Attitudes towards attrition among UK trainees in obstetrics and gynaecology

ABSTRACT

Physician dissatisfaction in the workplace has consequences for patient safety. Currently in the UK, 1 in 5 doctors who enter specialist training in obstetrics and gynaecology leave the programme before completion. Trainee attrition has implications for workforce planning, organization of health-care services and patient care. The authors conducted a survey of current trainees' and former trainees' views concerning attrition and 'peri-attrition' – a term coined to describe the trainee who has seriously considered leaving the specialty.

The authors identified six key themes which describe trainees' feelings about attrition in obstetrics and gynaecology: morale and undermining; training processes and paperwork; support and supervision; work–life balance and realities of life; NHS environment; and job satisfaction. This article discusses themes of an under-resourced health service, bullying, lack of work–life balance and poor personal support.

Currently in the UK, 1 in 5 doctors who enter specialist training in obstetrics and gynaecology leave the programme before completion. Trainee attrition and workplace dissatisfaction has implications for workforce planning, health-care services organization and patient safety.

Leaving a programme of medical specialty training (attrition) has wide-reaching consequences. Medical retention has been a longstanding area of concern for policy-makers (Department of Health, 2000; Health Education England, 2016).

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In the UK, training in obstetrics and gynaecology is a 7-year programme, which applicants are eligible to apply for after a minimum of 2 years foundation training following medical school. The reported attrition rate (trainees who leave the training programme before completion) for obstetrics and gynaecology is 20% (Royal College of Obstetricians and Gynaecologists, 2016).

Attrition in medical specialties has been studied by the UK-based Medical Careers Research Group's national longitudinal cohort studies of doctors' careers. Goldacre et al (2010) followed up large numbers of doctors who graduated from medical school in 1974, 1977, 1993 and 1996. They found that 19% of doctors in obstetrics and gynaecology posts changed career or specialty over a 5-year period.

Although it would seem that attrition rates have remained relatively stable, a major change took place in UK postgraduate training in 2005. It was called Modernising Medical Careers, and fixed the point of entry into specialist training. Pre-2005, doctors would work an undefined number of junior medical jobs in an array of specialities before settling on a chosen specialty. Post-2005, doctors have fewer opportunities to test out a specialty in a stand-alone job following foundation year training. Thus the statistics are hard to compare as Modernising Medical Careers changed the landscape of postgraduate training. 'Trying out a specialty' and making a different eventual career choice is a different issue from people leaving the specialty because they are unhappy.

Dissatisfaction at work in the medical profession represents a patient safety issue as well as an issue of doctors' welfare (Williams and Skinner, 2003; Bodenheimer and Sinsky, 2014) and can lead to poorer outcomes, patient dissatisfaction, and an increase in costs (Bodenheimer and Sinsky, 2014). A German cross-specialty cohort study of junior doctors explored predictors of leaving clinical practice in 557 residents (Degen et al, 2014). They found that lack of autonomy, unstructured training, and the inability to admit to or discuss their lack of knowledge predicted intention to leave. An American study identified demographic risk factors for attrition, including female gender, older age, underrepresented ethnic minorities, Asian race, and being international medical school graduates (McAlister et al, 2008).

This study explored attitudes towards attrition in obstetrics and gynaecology training in the UK, and trainees' reasons for thinking about leaving training (for whom the authors coined the term 'peri-attrition').

Methods

Study design

The authors chose a mixed-methods design, using a quantitative questionnaire to gather frequency data on respondents and their attitudes. Qualitative methods were used to analyse free-text responses.

Participants and sampling

Two questionnaires were conducted: the peri-attrition questionnaire for current obstetrics and gynaecology trainees, and the attrition questionnaire for former trainees who left the specialty training programme before completion.

At the time of distribution (September 2015), there were 183 obstetrics and gynaecology trainees within the training region of Health Education North Central and East London. Of these 182 had opted

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in to receive a regular email newsletter from the Health Education North Central and East London obstetrics and gynaecology trainees committee (elected body of representatives). This newsletter was used to circulate the peri-attrition questionnaire. Health Education North Central and East London administrators were unable to give the authors a list of trainees who had left training, so the trainees committee put together a list of people known to have left training in recent years (2009–2015), and sent the attrition questionnaire to these 10 people directly.

