The British Student Doctor, 2017;1(2):24-27
doi: 10.18573/j.2017.10174
Discussion

A few seconds now could mean an hour in the future

DISCUSSION

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No conflicts of interest to declare

Accepted for Publication:
06.03.2017

ABSTRACT

We are in a critical period in our country's history. The UK has recently been gripped by an unprecedented scale of strikes and demonstrations by junior doctors. Naturally, this reflects a state of discontent amongst the medical profession, with many feeling undervalued and unrepresented. Ultimately, tired staff working unsociable hours could compromise patient care. On top of this, what about a doctor's welfare? What indeed will become of the European Working Time Directive (EWTD), following the UK's secession from the EU? It is perhaps unsurprising that our profession is associated with high rates of burn-out.

Our article takes you to the year 2026: a time where there exists the concept of Doctor's Protected Mealtime (DPM). This refers to an hour during the working day where doctors are free to partake in a leisure activity of their choice – on top of lunch, if they wish. Some may choose to learn a musical instrument, others yoga. Some may enact a renaissance of pursuing past hobbies, which were sacrificed to the rigors of medicine. Indeed, the list is endless and limited only by the individual's imagination. We acknowledge that patient care should always be the utmost priority. Hence, doctors on-call would be exempt from DPM, for example. We also consider whether DPM may lead to some loss of professional duties and miscommunication between healthcare professionals. While our idea may appear to be in the realms of fantasy, our aim is not to discuss its logistics. It is instead to stimulate discussion on doctors' welfare. Medicine embodies a noble pursuit, but one where there may be little respite from its demands. DPM is merely one possible idea that could safeguard the welfare of both current and future medical professionals.

It's the year 2026, and the sun is shining brightly over Britain. Now a specialist registrar, you finish your morning ward round and delegate duties for the rest of the team to complete for the afternoon. As for your afternoon, no doubt you'll be heading to the outpatient department, or perhaps to theatre. However, there's a twist - because, having grabbed a quick bite from the canteen, you casually stride towards a nearby tennis court.

Wait - did you say *tennis*? Who has time for that? This is but one example of Doctor's Protected Mealtime (DPM). A scheme where doctors have an hour during the day to catch up with activities of their choice. Tennis is just one possibility, and some of your future colleagues chose yoga, others meditation, music, or running. The list is inexhaustible, as it's more than just an *"enlightened lunch hour"*.

What inspired this utopian idea? In many hospitals, patients are given protected times for meals. During this time, non-urgent clinical work ceases (1) which, from having spoken to patients ourselves, boosts their well-being and helps them to find solace during a stressful situation. So, with this in mind, why not consider the equivalent for stressed medical staff? These are men and women who wake up to make a positive difference to patients, their families and their communities - even at a time where morale is low. A time where many feel like unsung heroes, despite their labours.

In this time of great change, where the NHS must evolve for its own survival, we often hear about the stresses placed on services. However, we should also consider the stresses placed on doctors. With so many expectations upon them, depression is estimated to affect 10-20% of doctors, with a higher suicide risk than the general public. (2) Moreover, a recent large-scale survey of junior doctors showed that, while job satisfaction is high, lower scores were reported for perceived leisure time. (3) In 2013, the Royal College of Physicians highlighted that 10,383 healthcare professionals left the NHS due to low satisfaction with work-life balance. (4) Then, in 2016, a survey by the General Medical Council (GMC) of over 50,000 junior doctors found that 43.2% rated their daytime workload as "very heavy" or "heavy". (5) On top of this, since the referendum to leave European Union, what will happen to the European Working Time Directive and its impact on leisure time?

Therefore, DPM could have a great impact on welfare, and it may not be in the realms of fantasy. Many corporate organisations offer perks for their employees, including "*fun-days*". (6) These presumably help to foster team-building, relations between staff and to celebrate successes. Beyond DPM, simple measures could be introduced on the 'shop floor', as it were, to improve daily morale. This includes promoting transparent communication, fostering a team spirit and providing a safe environment for employees. (7)

However, much could be achieved by an hour enshrined in national policy for doctors to protect themselves from the rigors of their job. Indeed, we believe that it can be argued that a career in medicine may lead to the demise of one's extra-curricular passions. Ironically, it was these passions that deemed an individual "*well-rounded*" and suitable for acceptance to medical school in the first place. In fact, the principle of DPM is essentially implemented by medical schools: during pre-clinical years, we coveted Wednesday afternoons, where extra-curricular activities were rejoiced in the bold or the mundane – perhaps a means to protect and engender student wellbeing. Moreover, it helped provide that certain roundedness, which is so desirable for employers. So why has this concept not followed through to the NHS, the UK's single largest employer? Interestingly, the notion of protected hours for doctors is already under consideration. In the past few months, a new junior doctors' education contract has been reported in Wales, which includes protected time for education during the week. (8-9) Therefore, if something as crucial as education can be protected, then why not the same for welfare and morale?

