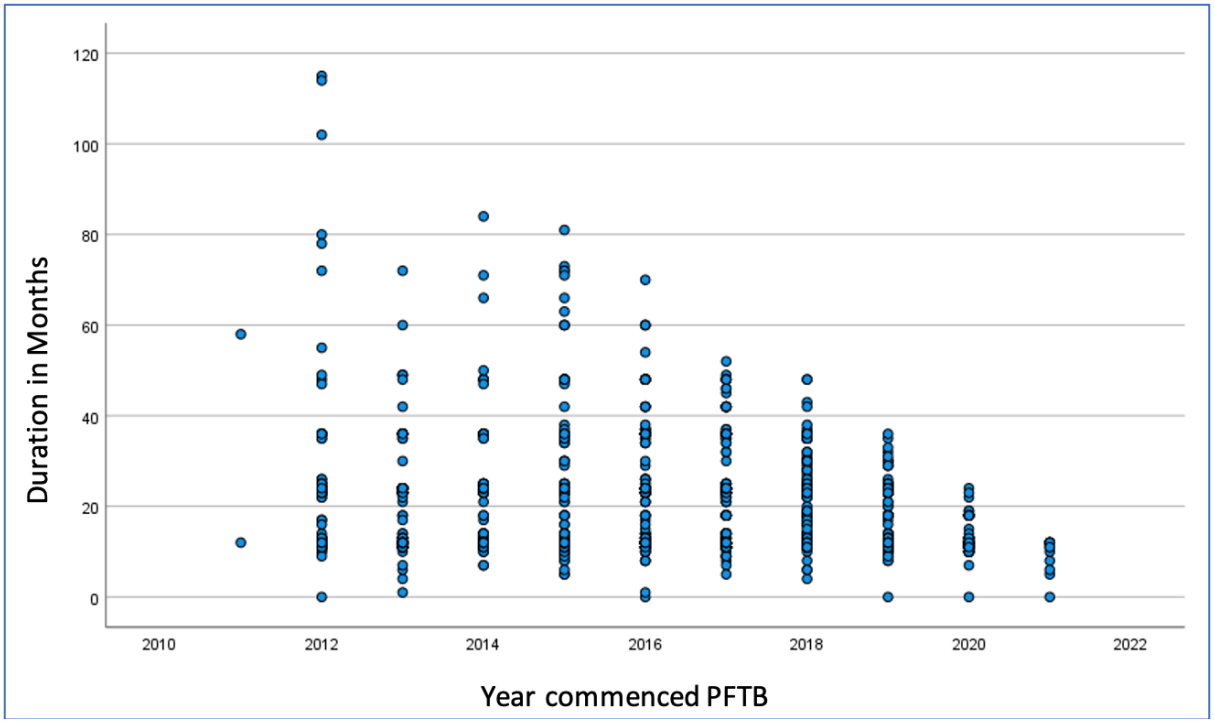

Figure 8: Scatterplot illustrating Year PFTB Commenced versus Duration of PFTB in Months (only includes doctors who had completed their PFTB)

However, this data must be interpreted with caution: Of the respondents who commenced their PFTB in years 2020, 2021 and 2022, over half were still undertaking their PFTB at the time of completing the survey (59%, 98% and 100%, respectively). As the above analysis included only those who declared that they had *completed* their PFTB at the time of the survey, the 2022 cohort were excluded from the analysis. The data pertaining to the 2020 and 2021 cohorts almost certainty under-estimates the average (and range of) length of PFTB, and the actual data will not be known until the doctors in these cohorts have completed their PFTBs in the future. Nonetheless, the trend of decreasing length of PFTB over time is still clear to see from the scatterplot between 2011-2019, in which a higher proportion of these cohorts *had* completed their PFTB.

3.1.2.2 Taking a PFTB versus applying for C/STP

Our survey explored whether the PFTB was the 'first choice' option for doctors, or whether it was seen as s 'back-up plan' for those who applied but were not successful in gaining a C/STP post. 87% of respondents chose to undertake a PFTB rather than enter a C/STP post immediately following FP; 73% did not apply for a C/STP immediately following completion of their FP and 14% declined their C/STP offer. Only the remaining 13% of respondents took an 'unexpected' PFTB when they applied but did not receive an offer for their C/STP of choice.

3.1.2.3 Activities undertaken during PFTB

96% (n=3865) of respondents worked clinically during their PFTB as a healthcare professional. Of these, 99% (n=3861) worked as a doctor either exclusively (n=3438), or in combination with an additional clinical role (n=423). Examples of the latter included being a simulation fellow, phlebotomist, clinical editor for a health journal, Care Quality Commission (CQC) inspector and optician.

Almost 90% of participants who worked as a doctor during their PFTB, did so purely in a hospital environment. Examples of working environments outside hospital included community medicine (e.g., sexual health clinics, hospices, community psychiatry, aesthetics, armed forces, Department of Work and Pensions and mountain rescue/expedition medicine) and academic areas such as research and being a clinical lecturer/educator.

Of the 4 respondents (0%) who worked clinically but not as a doctor, two respondents worked as COVID-19 vaccine administrators, one listed "Leadership and Management" as their role, and one listed "Expedition Medicine".

3.1.2.4 Location of PFTB

Of the 3869 respondents who worked clinically during their PFTB and provided their working location, 72% worked exclusively within the UK. 13% worked both within and outside of the UK, whilst 15% worked exclusively outside the UK.

Figure 9 demonstrates the number of respondents who reported visiting counties outside of the UK during their PFTB. Australia (n=472, 44%) and New Zealand (n=314, 29%) were by far the most frequently visited.

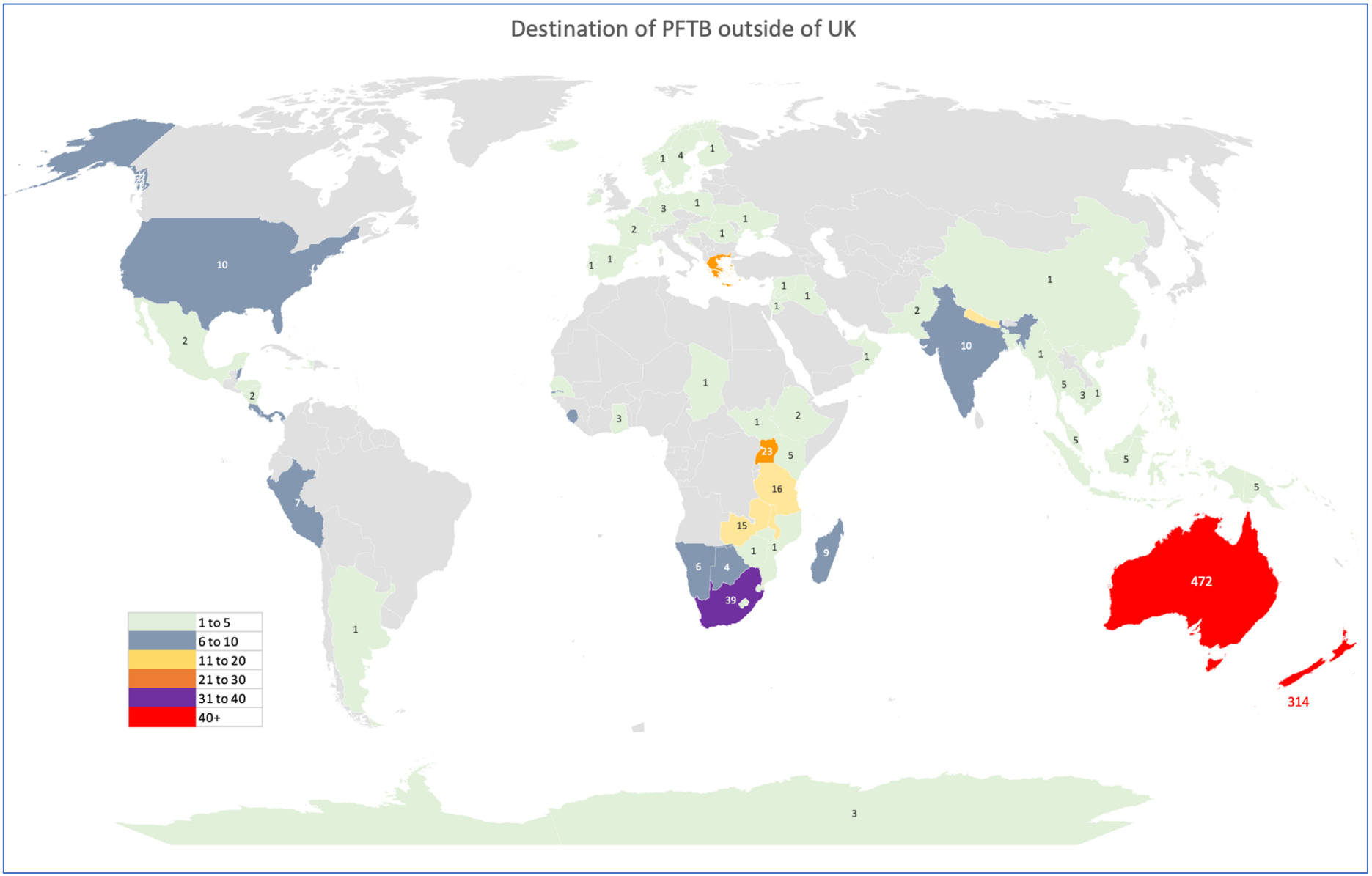

Figure 9: World Map showing destinations of non-UK PFTB

Figure 10 demonstrates how the travel restrictions surrounding the COVID-19 pandemic affected (and continue to affect) doctors' ability to travel during their PFTB. This bar chart shows the proportion of doctors who worked clinically during their PFTB and completed their PFTB within the year 2020 (the peak of the pandemic in the UK), before 2020, or after 2020 in relation to their geographical location.

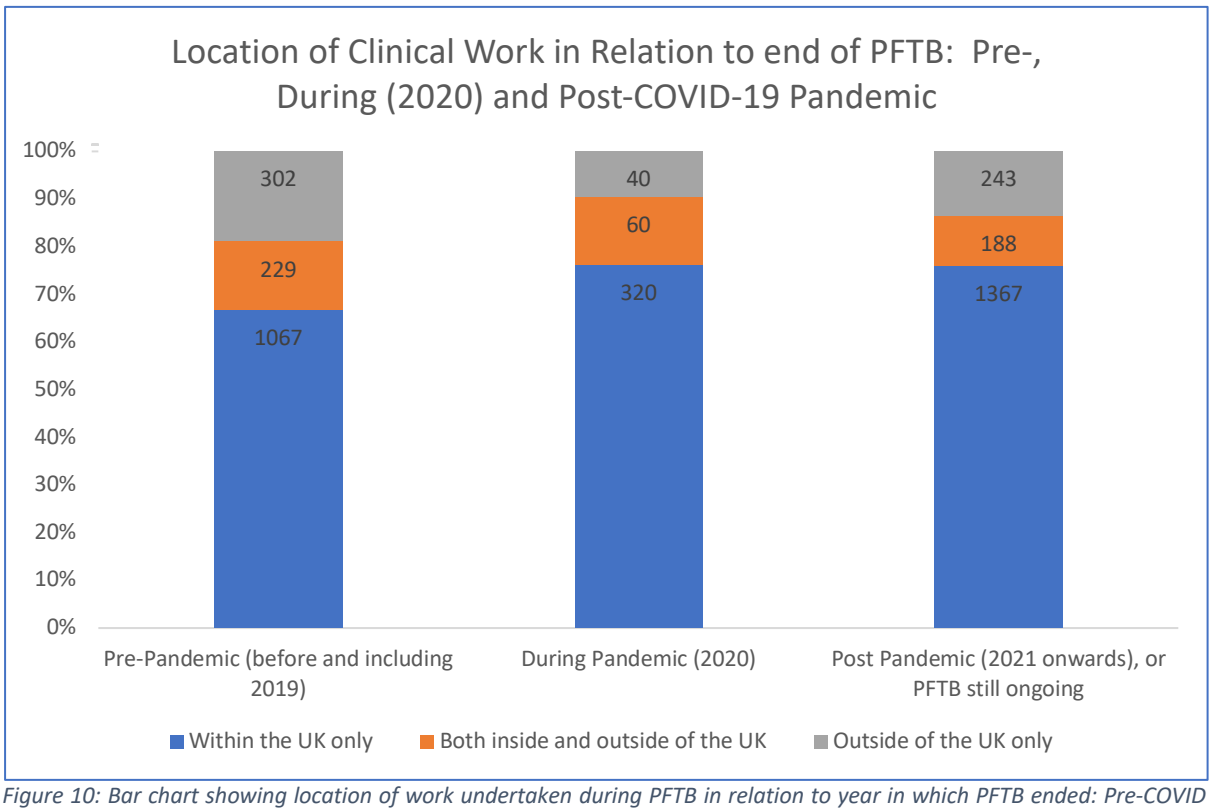

Figure 10: Bar chart showing location of work undertaken during PFTB in relation to year in which PFTB ended: Pre-COVID pandemic (2019 or earlier); During the height of pandemic (2020); or post-pandemic (2021 onwards, including those still on their PFTB)

Figure 10 shows the increasing trend of PFTB doctors working clinically exclusively in the UK pre-, during the peak, and post-peak of the COVID pandemic (66%, 76% and 76%, respectively). It also demonstrates a potential recovery in the proportion of doctors choosing to complete their PFTB outside of the UK post-pandemic (19% pre-pandemic, 10% during the peak and 13% post-peak).

3.1.2.5 Activities undertaken during PFTB: Employment vs Volunteering

Of the 670 participants who undertook non-clinical work, only 133 respondents subsequently categorised their work in more detail (537 non-responses). Figure 11 demonstrates that the majority of doctors who were either employed (75%) or volunteered (66%) within non-clinical activities did so in a role related to their clinical background. Table 9 contains examples of each role.

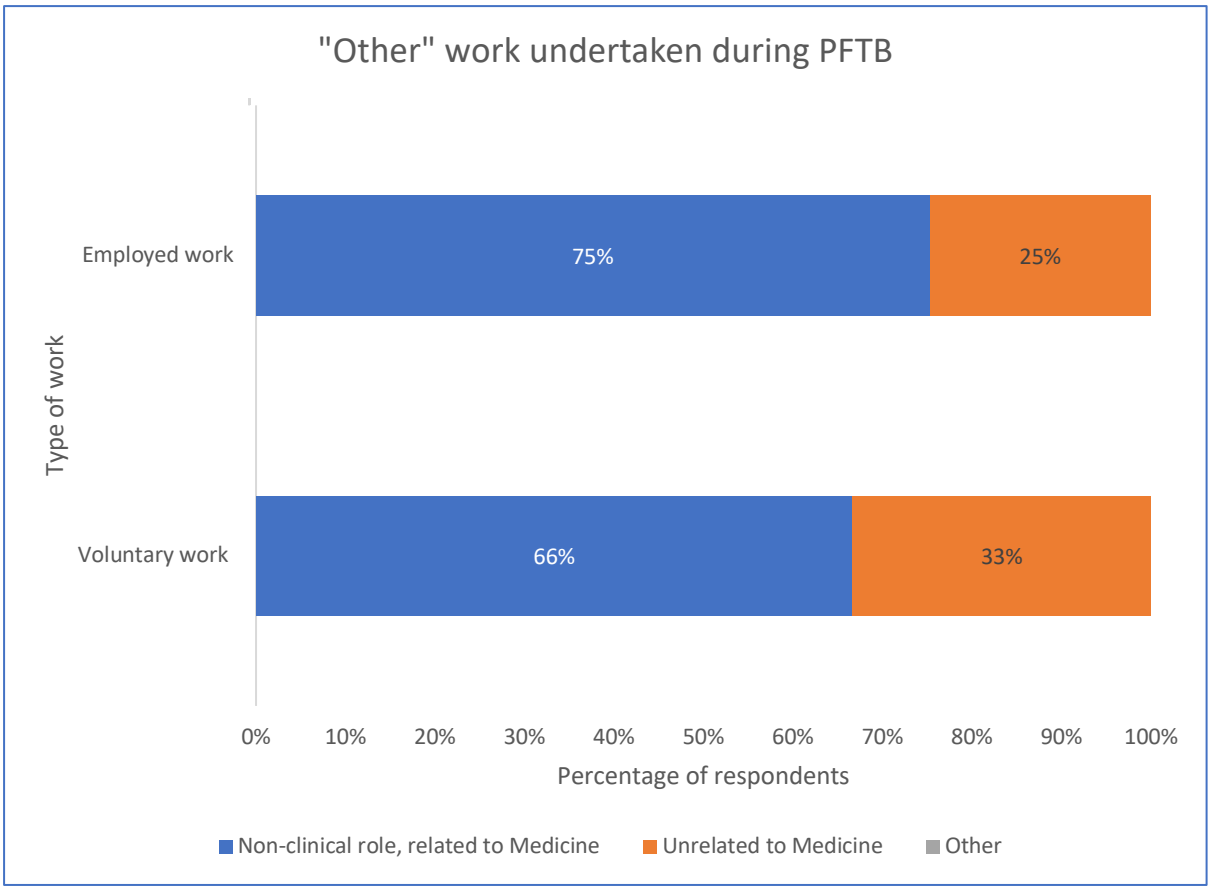

Figure 11: Number and proportion of respondents undertaking 'other work' related or un-related to medicine in either an employed or voluntary capacity

Table 9: Table of examples of non-clinical roles undertaken during PFTB

Role	Employed Work	Voluntary Work
Related to Medicine	Teaching Fellow Anatomy demonstrator Civil servant – Health Policy Medical School faculty Medical charity director Medical advisor at pharmaceutical company	Anatomy demonstrator Clinical skills lecturer Medical school Ethics tutor Medical art internship National Medical Director's Teaching Fellow
Unrelated to Medicine	Disc Jockey (DJ) Dance Teacher Writer Management Consultant Singer	Businessman Studying for MSc Foreign languages teacher Digital Artist Expedition guide

11 respondents did not categorise their PFTB experience into 'employment' or 'volunteered work', and instead selected "Other". These roles included Research Fellow, Teaching Fellow, and Chief Operations Officer for a charity. Whilst the roles listed for this category, and the others pertaining to this question, might be assumed to be more suited to alternative categories (e.g., Teaching Fellow is likely to be a "Employed role, related to medicine"), this cannot be verified without further details and hence, the data has not been re-categorised based on the researchers' assumptions.