Questionnaire design

The questions were devised by three of the authors, who were actively serving members of the trainees' committee. Questions and option lists were checked against previous questionnaires into recruitment in obstetrics and gynaecology (Whitten and Higham, 2007; Currie et al, 2013). Content was reviewed by the chair of the Training Programme Management Committee, the body responsible for overseeing obstetrics and gynaecology training in Health Education North Central and East London. It was felt that a formal pilot phase was not necessary.

In the questionnaire invitation email it was made clear that participation was voluntary, and that responses would be anonymised. Trainees were given contact details of the researchers and the chairperson of the Training Programme Management Committee if they wished to discuss anything in more detail, in confidence. Trainees who chose to contact the researchers were guided to the London Deanery Professional Support Unit, which provides funded career guidance and counselling services for all London trainees. Responses were collected and stored by the software anonymously. Identifying details were redacted from any illustrative quotations.

Data gathering

The electronic peri-attrition questionnaire and attrition questionnaire were sent by email to 183 trainees and 10 former trainees in September 2015. Three reminder emails were sent in September and October 2015. Qualtrics software was used to gather questionnaire data.

Analysis

Quantitative

Excel was used to calculate descriptive statistics.

Qualitative

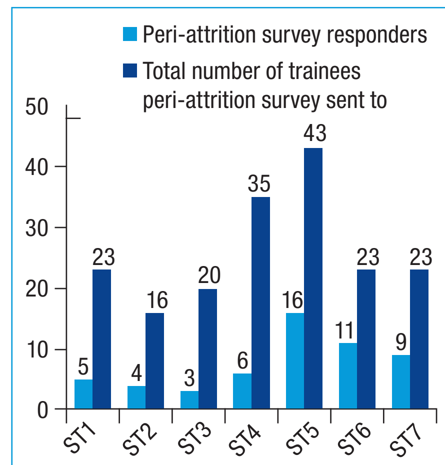
A constructivist approach was taken to analysis of free-text responses (Charmaz, 2006) in order to acknowledge that some members of the research team were themselves trainees. All free-text responses from both questionnaires were labelled and combined to create a dataset. Following immersion in the dataset, an initial set of codes was created to describe the entire dataset, which were independently grouped into themes. The process of constant comparison was used to create an agreed consensus of themes and codes. Any disparity was discussed and resolved.

Results

Peri-attrition questionnaire

Quotations have been presented in their original form, with corrections made for spelling errors.

Figure 1. Training grades of peri-attrition questionnaire respondents compared to overall trainee numbers in region.



Response rate

Of the 183 trainees, 54 (30%) responded. The representativeness of respondents varied by grade, ranging from 15% of ST3s (specialty trainees in their 3rd year of obstetrics and gynaecology training) to 48% of ST6s (*Figure 1*).

Demographics

Of the 54 respondents 48 (89%) were female, five (9%) were male and one (2%) respondent preferred not to say.

Attitudes and behaviours in relation to peri-attrition

Of the respondents 43/54 (80%) stated that they had considered leaving the specialty, which represents 43/183 (23.5%) of all Health Education North Central and East London trainees.

The reasons for considering leaving are shown in *Figure 2*. The median number of options selected was two with a range of zero to seven options selected. The free-text answers given in 'other' are represented in the coding framework.

Of the peri-attrition respondents four out of 43 (9.3%) had expressed their career doubts and concerns to careers guidance professionals.

Attrition questionnaire

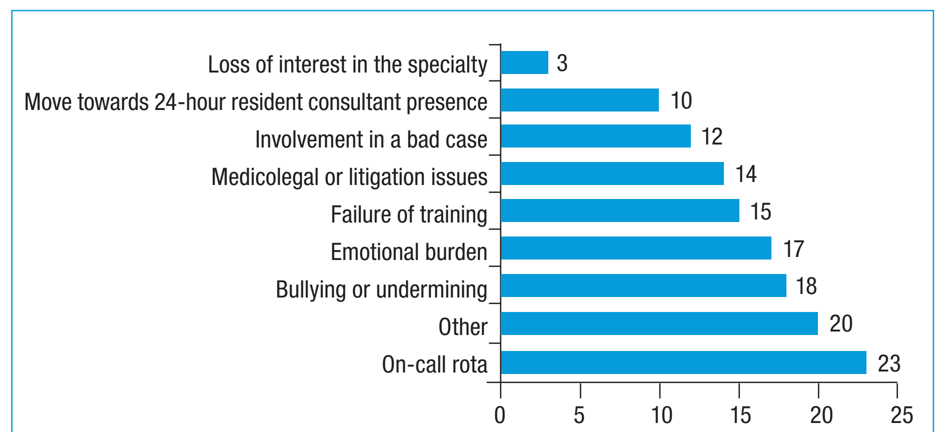
Response rate

Eight out of ten (80%) former trainees responded.