Whilst possibly a plausible idea, the benefits of DPM must be balanced with its potential flaws. Inevitably, doctors on-call and in the emergency department would be exempt from DPM. This would be in the interest of patient safety, which should not be compromised by the scheme. Likewise, while DPM would be a possible option for doctors, it would not be an absolute right. This could include urgent duties arising on the ward, such as taking bloods from an acutely deteriorating patient or perhaps discussing a patient's status with their family. Hence, it would be the doctor's daily professional judgement whether to partake in DPM. Underpinning our duties is the GMC's guidance on *Good Medical Practice*. (10) In the absence of adequate cover, DPM may compromise several tenets of our profession, such as safe handover of patients and teamwork.

As such, one aim of DPM is to alleviate the pressures faced by individual doctors, which could also be achieved through medical education. Naturally, great emphasis is placed on clinical acumen and patient safety. But there is perhaps scope to increase the time devoted towards future FY1s in coping effectively with time and energy demands, through improving awareness of hospital logistics. For example, while students may be aware of indications for x-rays, they may not be well versed in physically ordering such investigations. Another proposed method to tackle doctors' welfare may be resilience training in medical school. However, the term 'resilience' is hard to define, something which the GMC

recognises, but suggests involves people feeling supported and able to ask for help. (11) It has also been suggested that underpinning resilience is "*dynamic thriving with full engagement*" in the individual's environment. This is as opposed to simply coping with the rigors of the job, (12) which DPM could unintentionally promote.

One could even ask: would DPM address the underlying reasons for high workload, such as improving or retaining staff levels? If effectively given an hour off, this may not incentivise doctors to identify areas of improvement for service provision. It also raises the issue of a slippery slope. With a protected hour for leisure, would there then be a demand for additional time allocated for teaching? Similarly, patient care thoroughly depends on the interdependence between doctors and the rest of the multidisciplinary team. Thus, if doctors are granted DPM, one could also argue a parallel scheme for all allied health professionals. Logistically, this could pose communication difficulties, if staff of different disciplines are not available for longer periods. We recognise the current financial strains on the NHS and thus any new scheme implemented must account for this. However, considering that morale and productivity are linked, this might be an instance where a few extra pounds spent on welfare could lead to long-term savings as a result of increased efficiency and retention of staff.

In January 2017, the NHS was said to be facing a "*humanitarian crisis*" by the British Red Cross. (13) Although a strong statement, it highlights the ever-growing disparity between patient demand and service provision. In such times, while there could be made a moral argument against DPM, it raises the question of how we should balance the welfare of the individual with professional responsibilities. Whereas DPM is an innovative concept, broader considerations must be accounted for if any lasting impact is to be made. One proposed measure to alleviate burdens on secondary care includes greater availability of general practitioners through out-of-hours, especially over the weekend. However, a recent British Journal of General Practice survey found that, out of 881,183 patients, 80.9% reported no problems with current opening times. (14) This suggests that most patients find no need for this measure. As such, the question remains whether this option would alleviate the stress on secondary care. If successful, while such a measure could protect secondary care doctors, it would endanger the welfare of primary care physicians, who are already under great service pressures. Instead, could better patient education regarding what ailments need medical attention and when remedy these demands? This could negate the need for DPM.

To conclude, rather than debating the logistics behind DPM, we wish to encourage debate on its underlying ethics. That is, to what extent should doctors sacrifice their hobbies and past-times in the name of profession? No one denies that the patient is our top priority - their good health is both our aspiration and inspiration. However, should our welfare matter more than an hour of lost productivity? Medicine is more than hitting targets. It should defend health, defend welfare and provide equal opportunities where everyone is listened to. It should be a profession in which doctors are protected from the emotional, physical and psychological costs that their noble pursuit inflicts. This can be achieved by changes not only within our profession, but also through a concerted effort by the public, media and politicians.

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Journal DOI
10.18573/issn.2514-3174

Issue DOI
10.18573/n.2017.10170

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