3.1.2.6 Activities undertaken during PFTB: Personal Development

66% (n=2651) of participants reported that they undertook some sort of personal development activity during their PFTB. Figure 12 shows the categories of these activities, whilst Table 10 gives examples of the training courses, qualifications and activities both related, and unrelated, to medicine[g].

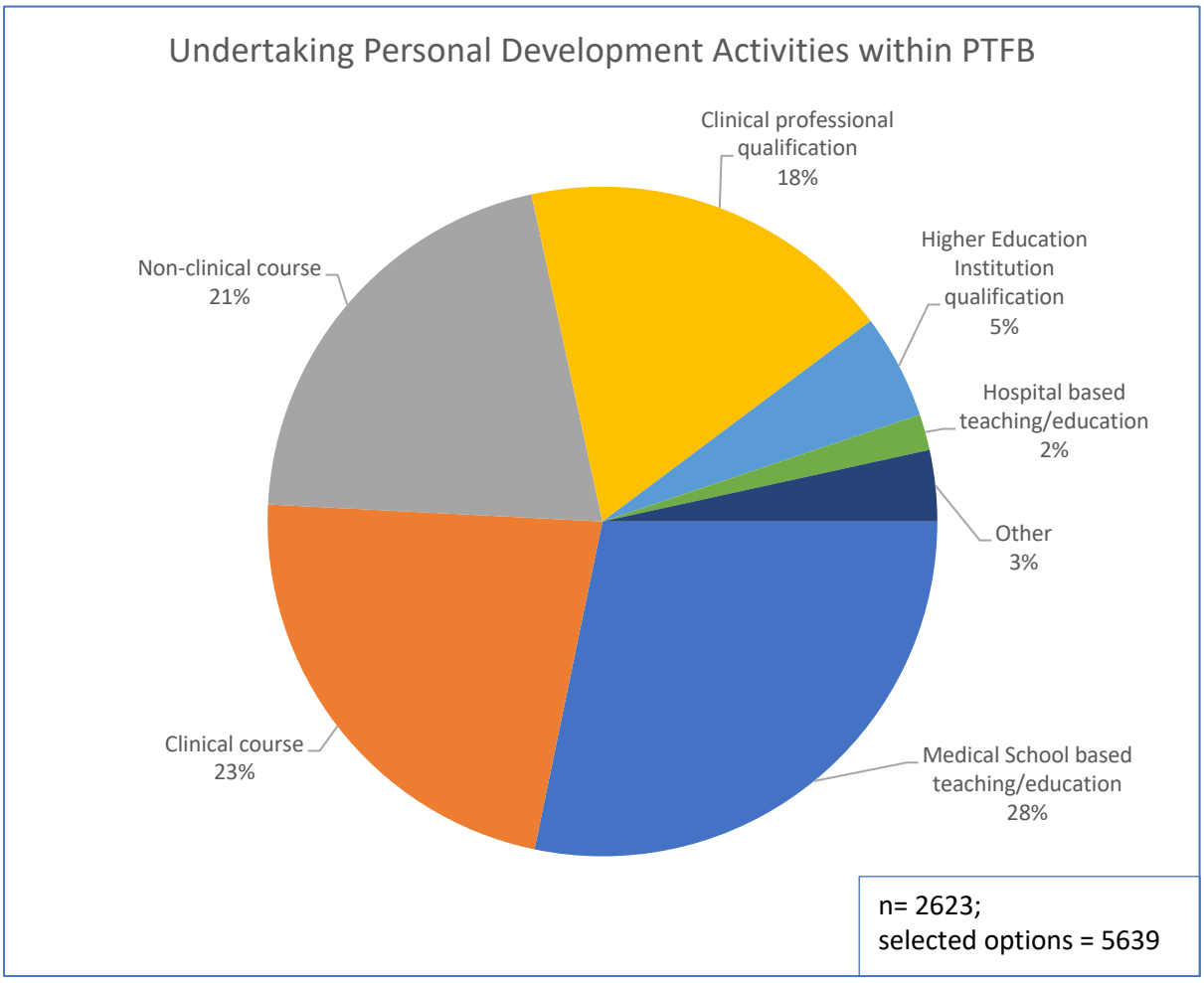

Figure 12: Number and proportion of respondents undertaking personal development activities during their PFTB and what these were

[g] 28 respondents did not give details of the activities they completed during their PFTB

Table 10: Table of examples of personal development activities undertaken during PFTB

	Related to Medicine	Unrelated to Medicine
Training course	Advanced Trauma Life Support (ATLS) Pre-hospital Medicine Course Basic Colposcopy Training Lifestyle Medicine Course	Military training Mountain leader training Nuclear engineering Fitness instructor course
Qualification	PGCert in Medical Education Clinical postgraduate examinations e.g., MRCP, MRCS, FRCEM, MRCPCH, FRCA Diploma in Tropical Medicine and Hygiene	Masters degree in Law Masters of Business Administration (MBA) Professional Association of Diving Instructors (PADI) Pilots licence
Activity	Hospital-based medical education provision Medical School-based medical education provision OSCE examiner Clinical skills tutor	Music lessons Art classes Learning a language Pottery course

3.1.5 Impact of the PTFB

Our scoping review [1] identified that career progression and improving health and wellbeing were amongst the strongest motivations for the PFTB. Yet since the majority of the literature reported prospective accounts of those who *intended* to undertake a PFTB, little evidence existed to suggest whether these motivations were often fulfilled.

Therefore, our participants were asked whether their career progression and health and wellbeing had been influenced by their PFTB, and if so - to what extent, and in what way. Following this, analysis was undertaken to investigate the influence on career progression and health and wellbeing for respondents who specifically stated these as motivators for their PFTB in an earlier question (Figure 5).

3.1.5.1 Influence of PFTB on Career Progression and Health and Wellbeing

All participants were asked whether their PFTB had influenced their career progression or health and wellbeing, either positively or negatively. Figure 13 demonstrates that most participants felt that their PFTB had a influenced both of these factors.

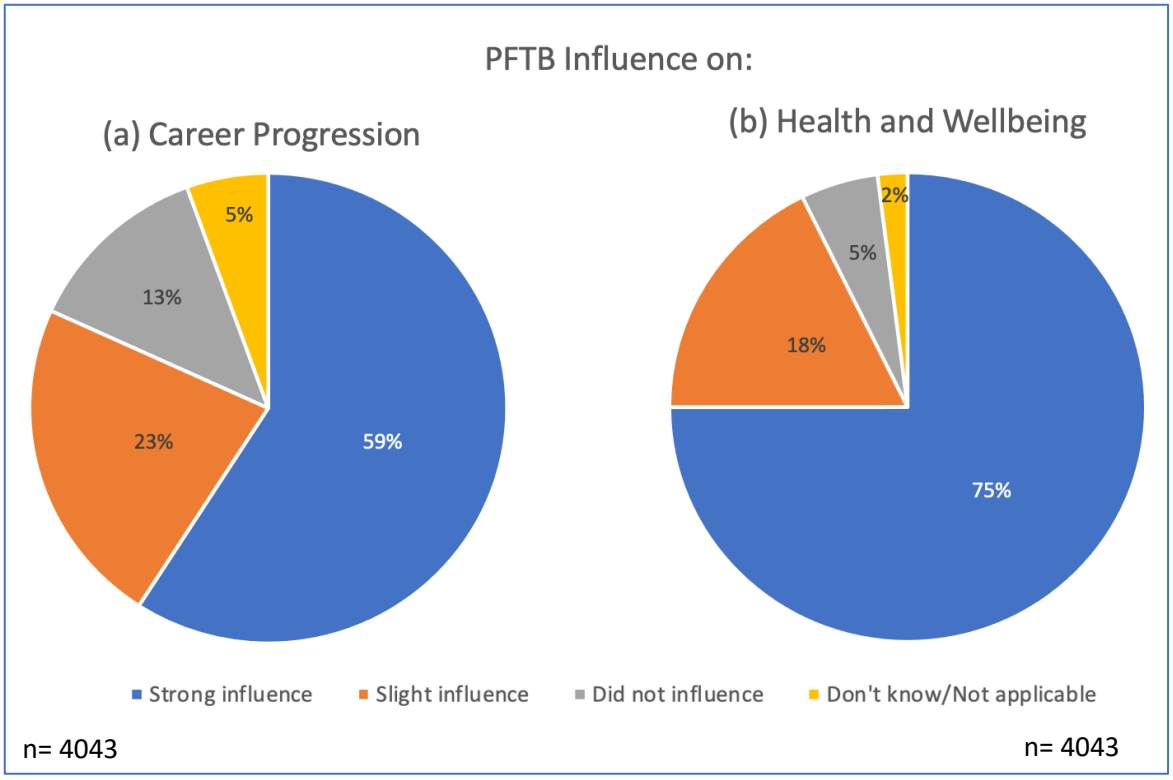

Figure 13: Chart to show influence of PFTB on (a) Career Progression, and (b) Heath & Wellbeing

Participants who had indicated that their PFTB had either a 'strong' or 'slight' influence on their career progression or health and wellbeing were asked more specifically the ways in which this had occurred. Participants were able to select as many multiple-choice options from a pre-determined list as they wished and were also invited to add their own additional comments by selecting 'Other'. Figure 14 and Figure 15 show the results for career progression and health and wellbeing, respectively. Examples of the 'Other' comments are found in Figure 16.

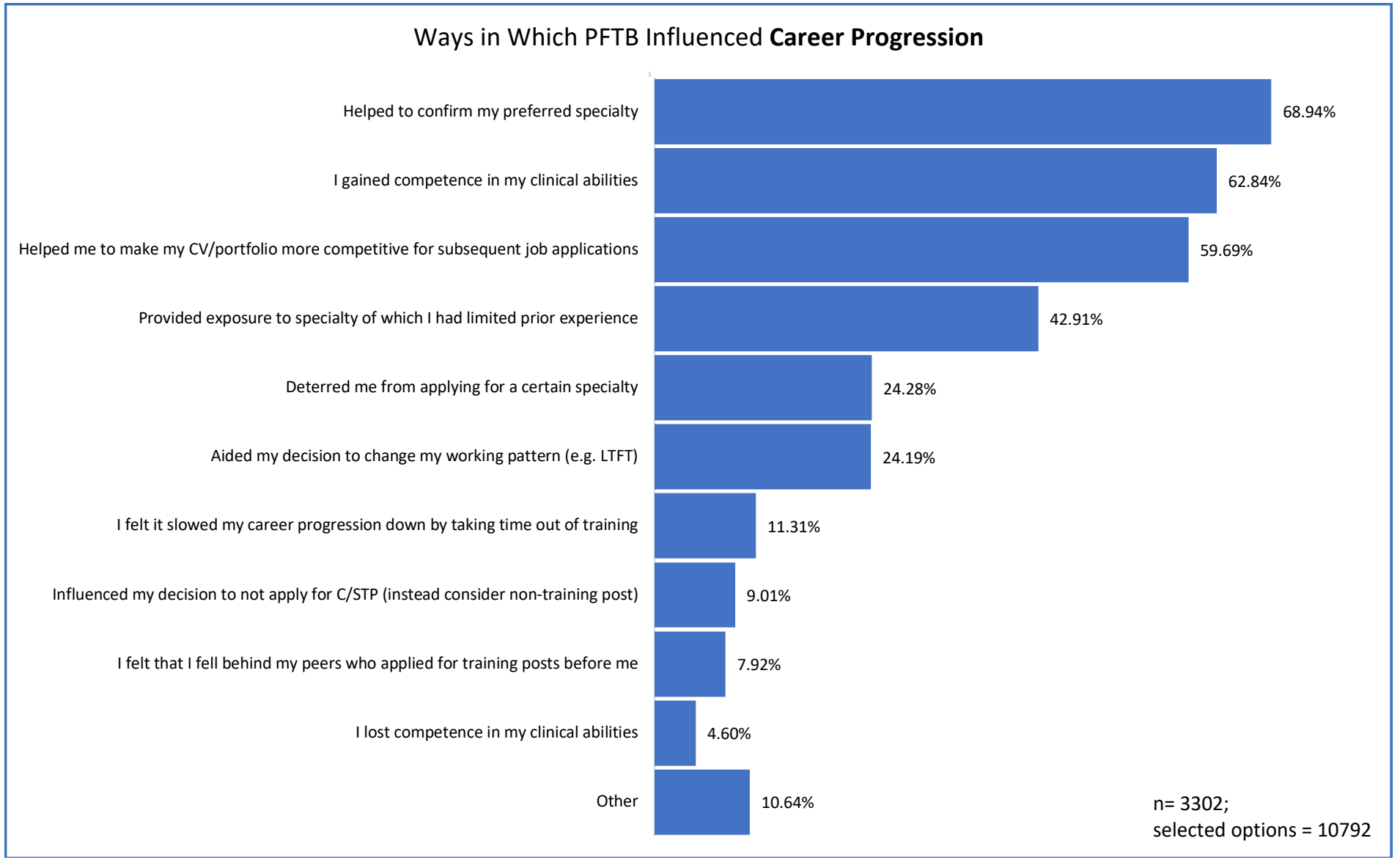

Figure 14: Chart to show ways in which PFTB influenced career progression (Figures shown are percentage of respondents agreeing with each statement)

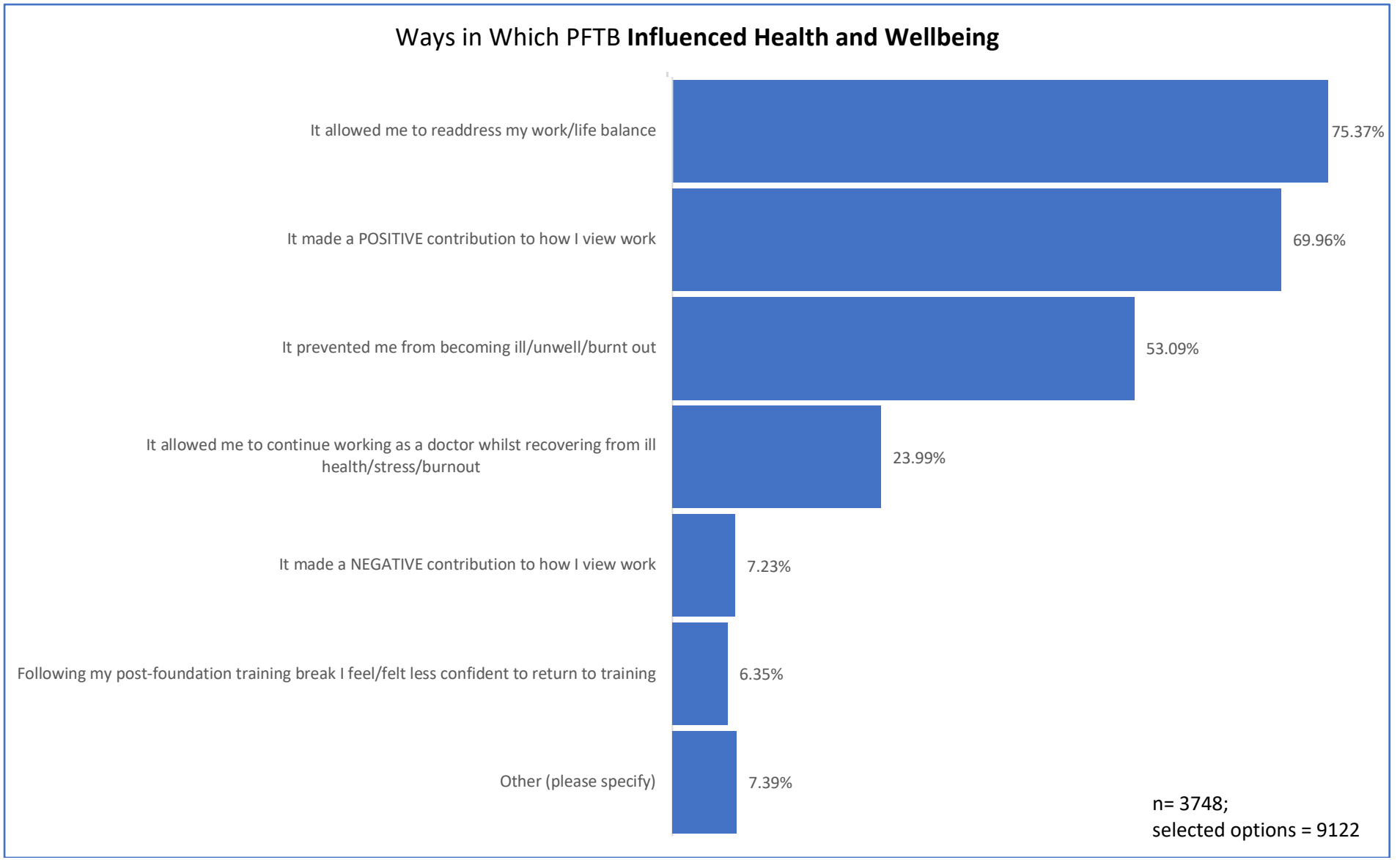

Figure 15: Chart to show ways in which PFTB influenced health and wellbeing (Figures shown are the percentage of respondents agreeing with each statement)

Career Progression	*"Slowed down my career progression' - in terms of grade but overall I gained more experience so this is a positive - theres no need to race to the finish line."*
	"Aided my decision to leave the medical profession."
	"Gave me passion for medicine again!"
	"Gained so much wider experience and so many skills I still use today. Also helped with confidence. Helped with interviews"
	"Gained certain clinical abilities in a specialized role however deskilled in clinical abilities with regards to general medicine "
Health and Wellbeing	*"Allowed me to pursue hobbies and travel with less constraints than those whilst working in the nhs/ training program"*
	"Allowed me to spend quality time with my son and start speciality training in a new region with time to settle in"
	"It left me feeling jaded about the application process and how futile "working well" is v.s. having a shiny CV full of bells and whistles and through having connections."
	"It showed me importance of flexibility and support in training"
	"Overall positive but did increase stress on return"

Figure 16: Comments within "other" influences on career progression and health and wellbeing

Figure 14 shows that the most common ways in which career progression was influenced included the positive outcomes of confirmation of specialty choice, improving clinical ability and boosting one's CV for future job applications. Interestingly, almost one quarter of respondents said that they had been deterred from applying to a certain specialty through their PFTB experience, which could be viewed as either a positive or negative outcome, depending on whether they found another specialty that they preferred/felt better suited to. This theme of 'career exploration' was popular, with over 40% of respondents agreeing that their PFTB allowed them to experience specialties to which they had prior exposure during their undergraduate and/or FP training. There were some negative influences on career progression for the minority – slowing career progression down, feeling that they 'fell behind' their cohort of peers, and losing clinical competencies were concerns for 11%, 8% and 6% of respondents, respectively.