Demographics

All respondents were female. They had left between 2009 and 2015, with the majority being in ST1 to ST3. Five have pursued a

Figure 2. Peri-attrition respondents' reasons stated for considering leaving obstetrics and gynaecology training.



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career in general practice and three have pursued alternative medical career paths.

Attitudes and behaviours in relation to attrition

Of these eight, five (62.5%) had expressed their career doubts and concerns to careers guidance professionals while still a trainee.

Coding framework

Figure 3 illustrates the six key themes that describe all the qualitative data.

Morale and undermining

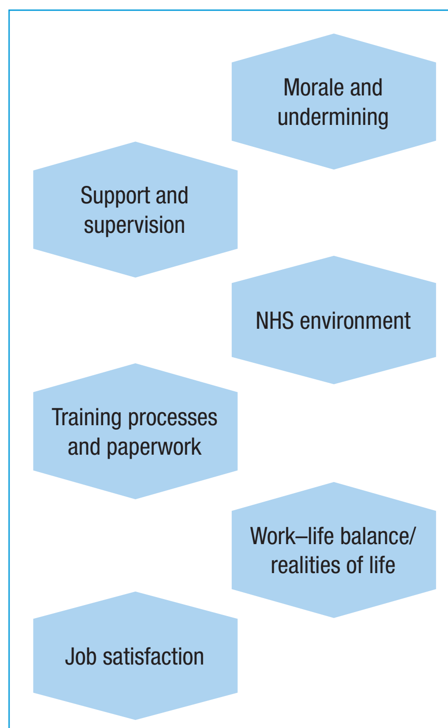
Trainees frequently described low morale working in obstetrics and gynaecology and receiving 'very little in the way of praise for a job well done' (peri-attrition questionnaire respondent 37, ST5).

When trainees attempted to broach their concerns within their departments or with the local educational leads, they described a lack of listening:

> **'Bad experience in a department notorious for bullying, which is raised year after year on the GMC [General Medical Council] survey and nothing changes!' (peri-attrition questionnaire respondent 12, ST7).**

Several trainees alluded to the need for a cultural change:

Figure 3. Six key themes identified.



> **'People are made to feel bad for considering other things. People need to be seen as individuals with respect to their plans, and not to be told that academics will be rubbish at clinical work before they have even started.' (peri-attrition questionnaire respondent 51, ST1)**

There was a single comment alluding to racial discrimination within the specialty:

> **'Constant hitting the visible and invisible walls of discrimination and prejudice – tired of running the extra 5 miles to be on par with white British trainees, seeing the injustice in training.' (peri-attrition questionnaire respondent 26, ST5)**

Training processes and paperwork

Many trainees described the difficulties associated with juggling 'the burden of endless ePortfolio, audit, QI [quality improvement], exams, ARCPs [annual review of competence progression], WPBAs [workplace based assessment], matching' (peri-attrition questionnaire respondent 57, ST4). 'Matching' refers to the process of competitive interview at key stages of training to allocate hospital rotations. Training-related paperwork detracts from some trainees' 'love of the clinical aspects'.

Some respondents felt that they were 'treated as a number' in the course of training:

> **'I'm on a conveyor belt to a consultant job I don't want and don't feel designed for.' (peri-attrition questionnaire respondent 21, ST6)**

As with all postgraduate training, obstetrics and gynaecology has formal examinations. Some trainees described the difficulties encountered in passing these exams and how 'assistance with exam preparation to keep you motivated' could help (peri-attrition questionnaire respondent 48, ST6).

Support and supervision

There were both positive and negative comments regarding trainees' experiences of educational supervision. The increased workload in the NHS also affects consultants and a few respondents indicated that this may be the cause for the lack of time to provide educational supervision. Consultant burnout and fatigue could affect their ability to take on an effective and empathetic role.

> **'Consultants were busy and did not have enough empathy for a commute/childcare/lack of sleep due to young children…' (attrition questionnaire respondent 8)**

Many trainees commented on how they felt unsupported following serious incidents with patients. Some specified that the loss of firm structure and camaraderie among medical staff may be part of the problem.