Just as the majority of PFTB influences on career progression appears to be positive, Figure 15 also shows a majority of positive outcomes pertaining to health and wellbeing. Readdressing work/life balance was an outcome for over 75%, with almost 70% also agreeing that the PFTB contributed to a more positive view of their work. Over half of the respondents who said that the PFTB influenced their health and wellbeing felt that it had prevented them from becoming ill or suffering from burn-out, whilst almost a quarter used their PFTB to recover from prior illness/stress or burnout. However, not all respondents felt

so positive about their PFTB, with 7% stating that it made a negative contribution to the way they viewed their work, and 5% were left feeling less confident about returning to training.

3.1.5.2 Motivations and Influence of PFTB on Career Progression and Health and Wellbeing

As the majority of previous research exploring the PFTB phenomena only states *motivations for,* and not *outcomes of,* the PFTB, it is difficult to ascertain whether these motivations are fulfilled. Therefore, a Chi-squared test of independence was conducted to investigate whether doctors who were motivated to take a PFTB based on career progression or health and wellbeing were more likely to report a strong influence on that outcome following their PFTB. Data from Figure 5 and Figure 13 were initially cross-tabulated, as shown in Table 11.

Motivation for PFTB			Influence of the PFTB				*Total*
			Did not influence	Slight influence	Strong influence	Don't know/Not applicable	
Was **CAREER EXPLORATION** a motivating factor?	Yes	Frequency	224	621	1970	157	*2972*
		Percentage	7.5%	20.9%	66.3%	5.3%	*100.0%*
	No	Frequency	257	267	370	56	*950*
		Percentage	27.1%	28.1%	38.9%	5.9%	*100.0%*
	Total		*481*	*888*	*2340*	*213*	*3922*
Was **HEALTH AND WELLBEING** a motivating factor?	Yes	Frequency	40	435	2639	29	*3143*
		Percentage	1.3%	13.8%	84.0%	0.9%	*100.0%*
	No	Frequency	159	249	322	43	*773*
		Percentage	20.6%	32.2%	41.7%	5.6%	*100.0%*
	Total		199	684	2961	72	3916

Table 11: Crosstabulation of whether (a) Career Progression and (b) Health and Wellbeing were motivating factors for PFTB, and the PFTB's impact on these factors

There were significant relationships between both

- taking a PFTB for career progression and the PFTB having an influence on career progression, X^2 (3, N = 3922) = 330.761, p < 0.001, and
- taking a PFTB to improve health and wellbeing and the PFTB having an influence on health and well-being, X^2 (3, N = 3916) = 794.011, p = <0.001.

Participants who were motivated to take a PFTB based on career progression or health and wellbeing were more likely to report a strong influence on that outcome following their PFTB (66.3% and 84.0%, respectively). Interestingly, the majority of respondents who did *not* take a PFTB for the above motivations also reported strong influences of their PFTB on career and health and wellbeing (38.9% and 41.7%, respectively). The direction of 'influence' is not known to be 'positive' or 'negative' in these cases, and whilst it is important not to make assumptions, the data in Figure 14 and Figure 15 demonstrate that respondents overwhelmingly agreed with more positive than negative outcomes from their PFTB pertaining to career profession and health and wellbeing.

3.1.4.2 Influence on Knowledge, Skills and Attitudes

Participants were asked whether their PFTB had 'enhanced' the domains listed within the GMC Outcomes for Graduates document [3]. Results are illustrated for each major Outcome in Figure 17, Figure 18 and Figure 19.

Participants reported a more positive impact of their PFTB on domains within the first two Outcomes of 'Professional Values and Behaviours', and 'Professional Skills'. The third Outcome, 'Professional Knowledge', received more neutral responses. Of note, the most domains which respondents agreed with the most (over 75%) included 'dealing with complexity and uncertainty', 'leadership and teamworking', 'communication and interpersonal skills' and 'diagnosis and medical management'.

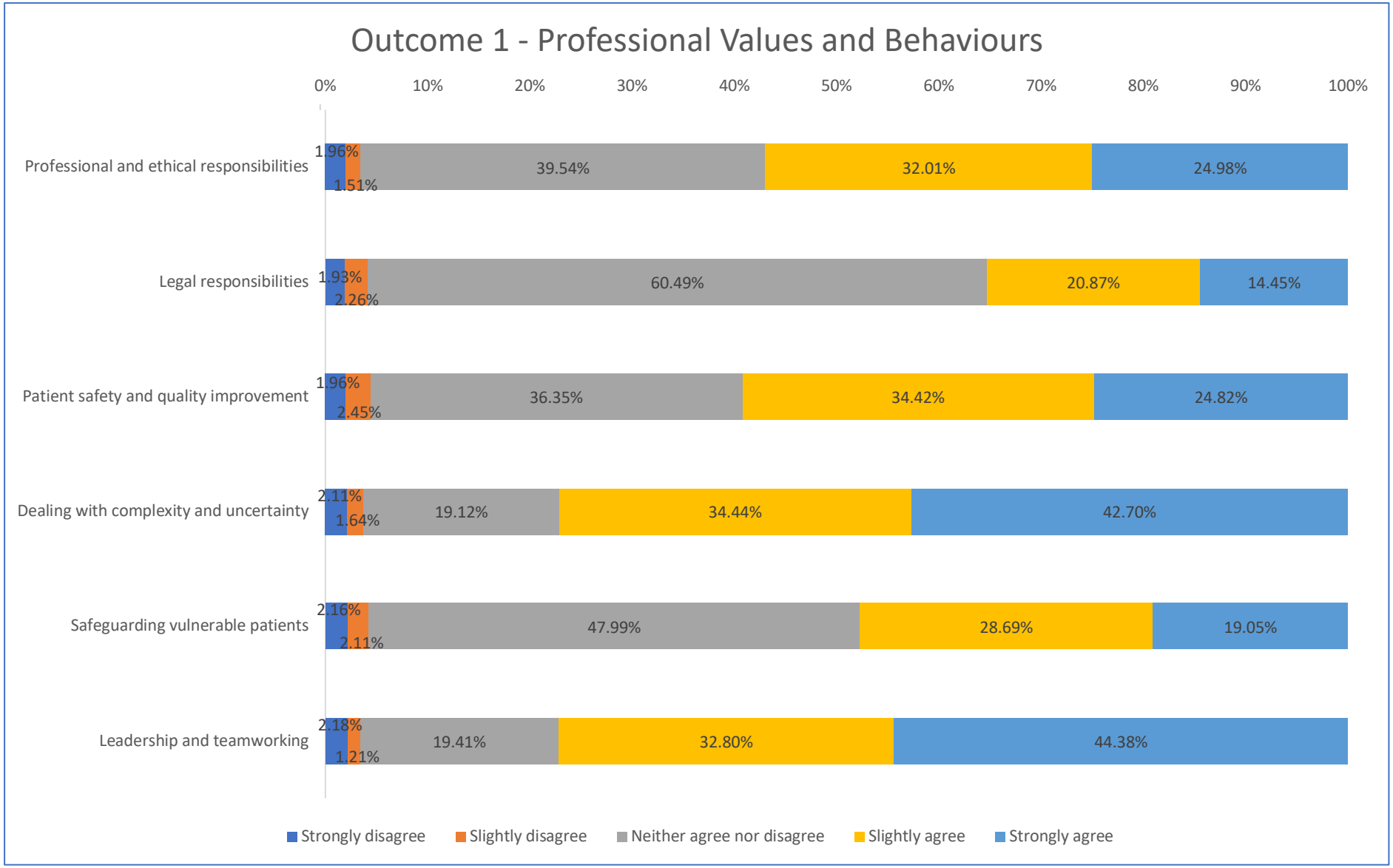

Figure 17: PFTB effect on domains listed in Outcomes for Graduates [3] Outcome 1: Professional Values and Behaviours

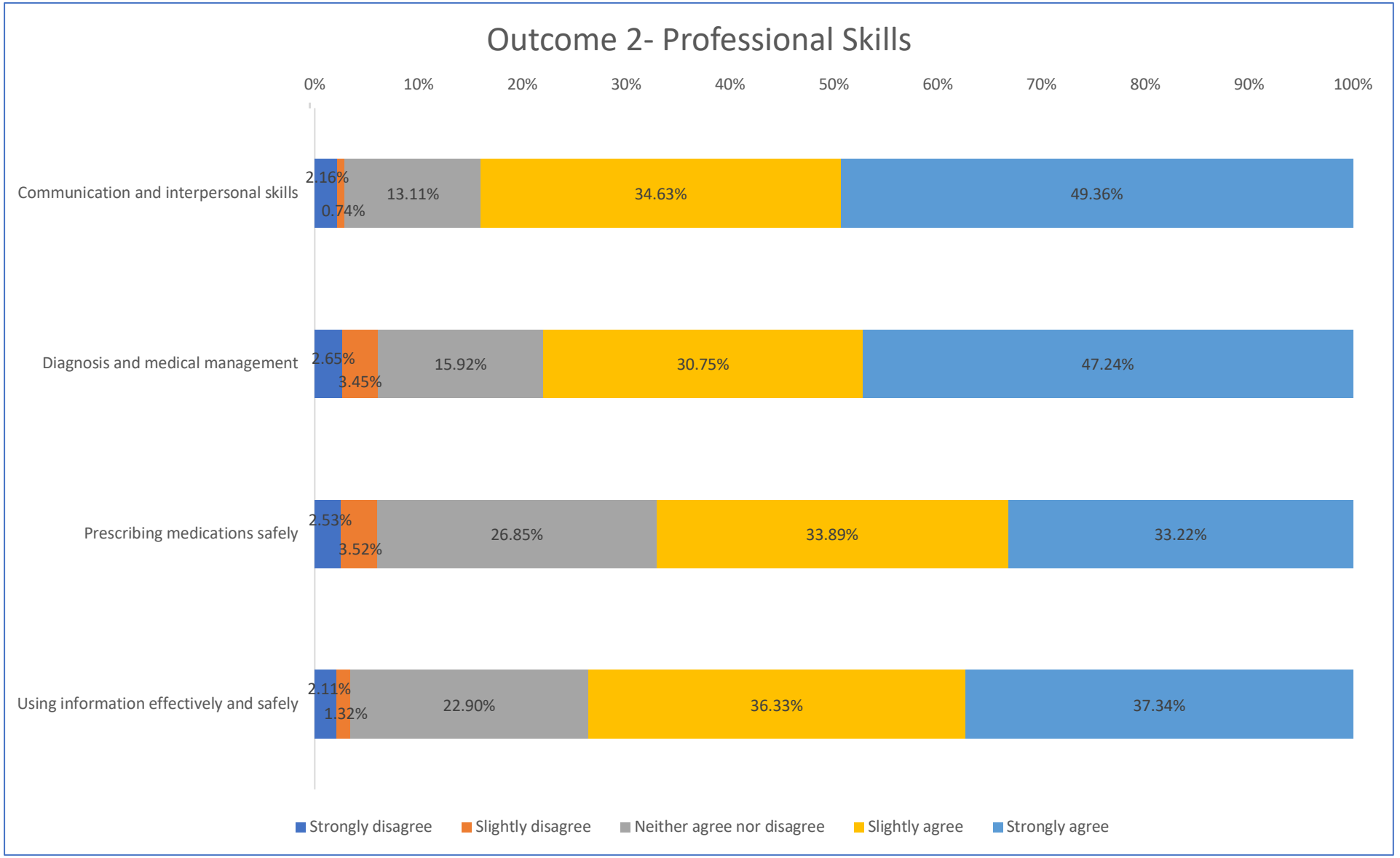

Figure 18: PFTB effect on domains listed in Outcomes for Graduates [3] Outcome 2: Professional Skills

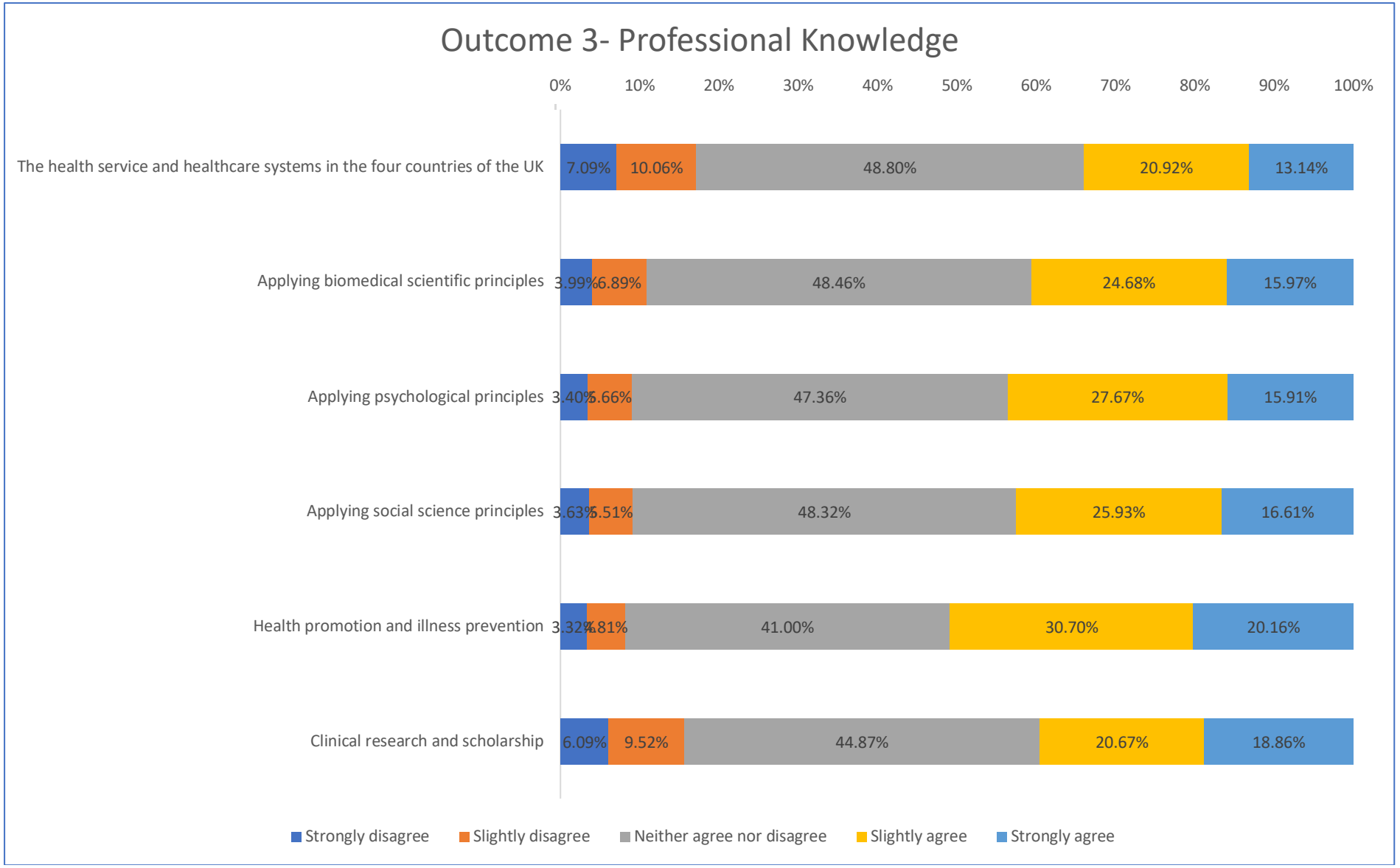

Figure 19: PFTB effect on domains listed in Outcomes for Graduates [3] Outcome 3: Professional Knowledge

3.1.4.3 Influence on Work post-PFTB

The experiences within the PFTB are likely to influence doctors' subsequent training and career pathways. For example, doctors may experience a more flexible approach to their working patterns and take time to consider their future career specialties and pathways- either within a C/STP, a non-training grade or leaving the profession entirely.

Of the participants who completed their PFTB, 96% continue to work as doctors, the majority of whom are in C/STP posts (76%). 6% work in an Associate Specialist/Staff Grade role out with the training programme at either Registrar or Consultant level whilst 14% have completed their training and are now Consultants or General Practitioners. 4% of respondents selected the 'Other' category, and went on to list roles such as Clinical Teaching and Research Fellows, Locum doctors, Trust level doctors working at 'SHO' (Senior House Officer) level and working abroad either within, or out-with a training programme.

104 participants stated that following completion of their PFTB, they were no longer working as doctors. Of these, only 14 went on to clarify their current working status; 6 were not currently working, 5 were employed in a non-clinical role related to medicine, 2 were employed in a role unrelated to medicine and one selected 'other' without further elaboration.

During a PFTB doctors may choose to take a more flexible approach to their working patterns, with some choosing to work less than full time (LTFT). To investigate whether the PFTB had a long-term effect on working pattern, participants who had completed their PFTB [8] were asked if they now worked LTFT and whether their PFTB had directly influenced this decision.

Of all the doctors who had completed their PFTB (and were at different stages of training) 28% now worked LTFT and of these, one-third said that this decision was influenced by their PFTB experience. they now worked full time.

Whilst it is difficult to obtain an exact number of LTFT doctors within the UK across all training and non-training stages (including Consultants, GPs, staff grades etc), according to the GMC State of Medical Education and Practice in the UK 2021 report, 15% of trainees now work LTFT.[5] Our data shows that 25% of respondents who are currently in a C/STP work less than full time post-PFTB (n=471), and of those 34% (n=159) said that their PFTB had contributed towards this decision.

Similarly, the PFTB might have allowed some doctors to reflect on whether they wished to continue working within the medical profession; 26% of respondents had left, or were considering leaving medicine, of which just under half (44%) stated that their PFTB experience had contributed to that decision.

Our survey data revealed that 10% of participants who completed their PFTB then started a C/STP and subsequently changed to a different C/STP (e.g., began Anaesthetics training, then resigned, and successfully applied to begin Psychiatry training). To contextualise this finding,

[8] Participants who declared that their PFTB was still ongoing were excluded, as were non-respondents.

this seems lower than the general population, with one recent poll revealed that one-fifth of physicians have changed their specialty at least once [4] .

95% of participants (n=3928) would recommend taking a PFTB to other doctors. 4% were unsure as to whether they would recommend the PFTB, whilst only 1% would not recommend the PFTB to others.

3.2 Workstream 2

Workstream 2 included semi-structured interviews of current and recent (within last 5 years) FP Directors and Heads of School. Sixteen participants were interviewed, varying by current (and past) FP roles and geographical working location (see Table 12).

Table 12: Workstream 2 Participant Demographics

Demographic	Description and Number	Frequency
Foundation Training Programme Role*	Foundation Training Programme Director (FTPD)	6
	Deputy Foundation School Director	1
	Foundation School Director	7
	Associate Post-Graduate Dean for Foundation Training	2
UK Nation in which currently working	England	9
	Northern Ireland	1
	Scotland	5
	Wales	1

* or most recent role if no longer held

Quotes have been used verbatim. Where participants used the term "F3", this may be considered equivalent to 'PFTB'.

Five key themes were identified, each with a set of sub-themes which collectively summarise the results of the second workstream of the study. Each theme is described in the remainder of this chapter, with illustrative data extracts.

3.2.1 Theme 1: Motivations for PFTB

Figure 20 illustrates the Medical Educators' views regarding the reasons why junior doctors take a PFTB. These are presented as three sub-themes- *Past Experiences*, *Present State* and *Future Plans*.

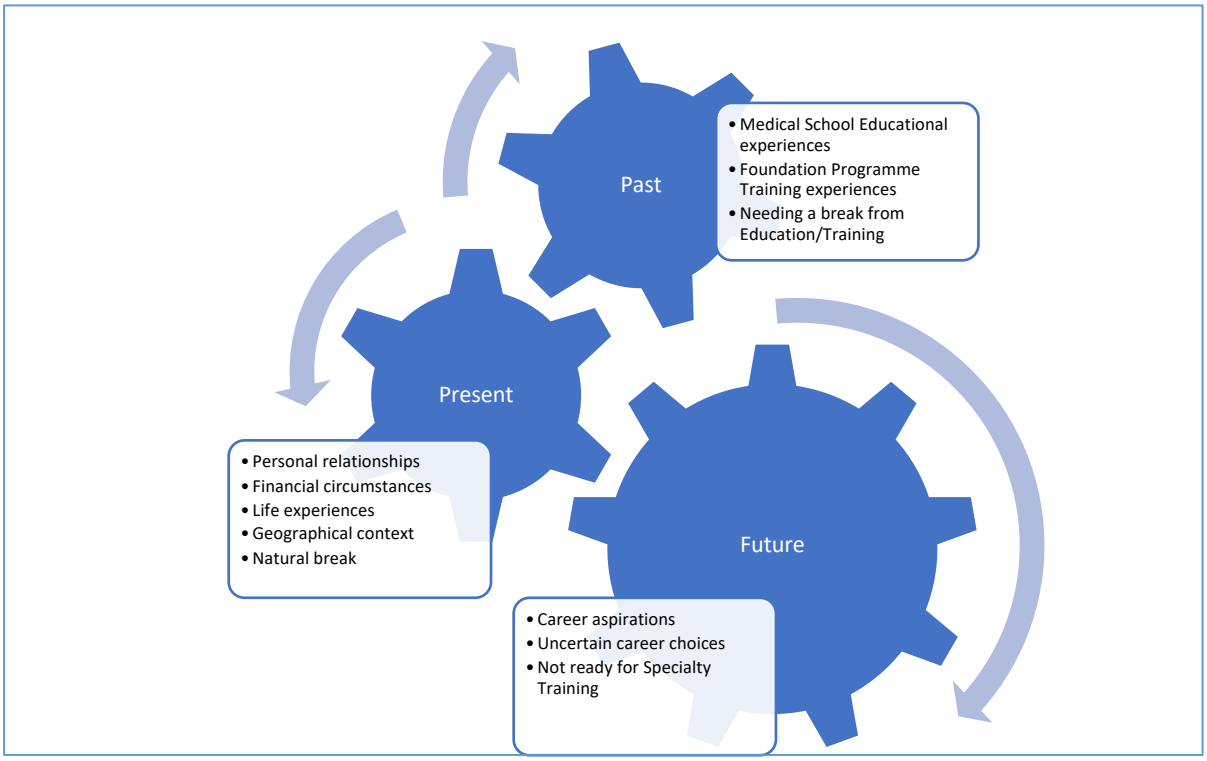

Figure 20: **Theme 1 – Motivations for PFTB**

3.2.1.1 Past Experiences

Several participants recognised motivations for a PFTB as being linked to prior educational experiences. Several participants referenced the educational journey of the majority of medical students who enter medical school immediately after leaving school or college having been on "*…a hamster wheel. And they've been in continual formal education from the age of four. Up to the age of 23…"* (WS2_11).

Some participants considered medical schools as a contributor to the PFTB trend, both through the *"burden of assessment, professionalism, achievement and constant scrutiny"* [WS2_8] within medical schools, and the standard of undergraduate education provided:

> *"[Medical schools] are not producing graduates who understand how the human body works (...) And if you actually knew how the body worked, you wouldn't feel as anxious, and therefore you probably wouldn't feel as fried at the end of the day and you would feel more satisfied in your work"* (WS2_12).

Many participants also identified that the FP was a driver for the PTFB, referencing the need to step off the 'treadmill' of training (WS2_16). Some articulated this as "*They [doctors] just want to sit and breathe"* (WS2_9) whereas others explained that doctors *need* a break, to gain some "*recovery time, I think from two very tough years"* (WS2_5).

3.2.1.2 Present State

This subtheme focussed mainly on the natural break between FP and C/STP as an opportunity to take a break (from the aforementioned treadmill) and take their career in a new direction or to another geographical location:

> *"…they [doctors] really value the freedom. Freedom of choice. Freedom to do what they want. Freedom to go where they want, freedom to pursue what's of interest. Freedom to go abroad if they want to. Freedom from e-portfolios for a year"* (WS2_13)

Working or travelling recreationally outside the UK was frequently described. However, the COVID-19 pandemic's effect on the ability to travel resonated differently between the participants: Some explained that *"…more of them have opted to go onto specialty [training]"* (WS2_2), whilst others felt that:

> *"…the necessity from trainees' perspectives to have that F3 concept type of year remained as strong as it ever did -perhaps more so for those F1s currently in the system who have really felt the impact of COVID, both [in] their final undergraduate and [in] their first foundation year."* [WS2_1].

The PTFB was seen to allow doctors to readdress work/life balance through *"a better rota, more control and more flexibility"* (WS2_3) and to accommodate life events such as "*get married and have a honeymoon afterwards"* (WS2_2) which seem more difficult to achieve during a training programme.

Some PFTB jobs, particularly locum posts, can provide opportunities to earn more money than C/STP posts, which might be an incentive for doctors, particularly those with personal loans to repay following graduation from university:

> "*…medical school is more expensive in the sense that, you know there are tuition fees and it's more I think it's more about the cost of living these days as you know (…) the cost of just being at university's a lot more and you're doing it for five years (…) It's not that you're not well paid when you graduate, you know the money has kept up with inflation and so forth but I can see people do have probably have a debt they want to pay off so, and that's only gradually got worse, hasn't it?"* (WS2_12)

Given the wide areas covered by Deaneries in which C/STP trainees can be placed for their rotations, some doctors are motivated to take PFTB for geographical reasons relating to relationships and family ties:

> *"…training programs [are] slightly unsympathetic to young couples and often one of them will go into a training program and the other one will do an FY3"* (WS2_8)

Simply by virtue of being between two training programmes, the PFTB is considered *"a natural break"* (WS2_1), particularly when doctors at this early stage of their career might not have the financial commitments of *"hefty mortgage and a couple of children keeping you at work"* (WS2_13).

3.2.1.3 Future Plans

Participants categorised the use of a PFTB to steer doctors' career pathways into three groups: The first were doctors with career aspirations in competitive specialties, where *"…it's quite tough to complete two years of foundation and be ready with a competitive application"* (WS2_14). Doctors would take a PFTB to *"gain knowledge of (…) the recruitment process"* (WS2_2), *"…gain some more experience"* (WS2_14), and *"build a CV that's going to make them more likely to be successful for a specialty application*" (WS2_5).

Conversely, some participants explained that there might be misunderstandings about the level of competition for C/STP posts:

> *"I don't know if this is a perception or reality. They all feel the need to have the first part of their exam done before they apply because lots of their contemporaries do. They also feel that they need to take an extra surgical-type post for their applications so they will seek out surgical type standalone posts*" (W2_8)

The second group were those who considered themselves "*not ready for the [core/specialty] training programme intensity"* (WS2_8), which in-part resonated with the idea of a recovery period following the FP, confounded for some by the effects of working through the COVID-19 pandemic.

The third group, most commonly referenced by participants, highlighted doctors who *"aren't 100% sure about what they want to do"* (WS2_14), for whom the PFTB afforded them *"a bit more time to decide"* (WS2_10) and *"gives them options to try different specialties"* (WS2_8), before they *"commit to a specialty programme which then takes them four to seven years to complete."* (WS2_14).

Participants explained that the motivations behind the decision to take a PFTBs are multifactorial:

"So this isn't just about training, necessarily, it's about life choices more widely. It's about geography. It's about relationships. It's around caring responsibilities sometimes. And all of those factors fit into the mix." (WS2_1)

3.2.2 Theme 2: PFTB Posts

This theme discusses participants' perceptions of different PFTB posts and their educational attributes. As will be explored below in more detail, participants made strong associations between clinical fellow posts having a higher standard of supervision and governance, compared to ad-hoc locum posts. The pyramid in Figure 21 demonstrates how, in the educators' view, the level of support and structure surrounding governance issues such as appraisal is often dictated by the level of supervision, and that in turn, this is dependent on the type of PFTB that a doctor chooses to undertake.

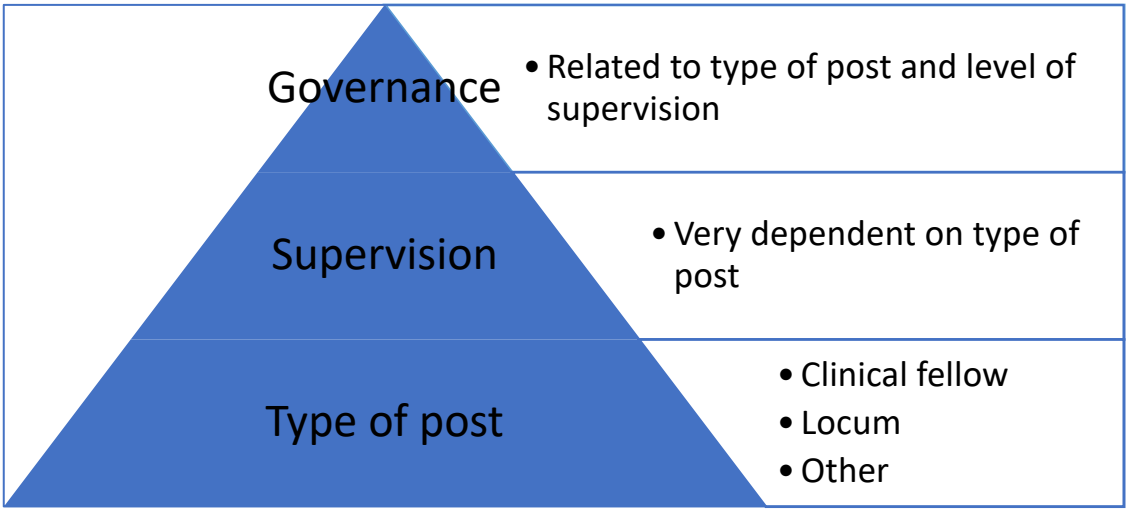

Figure 21: **Theme 2 – PFTB Posts**

3.2.2.1 Type of Post

Participants described two major styles of post: 'Clinical fellow posts' (CF posts) also referred to as 'locally employed doctor post', 'trust grade' or a 'structured non-training post', described jobs created by local Trusts on a short-term (typically 12-month) contract, often incorporating both clinical service provision and additional development opportunities; 'Locuming' referred to ad-hoc or short-term contract clinical service provision shifts. Less frequently mentioned PFTB posts included 'career breaks' where one might *"go off of the grid completely for four months"* (WS2_1).

A) Clinical Fellow-Style Posts

Participants positioned CF posts as a *"…continuation of the sort of level of F2, but maybe slightly stepping up a bit"* (WS2_14), akin to a first-year C/STP post, and are mutually

beneficial for doctors and the employing Trust: Doctors are given *"some choice of specialties"* (WS2_14) with *"a little bit of development time (…) [and] an attractive rota"* (WS2_13) and might have the opportunity to undertake "*postgraduate certificates, (…) research*" (WS2_5) or "*education or leadership or management training*" (WS2_2), where *"the vast majority of them probably get presentations that they can put on their CVs"* (WS2_2). These experiences are thought to *"give them something more to talk about at interview, added value if you like"* (WS2_6). For the Trust, the additional CFs provide a stable workforce "*because we don't have enough doctors. So, for example, in our department of 60ish trainees, 10 are clinical development fellows. If we lost those ten (...) we'd be sunk."* (WS2_13).

Furthermore, the CFs can utilise their academic experience to contribute to other services, for example they can "*take a lot of responsibility of medical students teaching and they're very committed, and they do a good job"* (WS2_4)

B) Locum Posts

Participants unanimously considered locum posts less favourable than CF posts:

> *"if you're just going to randomly locum (…) you don't have direction, you don't have mentorship and supervision, you don't have sick pay (…) they do have OH [Occupational Health] sort of with locuming but it's not the same. And I do worry about that group."* (WS2_13)

Whilst some participants appreciated that *"the flexibility and financial advantages of being a locum for many people outweigh the stability of a non-training post"* (WS2_12), they advised that doctors *"stay somewhere where you're going to have support"* (WS2_12).

3.2.2.2 Supervision and Governance

CF posts were considered to have similar supervision to C/STP trainees whereas "*if they're locuming, (…) they don't have any supervision apart from the sort of direct clinical supervision on the ward."* (WS2_10)

However, one participant felt that motivated doctors would be able to "*actively seek the mentorship and the supervision they require during that post as and when they require it*" (WS2_15)

One participant explained that governance within locum posts *"is a concern"* because *"the nature of the mechanisms by which they get their information, their data for an annual appraisal is something that's completely opaque to me"* (WS2_1).

Participants commented that Trusts often *"made sure that the training posts- that they were very similar"* (WS2_13) and that CFs are *"treated as trainees"* (WS2_4). One participant

cautioned that, given the additional development opportunities and more attractive rotas ascribed to the CF posts, *"…you have to be very careful that you don't then disadvantage the trainees"* (WS2_13).

3.2.3 Theme 3: Careers Guidance

Figure 22 illustrates the mechanisms by which doctors in their FP gain careers advice; either through information delivered within the FP and/or through self-directed learning.

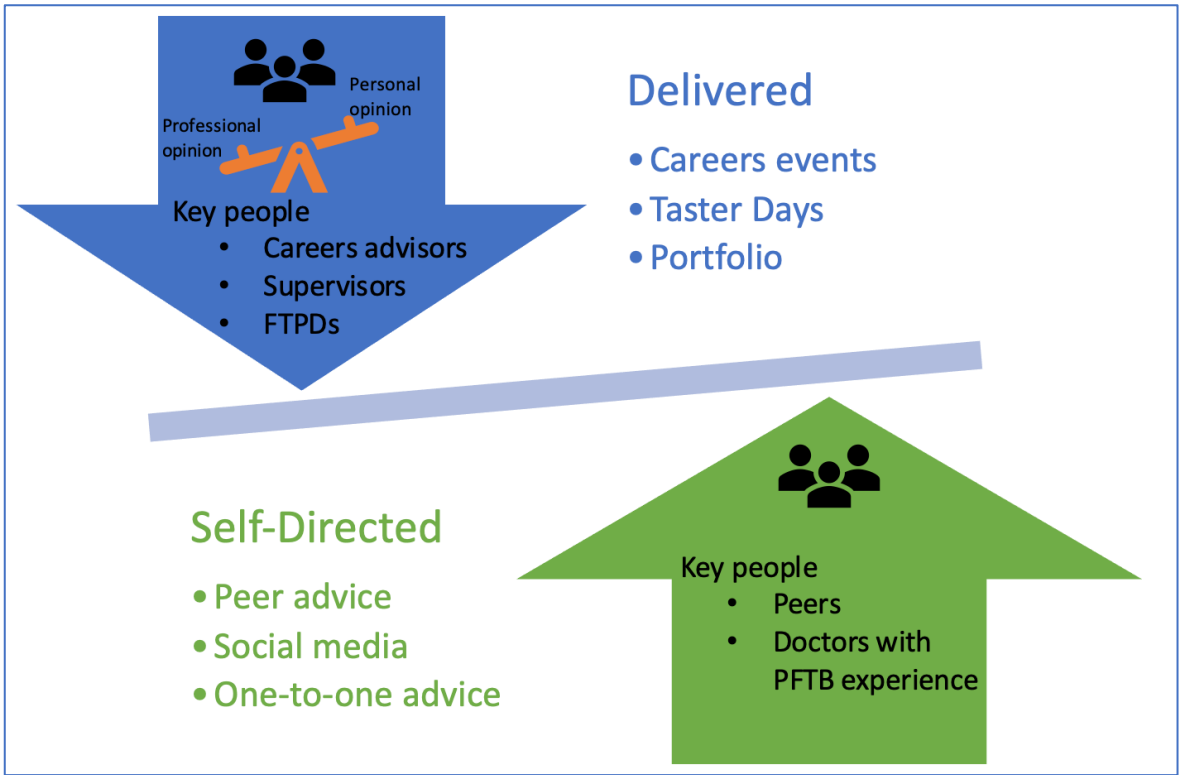

Figure 22: **Theme 3- Careers Guidance**

3.2.3.1 Delivered Careers Guidance

Almost all participants discussed the dedicated career-themed teaching sessions delivered as part of the mandatory FP education. Whilst they largely shared the overall objective to provide a generalised, broad view of careers, there were variations in the method of delivery. One example of this was in the organisation of the sessions, which ranged from *"lunchtime teaching sessions"* (WS2_10) to an entire "*regional [teaching] day*" (WS2_2).

Within these careers events, doctors would present their specialty like *"speed dating sessions where they did 5 minutes and they moved round on a sort of carousel"* (WS2_13). Due to competing clinical commitments, speakers were generally recruited through convenience and availability. Although invited primarily to represent their current C/STP specialty, serendipitously some of the speakers "*had taken an F3 year and were able to speak quite eloquently about their own experience"* (WS2_11).