> **'It's now much harder to get to know your colleagues, and therefore identify senior mentors… There's now less opportunity to talk through stressful events with senior colleagues, debrief, offload, and ask for informal advice.' (peri-attrition questionnaire respondent 47, ST7)**

The following is an extreme example of lack of support:

> **'I felt [leaving obstetrics and gynaecology] was a taboo subject… I did not speak to anyone in the deanery until I had handed in my notice… I felt I could not speak to anyone about it because there is a stigma around not seeming "keen" and not appearing to love it.' (attrition questionnaire respondent 3)**

Work–life balance and realities of life

Many trainees cited the option of less than full time working as a positive aspect of the job, or a 'pull factor' towards a career in obstetrics and gynaecology:

> **'Ultimately I still love the essence of the work. Hoping to achieve a better work–life balance by going less than full time...' (peri-attrition questionnaire respondent 55, ST4)**

Conversely, some respondents cited poor work–life balance as the reason for leaving training.

> **'The reasons that I left the training programme relate solely to the difficulties in achieving work–life balance – I have a young family and was finding that I just didn't see enough of them.' (attrition questionnaire respondent 10)**

Some trainees feel that challenges in gaining clinical experience while working less than full time are neither understood nor addressed.

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'I had taken 3 years out to do an MD in minimal access surgery. Afterwards, I was not getting enough support or operating time to develop the skills. The full-timers passed me by.' (attrition questionnaire respondent 8)

Flexibility in training does not only apply to balancing work with family life. Overwhelmingly, when asked for possible solutions to the problem of attrition, respondents mention 'more flexibility' and giving people time out of programme where needed. This would allow trainees more autonomy in determining their career path, or simply have a break and reflective space if they are having a difficult time during training.

NHS environment

The theme of the wider NHS environment generated mostly negative remarks:

'With the NHS in its current state there is very little that can be done' (peri-attrition questionnaire respondent 11, ST4)

This was made more explicit with references to intense workload, low staffing levels and poor funding.

'The endless juggling to make ends meet with rosters staffed by not enough doctors, locums that don't turn up etc.' (peri-attrition questionnaire respondent 37, ST5)

The culture of working in the NHS was discussed, with mention of infantilisation of trainees, a blame culture, and working conditions not improving as a consultant.

'A feeling of being treated like a child, a blame culture where I was working, poor working conditions in the NHS…' (peri-attrition questionnaire respondent 47, ST7)

Job satisfaction

Job satisfaction was consistently and repeatedly raised as a positive feature of working in obstetrics and gynaecology.

'I love the job, looking after the women and the satisfaction of caring for them to the best of my ability.' (peri-attrition questionnaire respondent 37, ST5)

Job satisfaction was a positive pull factor, keeping trainees in the specialty even when struggling.

'I love my job, I love my patients… the constant emotional burden of all these issues I have mentioned… it drains you, then some patient gives you a hug or a smile and thanks you. You just forget it.' (peri-attrition questionnaire respondent 26, ST5)

Discussion

Statement of principal findings

These findings outline trainees' attitudes towards attrition and peri-attrition, underlying reasons for leaving. These experiences can be summarized into the six themes in *Figure 3*.

Most respondents expressed their ongoing interest and passion for working in obstetrics and gynaecology, with job satisfaction from helping patients a key feature. However, there was an overall sense of frustration and exhaustion with both the system of working in the NHS and the underlying training process.

The authors did not specifically gather data regarding attitudes towards obstetrics and gynaecology specifically *vs* medicine in general. However, a large questionnaire study in 2004 on attrition among cross-specialty doctors in the UK revealed perceived poor working conditions in the NHS, long working hours, poor work–life balance, and a desire to travel and work abroad as reasons for wishing to leave medicine in the UK (Moss et al, 2004). It is interesting to note that doctors' perceptions of poor working conditions and lack of work–life balance have not improved in spite of the introduction of the European Working Time Directive in 2009, which limits the working week to 48 hours.

Strengths and weaknesses of the study

This study explored attitudes of trainees in obstetrics and gynaecology in a single region and thus may not reflect national concerns, although the findings are consistent with other studies (Thangaratinam et al, 2006; Whitten and Higham, 2007).