Following the COVID-19 pandemic, one participant explained that a *"careers webinar for foundation doctors"* (WS2_7) was arranged instead of a face-to-face session, whilst others were unable to deliver their usual careers events.

One participant referenced the provision of careers coaching, because *"it's 2022 and I'm not really supposed to tell people what to do"* (WS2_12), as opposed to the more traditional model of careers guidance, which they described as *"….'well, I think you'd make a great surgeon. Come on, let's do it'…"(*WS2_12).

'Taster Days' allow FP doctors to undertake a day of supervised work or observation in a specialty in which they have not worked. Participants unanimously considered Taster Days a positive way to gain insight into working within a specialty and to *"demonstrate commitment to a specialty at specialty application"* (WS2_11) but cautioned that *"…they [only] give you a taste"* (WS2_9).

Key People – Delivered Careers Guidance

Clinical and educational supervisors were the most referenced 'key people' involved in the delivery of FP-provided careers guidance. They address careers both in formal supervision meetings and informal chats during clinical service.

The FPDs were also mentioned frequently but their specific input was described as being more varied, between *"organizing (…) support through the foundation school"* (WS2_9), to ad-hoc meetings where *"a few people seek me out sort of independently"* (WS2_3) to scheduled, one-to-one meetings throughout the year (WS2_10).

Careers advisors, which included the synonyms "*career tutor"* (WS2_2), "*careers champion*" (WS2_13), "*careers lead*" (WS2_5) and "*careers business manager*" (WS2_1) were other key members of the FP careers contingent. Advisors either deliver careers sessions at the Trust or could be contacted for individualised advice.

One participant reflected that not everyone has access to the same career support:

> "*…each of our trusts in our region has a careers tutor, which I had thought was a UK-wide thing. But I learned the other day that wasn't the case*" (WS2_2)

Others believed that *"…just over half of the foundation schools (…) have virtually no coordinated careers advice. (…) there's a major variation in the delivery of careers, particularly in relation to post-F2 training"* (WS2_1). In an attempt to standardise careers advice, one participant explained their Trust previously *"outsourced to an external company"* (WS2_11) before the funding was withdrawn.

Personal versus Professional Opinions

All participants spoke positively about trainees taking a PFTB. Some unreservedly supported the PFTB, whilst others articulated specific reasons for their opinion: One major driver was the recognition that doctors are required to make very early career decisions:

> *"I personally don't believe that the majority of people should be ready to go straight into anything for the rest of their lives at the end of F2."* (WS2_6)

Others recognised the need for doctors to step off the *'*treadmill of training'. One participant considered that a PFTB lasting a single year might not be sufficient:

> *"I really do agree with this timeout. I don't even agree with one year. I ideally agree with two years"* (WS2_6)

Regarding encouragement of PFTB to trainees, most participants stated that they actively promoted PTFBs to those considering it and drew parallels between their own personal experience of training prior to the introduction of Modernising Medical Careers (MMC):

> *"…to be honest with you, I encourage them to do it because in our day (…) we had the option of doing lots of standalone SHO jobs"* (WS2_10)

Participants also discussed how trainees might optimise their PFTB:

> *"I think the only advice I'm very clear about is if you're going to do it, then do it with a purpose and be prepared to explain that at a specialty interview."* (WS2_5)

A more passive approach was to neither encourage nor discourage PFTBs, but instead "*talk about the benefits of doing it [and] the precautions of knowing that (…) you're not really having a total break from personal development, reflection, portfolio use etc"* (WS2_7).

No participants said that they actively discouraged trainees from considering a PFTB.

Some participants admitted feeling "*slightly conflicted"* (WS2_9) when speaking to trainees about PFTBs:

> "*…my conflict comes from knowing what the official position is and what we should be encouraging people to be, but I don't have any qualms about telling them what I think*" (WS2_9)

Whilst no participants recalled being instructed *not to* promote the PFTB to trainees, some were "*peripherally aware of that pressure*" (WS2_5) and recalled *"informal discussions with the Dean"* (WS2_14) about the topic.

Others explained their lack of conflict came from them being *"firmly in favour of F3 knowing the data we have, that they will come back and so I see it very much as a positive"* (WS2_16). Some participants said they would "*push back against any pressure I felt because I believe so strongly that choice is the way forward*" (WS2_13).

3.2.3.2 Self-Directed Careers Guidance

This theme incorporates the ideas shared by participants around the ways in which FP doctors cultivate their own careers guidance.

Sources of self-directed careers information included websites run by the Trust (WS2_6) and Deanery (WS2_2), and organisations such as the Royal Colleges (WS2_14) and the British Medical Association (BMA) (WS2_1). Medical journals, such as the BMJ (WS2_7), and wider literature around careers (WS2_8) were also mentioned, in addition to social media as a conduit for wider peer-peer communication, and provides *"very quick, connectivity*" (WS2_8) between doctors.

Trainees also reach out for one-to-one sessions from careers advisors, or FPDs/Heads of School. FPDs, particularly in smaller Trusts, utilise informal networks between educators/clinicians to direct trainees to specialty-specific careers advice.

Key People – Self-Directed Careers Guidance

The most referenced source of careers guidance was discussion with peers, both pertaining to C/STP applications:

> *"most of it [careers advice] or actually what is useful…probably actually comes from doctors in training (…)"* (WS2_11)

And regarding provision of advice for those considering a PFTB:

> *"I feel like we don't really have to tell them because I think they just see their peers and their contemporaries and the people in the year above just applying and taking on these [PFTB] jobs"* (WS2_10)

3.2.4 Theme 4: "Product of the System"

This theme describes the participants' awareness of, and explanations for, the popularity of the PFTB. Figure 23 demonstrates the three contributors to the growing PFTB trend; trainees, their post-graduate training, and their working environment. The mirror image on the right represents the comparison of each subtheme to the educators' own training experience. These comparisons or 'reflections' will be presented alongside each major subtheme in turn.

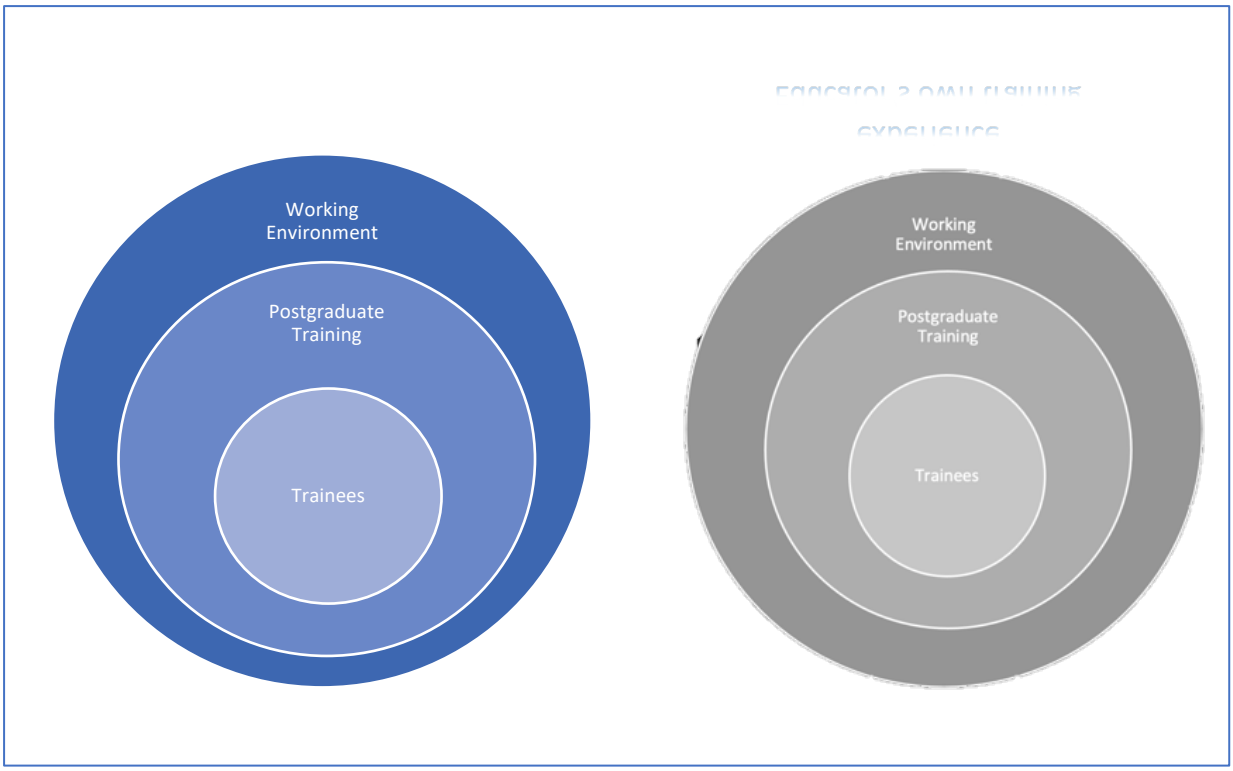

Figure 23: Theme 4- Product of the System

All participants recognised that the PTFB trend had increased over the past 10 years, whether that be from *"observation rather having actually the data"* (WS2_11), or from reading the literature, for example the "*the careers destination survey that UKFPO produce"* (WS2_1). However, the aforementioned publication has not been published since 2020, leaving participants *"not so confident about post-COVID"* (WS2_2) trends.

3.2.4.1 Trainees

Most participants could not identify difference in demographic characteristics between doctors who undertake a PFTB or immediately enter a C/STP. Two participants noticed that a PFTB is *"more likely with a UK medical school graduate than an international medical graduate"* (WS2_7) because the latter require "*a sponsor for their for visa and it was easier for them to do that if they were in a recognised training program*" (WS2_11).

Another participant added, "*people who are from some cultural backgrounds are much more likely to want to be near their sort of family home and stuff like that*" (WS2_2)

One participant observed that "*Mature students, by which I mean those have already got a degree, tend not to go for an F3"* due to a *"generational effect"* and because they have a *"very clear set career path".* (WS2_1)

Some participants identified specialties which were more predictive of taking a PFTB. One participant considered core surgical candidates more likely to take a PTFB because *"they do*

think that there isn't enough on their CV", whereas *"core medical trainees, probably less likely"* (WS2_1).

Doctors entering General Practice were deemed less likely to take a PFTB because, *"you can't do this [PFTB] in general practice"* (WS2_7) and therefore it would not be useful for career exploration.

Doctors' personality traits were also discussed in relation to the likelihood of them taking a PFTB. One such group were termed 'strugglers' described as those who have found it difficult *"being an employee"* (WS2_12) or those who are considered "*a round peg in a square hole".* (WS2_12). Expanding on the latter, the same participant explained:

> "[are] *we recruiting the right people to medical school? Is getting 3 A* the best way to pick people who will be…physically, emotionally and psychologically capable of managing the very complicated demands of being a doctor, you know it's not like being a PhD student. It's not like being a sociologist, I'm afraid" (WS2_12)*

Another participant pointed out that 'strugglers' are *"often good clinicians in a supported environment, but they fail to appreciate just what a supported environment foundation [training] is"* (WS2_3) and therefore taking an unsupported PFTB might not be wise.

One participant added "*anecdotally from my colleagues in the hospital, these [CF] posts are being filled with people of lesser quality and they're not delivering what the hospitals want them to"* (WS2_8), but another participant found the opposite: *"they often are quite competitive jobs for us (…). And so actually you get very good trainees doing it*" (WS2_9).

Educators' Personal Training Experience Reflection: *Trainees*

Generational differences between the participants and current FP trainees were highlighted as a potential driver for PFTBs. Participants felt that current trainees recognised that they *"are going to be working till they're 70*" (WS2_16) and therefore strive for a better "*work-life balance*" (WS2_6). Also, the *"lifestyle choices that people are making (…) are very different to the ones that I was making the age of 24/25 (…) People really don't want to be pinned down into a particular geography or indeed a particular specialty."* (WS2_1)

Whilst acknowledging this new focus on work-life balance, one participant highlighted that current trainees don't feel "*valued enough*" (WS2_6):

> *"There were a lot of things we did miss that maybe we shouldn't have missed, you know with family and stuff. I think it was just there wasn't an option and we didn't know any better but (…) I promise you we were a zillion times happier than all the*

junior doctors nowadays (…) you were exhausted. But you were so actually really happy after work and so valued. And so it was great. (…) And it isn't anymore" (WS2_6)

3.2.4.2 Post-graduate Training

Participants identified issues with the training programmes (both FP and C/STP) that have potentially led to the increasing trend of PFTBs.

Firstly, whilst it was acknowledged that the FP "*gives them their ability, the foundations of a of becoming a doctor*", it was criticised for not allowing specialty exploration:

> *"…they're [Foundation doctors] just ward doctors. So being a ward doctor does not explore any specialty in any specific you know any sort of bigger way really (…) they're not going to be able to really understand their specialties until they explore it a bit more. And the only way they can do that is with more time in those specialties. Hence, an F3 post*" (WS2_15)

Secondly, the PFTB falling between the two formal FP and C/STP programmes (or 'groups' as refered to below) has established a narrative surrounding responsibility for the rise in PTFB popularity:

> "*But each group [FP or C/STP] doesn't like to be criticized or perceived as being criticized by another group. So I think the IMT* [Internal Medical Training] *group feel, 'you're not doing your job getting foundation doctors as trained up good enough well enough to feel competent, confident to do our job'. And actually the foundation group feel 'well actually the IMT job is singularly unattractive [to potential trainees]"* (WS2_3)

Finally, it was suggested that PTFBs might be driving competition at C/STP application because *"all the colleges, in many ways are making entry into training, competitive in a way that the only way you can get your CV up to scratch is to do a gap of some variety and work in a clinical fellow post."* (WS2_12).

Participants reinforced the idea that a PFTB might be advantageous for C/STP applications:

> *"I think the additional [PFTB] experience often makes them stand out a little bit more than people applying directly from F2. They've got a little bit more about them"* (WS2_11)

One participant added, recruiting more experienced doctors for C/STP posts is also *"a big positive for the employing group, whatever specialty or GP that might be" (WS_16).*

However, participants were keen to stress that a PFTB is not mandatory to gain a C/STP post and were concerned that trainees might be misinformed about the need to take a PFTB.

Educators' Personal Training Experience Reflection: *Post-graduate Training*

Parallels were frequently drawn between the educator's own post-graduate training experience and the current post-graduate training structure. Participants suggested that the reduction in working hours, compounded by the need to make a career choice so early, made the PFTB movement inevitable:

> *"we've cut down time with European Working Time Directive and (…) the amount of time they spend in training has reduced and that inevitably reduces the time where you acquire skills, but not just skills, experience."* (WS2_14)

In addition, the C/STP *"in relation to flexibility and training and less than full time training opportunities, breaks and supported return to work (…) clearly isn't fitting the bill for the majority of trainees."* (WS2_1)

Despite this, most participants felt that the FP *did* adequately support career decision making because *"they get to experience six different specialties"* (WS2_10), in addition to career sessions, taster days and access to careers advisors. Several participants counter-argued that four months in a specialty is *"…no time at all to be able to understand what they want to do*" (WS2_15) and that due to the C/STP application launch date, trainees "*don't really have two years' time, they have one year and four months*" (WS2_4), meaning that they *"…have to make a decision quite early on without maybe even experiencing the specialty that they want to do"* (WS2_10).

One participant took the view that the FP is meant to be "*generic*" (WS2_5) and is helpful to "*narrow down*" (WS2_9) career choices.

3.2.4.3 Working Environment

The current working environment was considered a contributor to the increase in the PFTB trend:

> *"the reduction in hours in my mind resulted in a loss of lot of unknown benefits of working as a team for long hours together. And I think we've never resolved that-we design rotas to make the system function, but with no sense of impact on the well-being and the structure and the whole of the of the doctor working (…) and increasingly to make the rota work each tier of the rota has a slightly different number of people in it, has a different rotation in every angle. It's a bit like those games where everything goes into different direction, nothing lines up*." (WS2_3)

In agreement with this, another participant expanded on current morale within the NHS:

> "*Resilience in the NHS is at an all time low. Everybody is fed up and exhausted. (...) the general public who were immensely supportive at the beginning of COVID have run out of empathy. But the what's happened is this the staff…the nurses, the doctors, the healthcare support workers, everybody in the NHS is working harder than ever, but there's no there's no empathy left for everyone else. So knock on effect in terms of junior doctors is they're all fed up to the back teeth."* (WS2_13)

Educators' Personal Training Experience Reflection: Working Environment

Without prompt, every participant highlighted the similarities between the PFTB and their own, more positive, experiences of pre-MMC training:

> "*…this sort of F3/F4 phenomenon is a similar instance of actually people picking and choosing what they wanted to do a little bit and maintaining-keeping their options open*." (WS2_11)

Participants overwhelmingly resonated with the idea that the PFTB was recreating the "*lost tribe*" [9] (WS2_11) of doctors, (although many participants opposed the term 'lost') and that the introduction of the MMC *"basically developed a sausage machine for medical training and you basically went it in at one end and you got spat out the other end with no break in between"* (WS2_16). Another added "*[the] idea that everyone would just slot into a training program and five, seven years later to come out the other end as a specialist on the register was a bit naïve*" (WS2_7).

3.2.5 Theme 5: Future Challenges

Theme 5 discusses the issues that educators raised pertaining to future challenges for postgraduate training with reference to the PFTB movement. Figure 24 illustrates the four major future challenges of training which educators highlighted and their positioning within the different stages of medical training.

[9] The 'lost tribe' refers to the cohort of Senior House Officers who, prior to the introduction of the MMC, were perceived to be undecided and reluctant to enter C/STPs. They would move between 6-12 month rotations in different specialties, often over a period of many years, before entering into formal training (or gaining accreditation from their accumulated clinical experience) to complete training in a specific specialty.

Subthemes				
Careers advice				
Flexibility				
Curriculum				
Embracing PFTBs				

Figure 24: Theme 5- Future Challenges

3.2.5.1 Careers Advice

Participants acknowledged challenges to providing careers advice regarding PFTBs, including the potential conflict between their personal opinions and their professional role, and uncertainties regarding *how* to provide accurate advice on PFTBs given the wide variety of activities and opportunities undertaken. National careers advice was considered "*uncoordinated and there isn't really a strong push to make it coordinated."* (WS2_1)

Generally, participants agreed that *"it's well known amongst the trainee cohort what the options are*" but considered more could be done to *"make sure that in a career advice session you cover working abroad because there are pitfalls and working in the UK as a clinical fellow and non-training post"* (WS2_16).

One participant suggested the need to emphasise to trainees "*how to organize your F3 or F4 time most appropriately".* (WS2_11). To do this, participants agreed that more needs to be known about the PFTB to aide both doctors and educators, and perhaps careers guidance could be more standardised and coordinated through *"virtual working (…) at a national level"* (WS2_7).

Educators expressed the view that more careers support earlier on in doctors' training could be provided, with one participant proposing that it should begin at Medical School *"at least years 3/4 and 5. Ideally year 2."* (WS2_1)

Finally, one participant advocated for less *"formal career advice",* and more "*word of mouth, role models, you know, knowing somebody inspirational - so all of the sort of traditional things, because careers advice can be incredibly complex"* (WS2_16).

3.2.5.2 Flexibility

The concept of flexibility spanned the FP and C/STP, as well as the PFTB itself.

Whilst acknowledging that, logistically "*it's not easy*" (WS2_4), one participant championed the idea that when assigning FP rotations, *"*[trainees'] *interest should be considered"* (WS2_4)

to allow more bespoke or personalised rotations to enhance career exploration before entering a C/STP.

Other participants advocated for more flexibility in working hours, whereby *"for a sizable minority working five days a week is just not good for them."* (WS2_12) and explained the introduction of a new initiative for Foundation trainees commencing in 2023 whereby "*one post will be 80% if they [trainees] want it."* (WS2_12).

Tackling C/STP inflexibility due to financial constraints was a priority for some:

> *"We don't have the flexibility of starting a training program in one area and easily move into another area at the same level of training. (…) I would try and allow the money to flow with the trainee rather than the money to stick with the post"* (WS2_1)

Participants emphasised the need to maintain flexibility within the PFTB, referring to current training programmes as a "*straitjacket*" (WS2_16), hence their support for the PFTB to be a *"free for all, which maybe sounds a bit under-structured but the individual gets to choose"* (WS2_16). Others agreed with this sentiment:

> "*if you formalize it too much, then you create the very conditions that some of these people are looking to escape from"* (WS2_9)

Additionally, for trainees who wanted to immediately enter a C/STP after their FP, extending the FP by a year and incorporating a mandatory 'PFTB-style' post would be *"hampering them and slowing them down on a career path that they were already committed to.*" (WS2_11)

3.2.5.3 Curriculum

The current FP curriculum divided the participants, with some considering that the organisation of rotations "*…allows people to experience learning in different environments"* and even working within placements not directly aligned to future careers "*…will have helped you in a way that you may not recognize"* (WS2_12).

Others suggested changing the FP organisation, but these were never considered the 'ideal' solution: For example, the recommendation that *"F2 maybe should be six months and two different posts"* (WS2_15) would provide more experience in a specialty but would decrease the variety of specialties experienced across the FP.

Some participants advocated for some of the FP portfolio requirements to be reviewed and removed which were *"quite onerous"* and yet failed to produce "*any extra benefit."* (WS2_10). Another participant noted that, within the curriculum, trainees are not encouraged to reflect on their careers enough:

> *"I think getting them to reflect on actually 'I've decided this is a job. How does this make me feel as a job?' (…) Because that's the ultimate thing that's going to decide them, from a jobs or career or lifelong perspective is how does each thing make you feel?"* (WS2_9)

3.2.5.4 Embracing the PFTB

Participants were keen to reframe the perception of PFTBs as being a 'problem' to "*Seeing it as a…phenomenon that needs supporting*" (WS2_9). Participants justified this due to the reassurance that *"about 90% of a graduate cohort (…) three years down the line, they're back in UK medicine. (…)"* (WS2_16) and therefore considered that by supporting those who take a PFTB, *"then they're likely to come back (…) happier, well rounded, rested, non-burnt-out doctors"* (WS2_9).

Participants felt it important to "*recognize that we're talking about adults and (…) empower them to make the choice*" (WS2_13), and *"…not just think of it as a default option. But think of it as a 'this is my positive step that I'm doing'*." (WS2_9).

Despite the support for the PFTB itself, one of the contentious issues was the use of the term 'Foundation Year 3' or 'F3', for short:

> "*…my preference would be that we move away from calling it F3 (…) because it actually has nothing to do with (…) the foundation program*" (WS2_13)

Many participants agreed with this comment, saying that they "*hate the term*" (WS2_8) because it *"implies that I've got some sort of responsibility or oversight"* (WS_12) regarding supervision, governance and educational content of PTFB posts.

Despite not having official oversight *during* the PTFB, participants suggested ways to support doctors preparing for a PTFB and ensure their return to practice was smooth: A common concern was that some doctors undertaking PFTBs don't assume responsibility *"in relation to keeping their registration"* (WS2_12) and would "*drift on through and not really achieving anything in the long run and then you end up with discontented people who probably leave medicine*." (WS2_9). One suggestion was to alert trainees to *"resources available to them (…) for instance Horus [e-portfolio] is open for non-training grade doctors at F3 level."* (WS2_9).

Other suggestions for support *during* the PFTB included *"…a national standardized contract"* which would include entitlement to "s*tudy leave (…) and a study leave budget (…) just as you would with a locally employed doctor"* (WS_11).

For the Trusts creating these posts,*"…having some national or at least Deanery and regional guidance about the sort of posts that would support trainees into training"* (WS2_5) was also suggested. Furthermore, *"… if you're going to give us F3s, give us loads of extra staff to look after them!"* (WS2_6)

Of course, striving for "*slightly more formalized SHO-type post with some element of education*" (WS2_8) threatens the balance between autonomy and governance.

Participants also suggested more transparency from the Royal Colleges pertaining to "*how an F3 year is viewed"* (WS2_5) by recruiters for C/STPs across different specialties. Trainees must understand that simply taking a PFTB is *"not like a guaranteed route*" (WS2_4) into C/STP but depends on how they utilised their PFTB.

Participants generally agreed that "*all experience is good experience*" (WS2_12) and would be supportive of *"a system where they can take up posts that are recognized for training but not part of the formal training program as a positive thing"* (WS2_14). One participant viewed the PFTB as *"…not time out training per se, because (…) that continues, but out of formal training".* (WS2_14)

3.3 Workstream 3

Workstream 3 included semi-structured interviews of current and recent (within last 5 years) doctors involved in recruitment to any medical or surgical specialty that recruited for C/ST year 1 entry. 21 participants were interviewed for Workstream 3, varying by both experience and responsibility (e.g., assessing written applications, long/short listing, standard setting and conducting interviews) within C/STP recruitment (see Table 13). Due to their involvement with recruitment for an extended period, many had witnessed its evolution from a localised activity to a highly centralised national system.

Table 13: Workstream 3 Participant Demographics

Demographic	Description and Number	Frequency
C/STP Recruitment Role*	Short-lister Interviewer Both	0 14 7
UK Nation in which currently working	England Northern Ireland Scotland Wales	16 0 5 0
Specialty for which participant recruits	Anaesthetics Core Medical Training / Internal Medical Training General Practice Paediatrics Psychiatry Acute Care Common Stem (ACCS) Obstetrics & Gynaecology	2 6 1 4 1 5 2

* or previous role if no longer held

Despite recruitment efforts to ensure representation from all four nations (see Methodology section for details), no participants from Northern Ireland or Wales volunteered to take part in this workstream of the study.

Three key themes were identified, each with a set of sub-themes which collectively summarise the results of the third workstream of the study. Each theme is described in the remainder of this chapter, with illustrative data extracts.

3.3.1 Theme 1: Knowledge and experience of the PFTB phenomenon

Figure 25 illustrates the first theme, which encompasses participants' understanding of the PFTB year, including awareness of trends in the popularity of the phenomenon. There was some variation in personal opinions of the PFTB, including reasons for its increasing popularity, although participants were overwhelmingly supportive of PFTB as a career choice. Despite several reservations about the PFTB, the positive benefits of taking a PFTB were considered to far outweigh the negative.

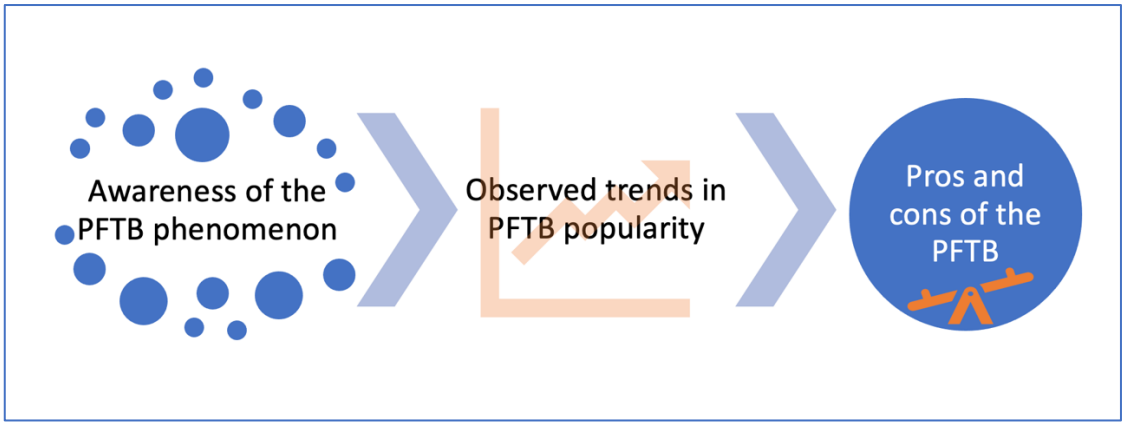

Figure 25: Theme 1: Knowledge and experience of the PFTB phenomenon

3.3.1.1 Awareness of the PFTB phenomenon

Participants articulated widespread awareness of the PFTB, with the majority having encountered it through clinical and/or training as well as recruitment roles. There was considerable overlap in perceptions of the motivations behind taking a PFTB and why it was an increasingly popular career decision:

> *"…there are several reasons they do that. One is to take a break from the training that they're having. One of the other reasons I've heard is that they tend to want to get more experience of the specialty they want to go into. Thirdly, if they've got any social issues going on or they've got mental health issues, they want a bit of a break from the shift work that they are obliged to do as a part of a contract. And I guess also for some of them it is better pay for them if they are locums as opposed to being in a contract in the NHS."* (WS3_01)

Others highlighted the element of career uncertainty that trainees might feel, and the role of the PFTB in helping to address this: *"They don't know perhaps exactly what specialty they want to do so, they decide they want a bit more time, so they will choose something that interests them".* (WS3_02) The same participant also acknowledged the desire for some doctors to create a break in their training where they are "*not working quite so hard, just pausing with all the training and exams. Maybe to go travelling*".

Participants considered augmenting the FP experience to be better informed and prepared to enter a C/STP worthwhile. Modernising Medical Careers (MMC) was often referenced negatively regarding its impact upon career flexibility with too great an emphasis on 'herding' trainees through the system and onto the specialist register which left little opportunity for them to fully explore career options. The PFTB was seen as a manifestation of doctors "*reinventing what used to go on many, many years ago, before the Modernising Medical Careers thing came along"* (WS3_03) to wrestle back a degree of control over their professional and personal lives, where:

> "*Getting that breadth of experience in all specialties and learning what you do like, what you don't like (…) is really important before you commit to whatever it is for the rest of your life."* (WS3_03)

Others highlighted that doctors may wish to explore different countries and healthcare systems which might offer a more flexible approach to training, similar to their own training experiences:

> *"…a lot of them will take the opportunity to do an F3 here in the UK or just as likely or maybe even more likely go abroad and go to Australia, New Zealand or somewhere like that. (…) So they get to do what we used to be able to do as HO [House Officer] which was just job-hop for a year or two, just to dip your feet in the water and that would not be viewed as a negative thing back then whereas you know the whole Modernising Medical Careers drive was to get people to consultants quicker*." (WS3_04)

Despite being aware of the increasing trend of the PFTB, *"I read in things like the BMJ that it's now up to about 50% and it certainly feels like that when we recruit."* (WS3_05), participants could see the benefits to the doctors and the care they deliver to patients:

> *"We want doctors who are well-rounded. Getting through training fast is of absolutely no consequence whatsoever other than either the government or GMC believing that people should train in the shortest time possible. It is fundamentally a very good thing for doctors to do all sorts of things which makes them better rounded clinicians, better competent doctors, and I see absolutely nothing wrong with it [PFTB]."* (WS3_06)

3.3.1.2 Observed trends in PFTB popularity

Participants did not identify many demographic characteristics that were specifically associated with increased likelihood of undertaking an PFTB, except for individuals from graduate-entry medicine programmes. Rather, the decision to take an PFTB was seen to be based on more generalisable factors, and often incorporated *"…a variety of reasons"* including *"…(1) because they haven't got into their program of choice; (2) because they want*

to travel, and (3) because they just want more time to kind of work out what it is they want to do." (WS3_02)

Participants acknowledged that PFTB trends might have been affected by the COVID-19 pandemic:

> *"I know some people work quite hard for six months and then go abroad for six months. Obviously, during the pandemic that was more difficult."* (WS3_07)

Participants perceived that FP doctors were deciding to take a PFTB to attain the de facto level of competence necessary to successfully gain entry to C/STP training. Several participants articulated that FP trainees perceived a C/STP post as too difficult to achieve without additional knowledge, skills and experience. PFTB was also thought to be viewed as a means of enabling the development of greater confidence to do well at interview and optimise performance in training.

> *"I think there's a culture, and peer pressure. They all feel probably 'I'm not good enough' or something. We have variations in specialty as well. Initially getting into medicine was not a problem (…) and now things are getting harder to get into CMT training [Core Medical Training] and things. So that's why some of my trainees, who are very focused to get into medicine but couldn't get it, they went out to do an F3 year- build up the CV to apply for CMT."* (WS3_08)

In many respects, participants described PFTB as a self-fulfilling prophecy, with an ever-increasing number of FP doctors taking a PFTB to maximise their competitiveness when applying for C/STPs:

> *"…the quality of the candidates, certainly at the last round was astonishing. And they were really, really good. I felt quite humbled by a lot of them, actually, and it made me realise that the trainees who've only done F1 and F2 will find it difficult to be competitive against those who've done F1/F2, run a marathon, climbed Kilimanjaro, volunteered for Mother Theresa and also done an F3 year in ITU [Intensive Care Medicine] or neonatal Paed[iatric]s or something like that, whilst learning to juggle."* (WS3_09)

Even the *perception* of increased competition at C/STP recruitment through comparing oneself with peers encourages the PFTB to become a self-fulfilling prophecy:

> *"So there's quite a bit of peer pressure goes on where people, and it's the classic doctor, I think, impostor syndrome, where they all think that everyone else is so much better than them and that they're just not ready to go into specialist training."* (WS3_16)

Participants suggested that the growth in the PFTB phenomenon was also driven by a pragmatic response to wider societal changes. Delayed retirement and related access to pensions, and the increasing challenge of the *"impossibility to afford a down payment on a mortgage and (…) get on the housing ladder*" (WS3_05) were influencing decisions around training breaks:

> *"…So they're going, 'you know, your careers until your age 68. Do you really want to come out of Med school and spend two years slogging and then another six years?' 'Great. I'm 31 and now I know exactly what I'm going to do for the rest of my life and think actually that's 37 years of work'. No chance. It's unrealistic."* (WS3_10)

3.3.1.3 Pros and Cons of the PFTB

Many participants highlighted that the flexibility provided by the PFTB was so important because neither medical school nor the FP could provide the full range of workplace-based experiential learning that could fully inform specialty career choice before making a definite career choice:

> "*We can't possibly give people all the experiences they need in medical school. Medical school experiences are not the same. It's not the same to work in an area as to study an area*." (WS3_06)

Despite the participants understanding the motivations for a PFTB, a common concern was that PFTB posts were not part of a formal programme and therefore individual posts differed markedly in terms of quality. It was suggested that quality assurance mechanisms needed to be enhanced:

> "*[F3] is a way of talking about it, but I think it papers over some of the cracks I've alluded to, that they're not in a contract, they are in a specialty doctor contract and it doesn't come with the luxuries, if you like, of exception reports. And I suppose you lack a certain amount of protection that trainees have as well."* (WS3_11)

Participants were clear that "*when it's [PFTB] just kind of rambling around unsupervised then I don't think it is educationally good or much value really. And there's probably a few governance issues in there as well*", instead calling for posts to *have "good quality supervision (…) a good education and training"* (WS3_05) to maximise the benefit of the training break.

As clinicians, participants also reflected on how doctors working in PFTB posts provided an invaluable contribution to service provision, particularly when doctors secured posts in Trusts where they had worked as F2s. One participant referred to PFTB doctors as "*a bit of the glue in the team"* (WS3_04) where they supplied continuity and organisational memory in a way that more rapidly rotating FP doctors could not:

> *"…they're generally, an incredibly valuable part of the workforce because they're almost like a junior middle grade. In some ways, they're people that know what's going on, they know how it works, they can supervise the F1s and F2s to some extent. And so they've become a very useful resource."* (WS3_02)

Regions with specific recruitment challenges, especially rural areas, were thought to particularly benefit from the PFTB phenomenon:

> *"In rural areas we are not so well catered for in terms of training grade doctors (…) we have to run our hospital on 50% of trainees and the other 50% (…) so I look very favourably at doctors who we can employ as Clinical Fellow or a Locum Appointment Service post…. We couldn't run our rotas if it wasn't for these doctors and (…) I think rural areas would really struggle if we did not have F3."* (WS3_12)

3.3.2 Theme 2: Perception of PFTB in relation to specialty recruitment application process

The second theme explores how participants perceive the influence of PFTB on the C/STP recruitment process (Figure 26). There was a dominant narrative surrounding the recruitment process where differences between FP trainees and PFTB applicants were *not* taken into account and should have no bearing on decision-making when offering posts. However, a counter-narrative was identified, which suggested that the additional knowledge, skills and experience gained during the PFTB year could indeed secure additional marks for an applicant at the interview stage.