Data were obtained through electronic questionnaires; while this generated large quantities of free-text responses (not compulsory) it might not have been as rich as data generated through interview or focus group. However, it allowed inclusion of opinions of a larger number of trainees than other methods would have allowed. A response rate of 30% is a typical response rate among doctors (Cunningham et al, 2015). A desire to complete the questionnaire could lead to a risk of response bias (Coggon et al, 2003), so the authors used mainly descriptive statistics and focused their analysis on the qualitative data collected.

There were only a small number of trainees that could be contacted for the attrition questionnaire, but the response rate was 80% (8/10). The authors feel it is imperative that training programme directors gather feedback from all trainees who have taken this huge life decision.

These findings support previous work done regarding the effect of stress and lack of work–life balance on obstetrics and gynaecology trainees, and the reasons why people choose obstetrics and gynaecology as a specialty (Thangaratinam et al, 2006; Whitten and Higham, 2007).

Meaning of the study: possible explanations and implications for clinicians and policymakers

Postgraduate medical training in the UK has changed tremendously over the past 10 years, as has the political and financial landscape surrounding the NHS (Tooke, 2008; Temple, 2010). The complexity of issues outlined in this study may explain how a simple reduction of working hours through European Working Time Directive implementation has not eradicated the problem of attrition and peri-attrition.

The introduction of Modernising Medical Careers and formalization of postgraduate medical education has led to the development of an elaborate framework of assessment for doctors. From the current findings, trainees have clearly experienced anxiety and pressure from these requirements.

Before the Modernising Medical Careers changes, junior doctors could test out a variety of specialties before making a final decision. Now, they must choose their career specialty at a more junior stage. When a trainee chooses to leave a training programme, it is considered a personal failure. Perhaps this stigma or taboo should be removed and the idea of 'testing out' a specialty normalized.

The quality of educational supervision can greatly influence a trainee's experience in a particular placement. Currently, General Medical Council guidance stipulates that only consultants with formal training in educational supervision should become educational supervisors, with time allocated in consultant job planning to perform this role. Evidence in the literature recognizes the importance of the supervision relationship,

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KEY POINTS

- Attrition in medicine can impact on workforce planning, patient outcomes and physician wellbeing.
- Job satisfaction is a major factor for doctors entering specialist training, and in workforce retention.
- Reasons leading to attrition are complex.
- Medical specialist trainees desire work–life balance, mentorship and educational supervision.
- A culture of bullying and undermining in medicine results in damaging psychological effects on doctors.

constructive feedback, sufficient time for supervision and adherence to a supervision framework (Kilminster and Jolly, 2000; Kilminster et al, 2007).

Supervision has been further disrupted by the loss of the firm structure following the introduction of full shift patterns, resulting in the collapse of the apprenticeship model of learning. Both trainees and educational supervisors have had to adapt to ensure that trainees continue to receive high quality training that meets curriculum requirements.

Furthermore, with obstetrics and gynaecology training, where adverse outcome is relatively common, there is a risk of trainees becoming 'second victims' following serious incidents (Scott et al, 2009; Schrøder et al, 2016). Thus the role of the educational supervisor needs to be extended to include trainee welfare.

Feminization of the UK medical workforce has been previously cited as the reason behind staffing shortages and roster gaps (McKinstry and Dacre, 2008), as a result of doctors taking time out for maternity leave and returning to work less than full time. Respondents to this survey made many positive comments concerning flexibility and ability to work less than full time. In current times where men and women share the responsibilities of childcare and wage earning in a household, the option of working less than full time for the purposes of better work–life balance is highly likely to benefit trainees of both genders. In the interest of overall long-term retention, the challenges that less than full time working puts on the workforce need to be tackled more creatively than simply condemning less than full time working and parental leave.

Less than full time working is also associated with other challenges. The problem of lack of training opportunities and emphasis on service provision may seem amplified if a trainee is working less than full time. The prolonged period of training may not compensate for the need for continual hands-on experience in developing surgical skill (Moulton et al, 2006; Reznick and MacRae, 2006).

Conclusions

The respondents to this survey echoed the predictions of the Tooke report, which stated that Modernising Medical Careers was 'unlikely to encourage or reward striving for excellence, offer appropriate flexibility to trainees, facilitate future workforce design…' (Tooke, 2008). However, with increased awareness of current challenges in postgraduate specialty training, positive steps can be taken to make changes as we move forward. **BJHM**

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