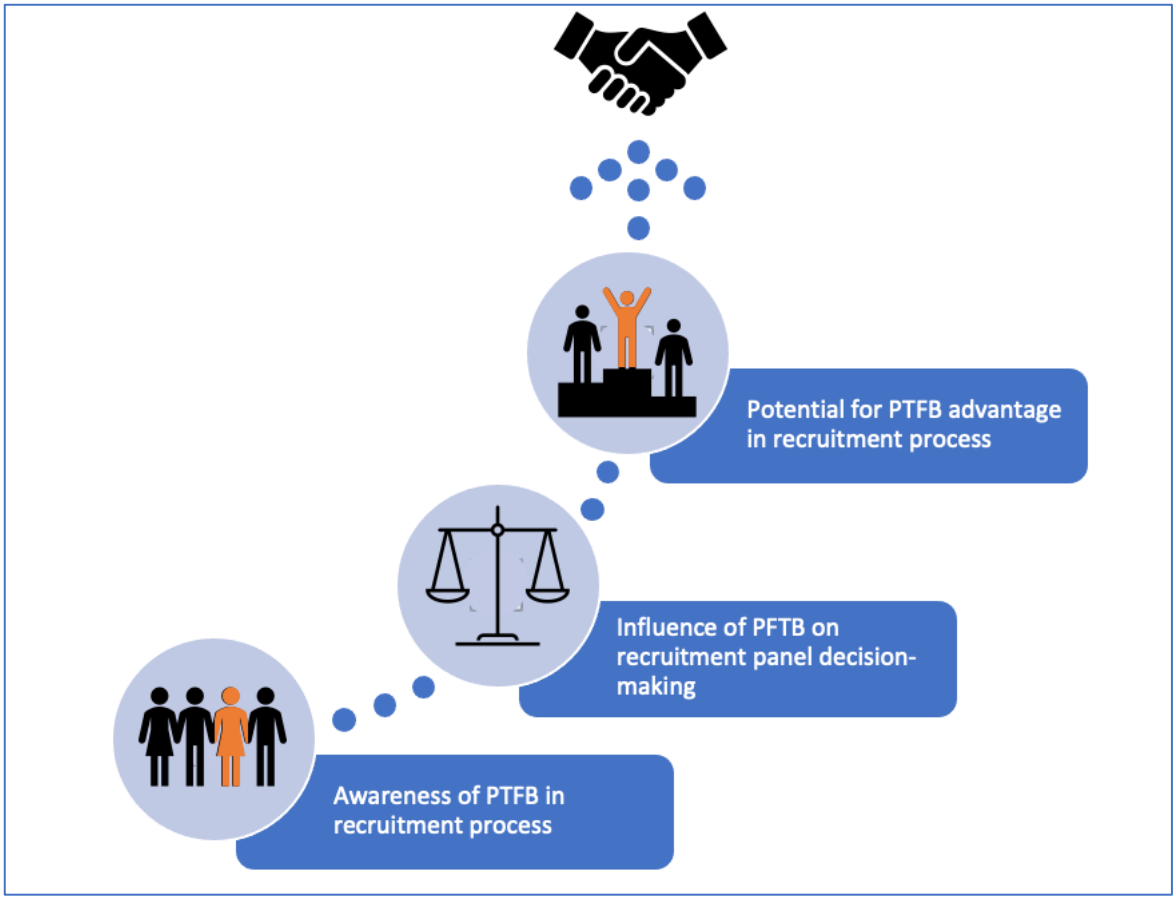

Figure 26: Theme 2: Perception of PFTB in relation to specialty recruitment application process

3.3.2.1 Awareness of PFTB in recruitment process

Almost all specialty recruiters stated that they were not made explicitly aware of whether applicants had PFTB experience. For some, it would be alluded to in the application form in terms of "*what posts they're doing and their present post*" (WS3_03) and further elaborated during interview. Whilst for other specialties, one participant explained "*don't see the application forms*" (WS3_09) and would only be aware of applicants' PFTB experience incidentally "*as a result of our questioning.*"

For the latter, certain recruitment interview questions were identified as those most likely to invite applicants to differentiate themselves as having undertaken a PFTB:

> "*One question we always ask is why this specialty or something around commitment to the speciality. When we ask this question invariably people talk about their F3 years.*" (WS3_08)

There was variation between specialties regarding their recruitment processes; some reported using selection centres whilst the majority had adopted Multi-Specialty Recruitment Assessment (MSRA) scores exclusively, or in combination with online interviews. One

participant explained that the use of face-to-face multiple-mini-interviews is likely to be a thing of the past:

> *"There's been quite a lot published recently looking at the predictive value of MSRA scores. Even though selection centres were initially stopped because of the pandemic, it would be one of those things that would be very difficult to restart, first because it didn't add much to the process and also because it was very costly and actually labour intensive. (…) I think, over the years, MSRA has been refined and we have much more knowledge of it as an assessment method (…) and I'm comfortable that it does the job it's intended to"* (WS3_07)

3.3.2.2 Influence of PFTB on recruitment panel decision-making

The overriding perception was that the recruitment process was fair and had been designed to enable all applicants who met the eligibility criteria to have an equal chance at success:

> *"Sometimes they'll have gained very similar experience in F1 and F2. You know, it's not a done deal that, just because they've only done F1 and F2, they haven't got as good an experience as somebody who's done F3".* (WS3_09)

For specialties who recruit entirely based on MRSA scores, taking PFTB experience into account is less possible because *"…the entire thing is MSRA score. There's no portfolio, there is no interview"* (WS3_13) and that *"MSRA scores correlate much better to people passing their final CT ARCP more than portfolios or interviews actually added".*

For specialties who still conduct interviews, participants acknowledged the potential implicit bias in favour of doctors who had undertaken a PFTB "*does demonstrate a certain commitment to the specialty, so that probably does enter your head when you're scoring these people although as I say it's a pretty objective marking structure*" (WS3_02).

3.3.2.3 Potential for PFTB advantage in recruitment process

Many participants recalled differences in C/STP application standards between PFTB and FP trainees. Additional experience and demonstration of commitment to specialty were highlighted:

> "*…they've done, generally a job which has time set aside for doing audits or research or courses or things like that. So they generally will score higher in this section that gives you points for having clinical experience and then they generally have a little higher score in research or audit.*" (WS3_11)

The PFTB was also alluded to as demonstrating non-clinical skills, comparable to other qualifications:

> *"…it certainly demonstrates commitment and personal organizational skills, and all of those other personal skills really, really well. You don't have to have an additional degree to be able to demonstrate them.*" (WS3_09)

Many participants gave shared conflicting stances on whether the PFTB might offer an advantage at C/STP application. Participants maintained that *"It's pretty objective, the interview. I mean you ask a question and they answer it and you are scoring. It's a pretty rigid marking structure, so if they answer the question they get the marks. If they don't, they don't get the marks"* (WS3_02).

However, they also acknowledged that certain questions were likely to afford those with extra clinical experience an inherent advantage:

> "*One of them was around the future of emergency medicine. I think as a general rule, I guess, the more emergency medicine you've done, so if you've done an F3 job, you probably answer that question maybe slightly better just because you're a bit more mature, you've got another year of experience. So there's potentially a slight advantage there*." (WS3_02)

Particular stages of the application process which might advantage PFTBs over FP trainees were identified, in particular the written application and portfolio, when assessed:

> "*…one station where we go through the portfolio and the structure, things invariably where those with F3 year, they have more time to do work on their teaching or leadership skills or work, you know, they can be a bit more focused. And also they have more time to prepare for the interview. So they tend to do better*." (WS3_08)

Potential differences between PFTB and FP trainees' applications, and the opportunity to enhance the application, do not appear to be *explicitly* taken into consideration within C/STP recruitment processes:

> "*I don't think I would want to weight applications towards people having done an F3 because that does then slightly bias against the very committed person who has worked really, really hard and knows what they want to do. (…) I think it suits people to have done an F3 year, but equally if somebody very motivated to get those criteria ticked off, then I think they can do it."* (WS3_04)

Some participants explained how applicants who have not undertaken a PFTB can utilise their FP experience to answer application questions:

> *"…say they were supposed to give an example of a difficult communication. I wouldn't necessarily look at whether that was a paediatric focus communication or an adult communication with end of life care, for instance. I think those generic skills are there, whether you've got a specialty example or not"* (WS3_01)

However, other participants acknowledged that, whilst not impossible, the C/STP application eligibility criteria (particularly the desirable criteria) might be easier to achieve for an PFTB doctor compared to even the most dedicated FP trainee:

> *"I think there are some stellar foundation trainees there who are able to do all sorts of things. (…) But certainly, if you've done an F3 you've probably got a slightly better chance of ticking all the boxes I suspect."* (WS3_04)

3.3.3 Theme 3: Preparedness for specialty training

The third theme includes perceptions of careers support made available to doctors in preparing for C/STP applications, including variance in infrastructure and provision at national, regional and local levels (Figure 27).

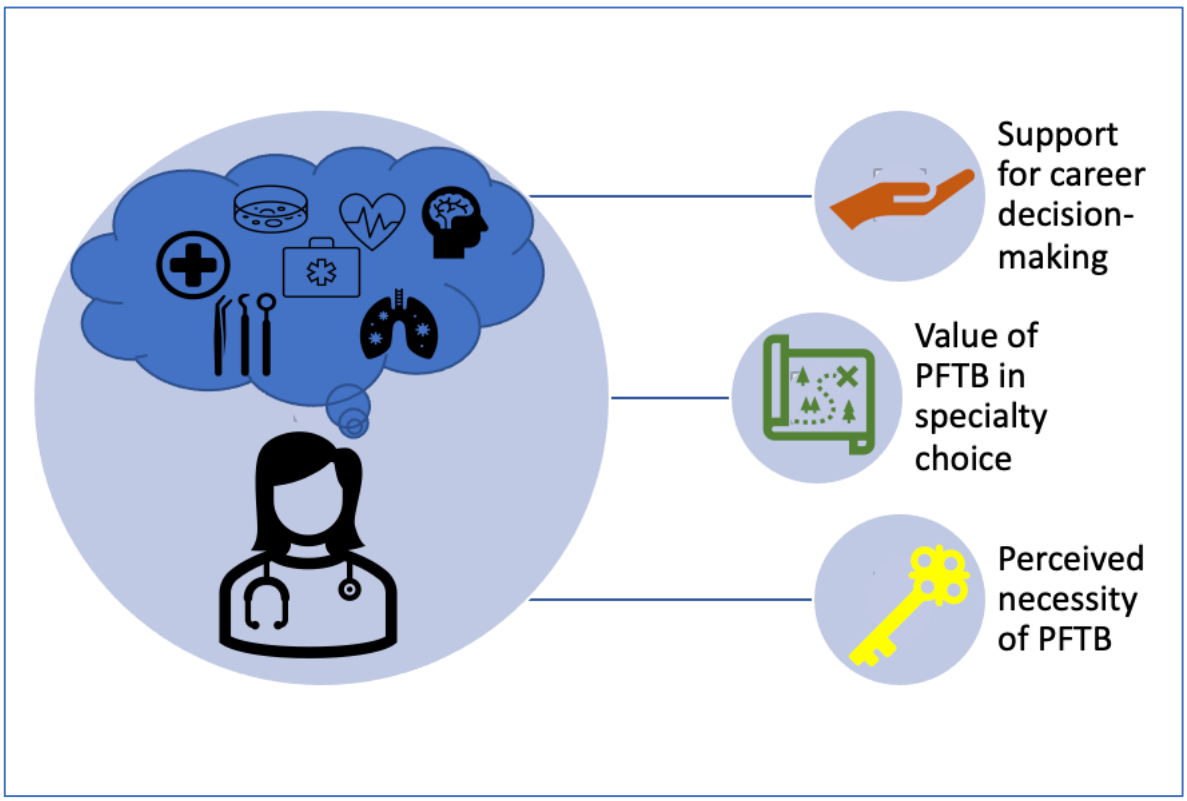

Figure 27: Theme 3: Preparedness for specialty training

3.3.3.1 Support for career decision-making

Drawing on their experience of being both recruiters and educators, participants acknowledged considerable disparity in the degree of careers support made available for FP

trainees across the nations and regions. The majority agreed that sustained provision of careers support required sufficient resource but was "*absolutely essential*" (WS3_14). Several participants argued for change 'downstream' in medical schools and the FP to aide recruitment at postgraduate level:

> *"I would like to see medical schools taking a kind of weighting, the amount of time that the students spend in various specialties. And so giving the medical students more exposure to anaesthesia so that they get a better feel for it at an early stage. I think after that actually, it would be nice to see a few more F1/F2 jobs in critical care, because I think that could encourage a few more trainees into our specialty, but actually out of it as well. You know, if they've realised that it's not for them."* (WS3_09)

The highly structured nature of postgraduate training was highlighted on numerous occasions as impeding informed career decision-making. Lack of flexibility was, at least in part, driving the increasing prevalence of PFTB:

> *"We've almost gone too far away from the old system where people used to vaguely drift about, 'the lost tribe' as it was called. That probably wasn't right but I'm not sure this is quite right either. It's almost too early (…) You're still pretty young to be making that decision as to which career you're going to follow, whereas people of my generation, we had the luxury of two or three years of just trying to find their groove."* (WS3_02)

Many acknowledged the value of the PFTB in offering "*a degree of flexibility that suits a variety of different people"* (WS3_02). Indeed, the idea making the PFTB a formalised part of the postgraduate medical training system was viewed by most as a retrograde step:

> *"…forcing [doctors] into F3 posts I think would be the wrong way forward. I think that perfectly capable people come in from F2 and should be allowed to do that if they so wish."* (WS3_17)

3.3.3.2 Value of PFTB in specialty choice

The general consensus was that PFTB provided considerable benefit in affirming C/STP choice:

> "*…by the time the F3s come to apply for ACCS [Acute Care Common Stem], they are much more motivated. They know what they want to do, they tend to come across much better at interview because they've taken a bit of extra time, they're absolutely sure is what they want to do. (…) They've got the knowledge, they've got the experience and they're defending their decisions. They're often much more, come across as much more committed and convincing."* (WS3_03)

Given that 'commitment to specialty' is assessed within recruitment application criteria for all C/STPs, this may highlight another potential disadvantage to doctors wishing to enter C/STP immediately post-FP:

> "*It does make it difficult for F2s because you might only have done four months of Emergency Medicine, and you've got to try and turn that into something convincing like 'I've done four months of Emergency Medicine and I really want to do it'. Like, really? Convince me."* (WS3_03)

PFTB was seen as beneficial, not only in relation to supporting career decision-making, but also in enabling doctors appointed to C/STP posts to establish themselves in a training programme rapidly and confidently:

> *"I wouldn't go so far as to say it was necessary. I do have doctors who have come straight from F2 and they function perfectly well but I would very much encourage any F3 coming into our specialty. (…) So having that [F3] year means that you were just starting at a slightly higher level and helps you in that big jump, in particular, when we ask our doctors to go from a junior tier rota to a middle tier rota"* (WS3_15)

3.3.3.3 Perceived necessity of PFTB

Regarding whether undertaking a PFTB is *necessary* (rather than simply helpful) for career advancement, most participants recognised that their perceptions differed from the trainees':

> *"I don't think it's necessary, but I think the junior doctors now think it's necessary. They have voted with their feet around it" (*WS3_12).

Participants reflected upon the impact of "*what your peers, your colleagues and friends are doing"* (WS3_08) on the culture and trend of the PTFB.

Despite this, some participants suggested that they would actively encourage doctors to consider taking a PFTB. Such encouragement was particularly pronounced for early-career doctors planning to apply for more competitive specialties:

> *"I think if you're a UK-trained doctor and you haven't had the opportunity of doing other things abroad when you graduated, then probably your best chances of getting in a competitive speciality like anaesthetics, it's pretty much it essential really because you've got to be able to get yourself into that 'one in seven' position really. It is good for people to have something to talk about and I think the F3 experience is the most practical way of getting yourself there.""* (WS3_05)

4. Findings

In this section of the report, we will utilise the data presented in the Results section to address the three main research questions of our study.

4.1 How does taking a PFTB affect subsequent career progression?

The two major aspects of the PFTB which affect career progression are the initial career exploration undertaken within the PFTB, prior to choosing one's preferred long-term specialty, and subsequent effects on doctors' future career.

4.1.1 Career exploration

From our survey, doctors indicated that career exploration was the fourth strongest motivator for taking a PFTB and was a stronger preference for younger doctors at the time of completing the survey.

Motivations for a PFTB are multifactorial and often intertwined; often those more obviously aligned with wellbeing or personal fulfilment, such as taking a break from the work environment or exploring a non-clinical career interest, also allows time to reflect on whether the doctor wished to continue in a clinical career. For some respondents, career progression enhancement appeared to be an unplanned outcome of their PFTB: of the 950 doctors who stated that career progression was *not* a motivation for the PFTB, two-thirds indicated that retrospectively, it did influence their career progression.

Underpinning the need for career exploration within the PFTB, both survey respondents and recruiters shared the opinion that the FP and medical schools fail to provide adequate exposure to many of the different specialties. This was considered to be a contributory factor to career uncertainty, which is compounded by the time-constraints of the C/STP applications which launch within the first few months of the second FP year. Although FPDs defended the range of opportunities available for career exploration, the overall message of having to decide one's specialty 'too soon' in one's career was clear, and at odds with their own career experiences in which they worked SHO jobs in different specialties for short-term periods to gain a range of experience before deciding on one's specialty of choice.

Most survey respondents took a PFTB for 12 months or less, and the trend in recent years was for the PFTB to be shorter, rather than longer. Whilst one FPD questioned whether this allowed *adequate* career exploration, respondents (both those who identified career progression as a specific motivator for the PFTB, and those who did not) reported a high level of impact on career progression. Perhaps, as the PFTB has become a more established movement it has provided both a rapidly-increasing pool of experiential advice from peers who have completed their own PFTB from which current FPs can draw, and the development

of more structured PFTB posts in local trusts which allow doctors to achieve their objectives within a shorter timeline.

4.1.2 Subsequent career progression

Of the survey respondents who considered their career progression to have been influenced by their PFTB, almost 70% agreed that the PFTB had helped to confirm their specialty of choice, and an additional quarter stated that it had deterred them from a specialty. In keeping with the idea of using the PFTB to explore and navigate potential career interests, over 40% felt that they gained exposure to specialties in which they had little prior experience. Approximately 60% indicated that their career progression was aided by CV/portfolio building for subsequent job applications: some respondents felt that the FP did not allow them the time or opportunity to develop their application to secure their preferred C/STP, and therefore used their PFTB to gain further qualifications and experience in both clinical and non-clinical disciplines. Whilst FPDs and recruiters rebutted the need for a PFTB for portfolio-boosting, they acknowledged the advantages for those who optimised their PFTB experience. In terms of addressing career uncertainty, only 10% of respondents subsequently began one C/STP post and then changed to a different specialty (compared to a recent poll which revealed that one-fifth of physicians have changed their specialty at least once [4]).

Just over 10% of survey respondents recognised that the PFTB slows down progression to complete training (gain CCT) in a specialty. However, given the majority of more positive outcomes reported by doctors pertaining to the effects of their PFTB on career progression, and the similar perception of the PFTB from educators and recruiters, it would appear that for most doctors, this 'extra' PFTB time is not wasted: The direct effects of the PFTB are evident in survey respondents' self-reported improved clinical skills and knowledge across the domains mapped to the GMC Outcomes for Graduates [3] standards – particularly in those areas related to 'Professional Skills'. 'Adding value' through the PFTB was echoed by the FPDs who agreed that the PFTB enabled doctors to mature as clinicians, whilst recruiters identified criteria within the specialty person specification guidance that were more readily met by PFTB doctors than their F2 counterparts. Unsurprisingly, but in contrast to previously held ideas, the PFTB should no longer be considered a 'back-up plan' for those who cannot secure a C/STP post, as almost 90% of survey respondents *chose* to take a PFTB rather than apply for/enter a C/STP.

Of those continuing to work clinically post-PFTB, the majority have returned to the traditional training pathway model despite their positive experiences outside of training. Perhaps this reflects that the PFTB served its purpose and supported the transition back into a formal training scheme, or that this route is simply the status quo.

Longer-term effects on careers were demonstrated in post-PFTB working patterns. One-quarter of respondents who were in a C/STP at the time of survey completion work less than

full time post-PFTB. This statistic exceeds the national average of 15%, as stated in the GMC Medical Education and Practice in the UK 2021 report [5] and therefore may indicate that doctors who take a PFTB might be more likely to work less than full time.

According to some of the free-text comments, some doctors who worked in a different location during their PFTB (either within or outside of the UK), articulated their appreciation of working within other healthcare systems before returning to the UK, whilst others made a more permanent move to enter specialty training in another country.

Success of a PFTB for the individual is best conveyed through the level of recommendation to others; 95% of doctors who completed our survey would recommend the PFTB to their peers and colleagues. This demonstration of the value of the PFTB for those doctors is echoed by FPDs and recruiters who overwhelmingly drew positive parallels with their own post-graduate training experience.

4.2 What are medical educators' perceptions of doctors undertaking a PFTB?

Our research highlighted a number of discussion points surrounding medical educators' perceptions of the PFTB; their understanding of the phenomenon, and how they approach the subject with trainees considering this career choice.

4.2.1 Educators' understanding of the PFTB phenomenon

FPDs and Heads of Foundation School demonstrated a thorough understanding of both the PFTB movement and its trend over the past few years, mainly through their own observations and discussions with Foundation Trainees.

FPDs and recruiters alike shared the perception that the current generation of junior doctors were often motivated to take a PFTB for their own wellbeing, and this is reflected in the survey data where the most popular responses of 'personal fulfilment', 'break from training or work environment' and 'improve health and wellbeing' have trended upwards over the past 10 years. Furthermore, our data demonstrated the trend of younger doctors preferencing the motivators connected with health and wellbeing, as opposed to doctors in the 40–49-year category for whom logistical/practical motivators were more prominent. This aligns with the 'generational' differences alluded to by the educators in which younger doctors have a greater acknowledgement and desire to achieve a better work/life balance. The NTS burnout scores demonstrated that educators were also correct in their assertions that some doctors are motivated to take a PFTB due to 'burnout', with scores at the end of each FP year being higher in those going on to take a PFTB (but only statistically significant for scores at the end

of the 1st year of FP). This result may be explained by the additional finding from our survey that, whilst most are *aware* of the option in Medical school, they *decide* to take their PFTB during their FP (perhaps when experiencing burnout).

The idea of missing out on, or difficulty with organising, life events was a common thread throughout the survey and FPTD interviews due to the perceived inflexibility of the FP and C/STP. Many assigned this to a change in generational expectations of work/life balance, particularly given the likelihood of longer working lives (for which the majority were in full support). However, others considered this a manifestation of doctors not feeling valued in their role, compounded by a lack of belonging and collegiality within the traditional 'firm'. Furthermore, for out-of-hours work, doctors within the same training level often work within a rota pattern which does not align with the rota pattern of those at more junior and senior levels; these 'hierarchical' rotas do no align to form stable teams during out of hours shifts. These too cannot foster feelings of familiarity and clinical continuity within a team, particularly during these shifts when staffing is often at its lowest, and team-working is even more important to optimising patient care

Whilst FPDs sympathised with doctors having to make their specialty choices so early in their careers and recognised that there was a significant proportion of doctors who 'didn't know what they wanted to do' after their FP, they defended the career exploration options and the programmatic organisation of the FP. This view was not shared by survey respondents, or recruiters who felt that that there was a lack of exposure to different specialties, compounded by the time-pressure associated with the launch of C/STP recruitment rounds early in FP year 2.

FPDs categorised PFTB activities into 'clinical fellow' or 'locum' posts. Whilst supportive of the PFTB as being an individualised and un-structured opportunity for doctors to enhance personal wellbeing and explore career options, they cautioned against locum work due to lack of supervision, guidance and revalidation arrangements. Clinical fellow posts were viewed as the better PFTB option by both FPDs and recruiters, not only due to the infrastructure not afforded by a locum post, but also due to service provision and value-added activities, such as contributing to teaching, quality improvement projects and department workforce stability, that these posts provide. These value-added elements of PFTB posts resonate strongly with over 75% of survey respondents who felt that their leadership skills had been enhanced during their PFTB. A small number of survey respondents reported a decline in their clinical competency and a lack of confidence to apply for a C/STP post-PFTB; these issues might demonstrate the issues raised by educators about less structured posts.

FPDs and recruiters spontaneously acknowledged their own post-graduate training experience, which resonated with the PFTB phenomenon in terms of career individualisation and exploration. The perception that the PFTB is a re-creation of the FPD's own career

pathway as pre-MMC 'Senior House Officers' may explain why they considered the PFTB a positive movement, and in the context of offering careers advice, could be considered an integral member of FP trainees' extended peer network. Educators unanimously spoke affectionately about this early stage of their own career, which seemed in direct opposition to how they perceived current junior doctors who did not seem to enjoy their postgraduate training. Survey respondents echoed similar positive messages about their own PFTB, for example almost 70% reported that the PFTB made a positive contribution to the way they viewed their work and over 50% considered it to have prevented burn out.

4.2.2 How educators approach the PFTB

Two potential challenges were uncovered pertaining to the way in which educators approach the option of the PFTB with FP trainees: (i) *how* educators can discuss the PFTB when the possibilities and range of activities that can be undertaken is so vast, and (ii) *whether* the PFTB should be discussed given their official role within the FP as part of the formal postgraduate training infrastructure.

Despite their acknowledgement of the increasing popularity of the PFTB, FPDs gave mixed responses as to whether the phenomenon is formally broached within career sessions. As demonstrated by the wide range of survey responses detailing different PFTB activities, FPD explained the difficulty in providing any specific guidance to trainees. FPD reported a lot of variation both at local trust and regional level regarding how much the PFTB option was represented during FP career sessions. Many acknowledged that it should be discussed more formally given the popularity of the phenomenon, particularly regarding the regulations surrounding maintaining a license to practice, with coordinated guidance within the regional networks, or even nationally.

FPDs often also spoke to trainees who would seek out one-to-one advice about the specialty in which the FPD worked, or in spontaneous discussion which arose organically during their day-to-day clinical work, such as during ward rounds. Although the majority of FPDs reported that they did not feel pressure from their senior colleagues in the regional HEE office to not promote the PFTB pathway (in favour of encouraging doctors into C/STPs), those who were aware of such a pressure felt more able to share their personal opinion within their clinician role, rather than when they assumed their FPD title.

Given that the majority of survey respondents stated that they made their decision to undertake a PFTB during their FP, over half could not remember discussing or receiving advice about this career decision during this time. Despite this, just over half of survey participants felt that they had adequate information to make their decision about undertaking a PFTB from other sources. This may have been in part due to the value of peer support for career advice, which was acknowledged across all three workstreams. There was a sense that the

FPDs justified not addressing the PFTB formally because the FP trainees received so much advice and information from their peers (especially those undertaking PFTBs).

4.3 Is the increasing number of doctors undertaking a PFTB year affecting subsequent training post applications?

To address this question, we will consider the data collected pertaining to both whether the PFTB is driving competition at C/STP recruitment, and the role that the PFTB may play in the diversity our of future workforce.

4.3.1 PFTB driving competition at C/STP

A conflicting message exists about the relationship between competition at C/STP application and the PFTB: Doctors undertaking a PFTB can accumulate an impressive array of clinical experience, non-clinical activities, and qualifications. Whether this was a primary motivation for the PFTB or not, almost 60% of survey respondents stated that their PFTB influenced their career progression by enhancing their CV for subsequent job applications.

There are wide variations in the recruitment systems for C/STPs in different specialties. Some specialties rely heavily or almost entirely on the MSRA examination for recruitment, allowing little opportunity in the written application (which is often used to shortlist for invitation to the MRSA examination) to demonstrate the additional skills, knowledge, experience and qualifications that a PFTB affords. General Practice and Psychiatry are examples of such specialties, with the former being of particular interest given the very few survey respondents who worked within a General Practice during their PFTB. As one recruiter asserted, taking a PFTB to explore General Practice is very difficult, as the Clinical Fellow and Locum-type posts do not exist in the same way as for secondary care-based specialties. This may explain why General Practice is not associated with the PFTB movement (57% of those who entered a General Practice training post had not undertaken a PFTB) but raises issues about how doctors might explore this career pathway prior to applying for a C/STP.

Furthermore, an interesting observation in the case of General Practice is that the proportion of PFTB doctors (8985 out of 25980) and non-PFTB doctors (11800 out of 33790) entering General Practice training was almost identical at around 35% (see Table 5). Whilst this may imply that the PFTB experience has no effect on recruitment to General Practice, without investigating the reasons behind this statistic, this can't be stated with any conviction. Possible explanations might be that doctors who eventually enter General Practice training take a PFTB for non-career progression/exploration reasons (having already planned to enter General Practice training with conviction during FT), may use the PFTB to explore (and rule-out) an alternative hospital-based specialty as a career choice or that the PFTB's work/life balance associations also align with this future career choice.

Pre-COVID pandemic, most specialties used face-to-face multi-station interviews which included time to discuss portfolios, CVs and dedication to specialty. Post-pandemic, the specialties which still utilise interviews have now adopted a condensed, online interview style. Despite this new streamlined interview system, recruiters explained that they were often aware of whether the candidate being interviewed had undertaken a PFTB, either from having access to their application form, the candidate referencing their PFTB experience when answering a question, or through more indirect hints of more advanced clinical experience beyond that expected of a FP trainee. This resonates with the survey respondents who felt that their PFTB improved their clinical skills and knowledge across the domains mapped to the GMC Outcomes for Graduates [3] standards.

The majority of recruiters explained that, if they were aware of the candidate having taken a PFTB, this was *not* taken into account – either to award them for taking a training break to demonstrate career commitment, nor to diminish any of their achievements due to them having had more time and/or opportunity to do so than their Foundation trainee counterparts. Some recruiters were more flexible in their interpretation of the interview assessment protocol, considering it more as 'guidance' when assigning scores to achievements completed within an FP or PFTB.

Recruiters across the different specialties identified many domains within the Person Specification documents for which it would be easier to achieve and demonstrate the listed items for a doctor who had taken a PFTB, than one who was applying for C/STP within their second Foundation year. They were keen to emphasise, however, that not only is it not mandatory to complete a PFTB to be successful at C/STP application, simply taking a PFTB does not automatically fulfil any of the Person Specification criteria. They emphasised that doctors should be mindful of how they best utilise their time and opportunities to align with their career aspirations, should this be one of the motivation factors for undertaking the PFTB. FPDs agreed that the competition levels are so high for C/STP applications that it is understandable that doctors may feel the need to complete examinations or undertake further clinical training/experience in a specialty prior to C/STP, and that the PFTB doctors might have a 'little more about them' at interview. This may, in part, be explained by the improvement in communication and interpersonal skills that over 75% of survey respondents felt was afforded them by their PFTB experience. Clearly, there is disparity between the perception and reality of the level of competition at C/STP, which is likely to affect the advice that they received, and subsequent decisions that they make.

4.3.2 Diversity within the workforce

Although educators and recruiters did not identify any specific demographics associated with those taking a PFTB, our data suggest otherwise and reinforces some of the findings from previous research by Cleland et al.[6] The previously-established associations between PFTB and white (as opposed to non-white), male, and who have parents educated to degree level

are still prevalent. Factors too that were previously highlighted as influential on PFTB likelihood, such as being privately-educated, and a school-leaver (compared to graduate entrant) have now become statistically significant variables. In contrast to previous reports, POLAR data now shows significance in the association of doctors from low participation areas now taking a PFTB. Geographical predictors of PFTB are less significant, with the exception of those born in Scotland (20% less likely to take PFTB than those born in England), and those completing their FP in Wales (51% more likely than those in England).

There are certain specialties which are more heavily populated by doctors who have taken a PFTB than those who entered C/STP immediately post-FP. These include anaesthetics, ACCS, Emergency Medicine, Public Health and Sexual and Reproductive Medicine – all but the latter were also identified in the study by Cleland et al., [6] but their data were related to *intentions* rather than confirmed specialty C/STP CT1 post. Many recruiters identified their specialty as attracting many post-PFTB applicants and others, e.g., surgery, were thought to attract more PFTB applicants, but our data do not support this as statistically true (at this current time).

5. Implications for Practice

Our findings have focused on addressing the three research questions identified by our preliminary scoping review. [1] We believe that our findings have raised some important points for reflection and action by the different organisations involved in under- and post-graduate training to better understand and support this ever-popular training break, and therefore offer a series of questions which might be useful to consider:

- *Should the use of the term "F3" be replaced to avoid misleading associations with the FP?*
- *Is the undergraduate curriculum currently preparing future doctors with the skills and knowledge to cope with the demands of the job and to prevent burnout (and the need for a PFTB to recover) within their early post-graduate years?*
- *Within the FP, is the PFTB option currently discussed with trainees, and can more be done to support trainees considering this option, including more purposeful representation of current or former-PFTB doctors at careers events?*
- *Is there a case to be made for the development of national guidance around the PFTB to support FPDs in discussing this option with trainees?*
- *Is there scope to delay the opening of the recruitment window for C/ST1 applications to allow doctors to have completed more of their FP before applying?*
- *Are C/STP programmes confident that their recruitment criteria do not positively discriminate towards recruiting doctors who have undertaken a PFTB?*
- *Does the perception that one has to complete an PFTB to gain a C/STP post (particularly in the most popular/competitive specialties) need to be challenged and clarified for future FP applicants?*

- *During recruitment, should additional accomplishments which might only reasonably be considered achievable post-Foundation be weighted accordingly to not disadvantage F2 doctors?*
- *Are specialties who recruit heavily from either the PFTB or non-PFTB cohort at risk of perpetuating a narrowing demographic profile into their C/STP?*
- *Can more be done to create opportunities for trainees to undertake similar PFTB experiences during their training programmes (such as education, research and leadership opportunities, and/or formal qualifications)?*

Whilst some of the above questions might be more appropriately addressed by key stakeholder bodies, we encourage those across all specialties and within all levels of responsibility for the education of junior doctors to identify marginal gains in their own practice which might positively contribute to the recognition of the PFTB as a positive career choice and support our future workforce in their career options.

6. Limitations

Whilst the research data provided in this report aims to be robust and representative of the population of interest, there are inherent limitations. Workstream 1 had a 11% response rate, and in the current climate of 'survey fatigue', we were advised by the GMC research managers that this was a good response. However, it cannot be overlooked that this is still a relatively small proportion of the PFTB population and our demographic analysis revealed that our survey potentially underrepresented the Asian or British Asian cohort. Therefore, our results must be interpreted with these factors in mind. Workstream 2 included a range of participants with different roles within the FP. Whilst this adds different dimensions to the data, it is also worth recognising that this increased range simultaneously decreases the number of voices representing each level of the FP hierarchy. Whilst this is not generally considered an issue for qualitative research, we flag this to the reader in the spirit of transparency. Workstream 3 was devoid of any recruiters from Northern Ireland or Wales. This is hopefully countered in part by the 'national' recruitment strategies, but gaining the insights of recruiters from all four nations of the UK (especially their experiences of pre-nationalised systems) would have been of interest. Ideally, to draw definitive conclusions pertaining to the proportion of PFTB doctors who received offers for C/STP posts compared to their F2 counterparts, we could have approached representatives for each specialty and asked for this specific data. However, we were aware that these data are unlikely to be readily available and might not account for doctors who have taken 'career breaks' for other reasons (e.g., maternity leave, and not strictly a PFTB). Furthermore, in the post-COVID era of recruitment, some specialties may not hold information on whether the candidate was an F2 or undertaken a PFTB as they recruit purely on MSRA scores. The interviews with recruiters allowed us instead to explore the potential 'added value' that PFTB candidates might gain and specifically how this related to the person specification. Finally, for those

specialties that no longer utilise interviews, their insights on the effects of taking a PFTB and successful recruitment might be less useful in the post-COVID era.

7. Areas for Future Research

This report contains the results of the largest national survey on the PFTB to our knowledge, in addition to capturing insights and perspectives from Foundation Programme Directors, Heads of Foundation School and Core/Specialty training programme recruiters.

In contrast to the majority of articles found in our scoping review,[1] our study involved participants who had already completed (or were currently within) their PFTB. This allowed us to ascertain what doctors *actually did* during their PFTB, as opposed to intentions, and allowed us to evaluate whether the motivations for their PFTB had significant impact on the outcomes.

Although we hope that our study has made significant contributions to better understanding this career pathway, it has also identified many avenues for future work. One such example would be to explore how the additional knowledge, skills and experiences acquired during the PFTB directly contribute to a doctor's future engagement in teaching, research or leadership within their long-term career and therefore whether PFTB posts can be used to develop the leaders of the future our of healthcare system. Another project might aim to investigate the less common, but important area, of the poor PFTB experience, including its long-term effects on career progression and identifying the specific contributors which could serve to inform policy pertaining to the design of PFTB posts at local trust level. Finally, the observation that a very similar proportion of doctors enter General Practice training, regardless of whether or not they have completed a PFTB warrants further investigation. Given that it appears difficult to undertake a PFTB in a General Practice, the specific motivations for undertaking a PFTB might differ to their colleagues who enter secondary care specialties.

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