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Enhancing junior doctors’ working lives

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Abstract
Junior doctor wellbeing has been a topic of increasing interest in recent years. There is increasing evidence of poor workplace satisfaction, rising levels of burnout and increasing diaspora of UK-trained junior doctors. There is therefore a pressing need to address the wellbeing of our trainees and recent concerted efforts at local, national and international levels are working towards this, with the ultimate goal of also improving patient care. The tension between the personal and the professional may never be so keenly felt as during the unique challenges we are facing this year, in 2020, as we tackle the biggest global health emergency of our lives brought about by COVID-19. There are many positive examples of new initiatives aimed at supporting the medical community at this time; however, we must all work together to sustain these endeavors in post-pandemic times. We here summarize a number of pertinent issues affecting trainee wellbeing, outline current attempts at addressing these and make further suggestions as to how to enhance the working lives of our junior doctors. However there is much still to be done.

Keywords COVID-19; junior doctor; surgical training; wellbeing; work–life balance

Introduction
The balance between the personal and professional is often difficult to achieve due to the collision of personal life events with career bottlenecks. Junior doctors often experience increasing responsibility in their personal relationships and family life and these are poised against the challenges of specialty training, professional exams and the changing horizon of the incentives (and disincentives) of consultant life. These conflicts are inevitable in the medical profession (as well as other non-medical professions). It is inconceivable that the perfect work–life balance can be achieved at all times and junior doctors, like many other working people, should expect to experience peaks and troughs in both domains. As a profession we should strive to identify and address some key issues that may contribute to improved wellbeing, which is likely to have a downstream effect on work efficiency and patient care.

The changing face of the junior doctor role
The past few decades have seen major changes in the roles and responsibilities of junior doctors. The old adage of ‘see one, do one, teach one’ is no longer a mantra lauded by trainees, who are now expected and wish to learn in a more structured and supervised environment. Previously, trainees racked up >100-hour weeks, faced grueling rotas and operated frequently out of their comfort zone, and much has been done to change such working practices in order to improve trainee wellbeing, long-term resilience and patient outcomes. This inevitably comes with a cost to training hours, with the perfect balance between supervised training, wellbeing and an appropriately trained finished product for consultant practice still to be elucidated.

The demise of the ‘firm’ structure
The old-fashioned model of medical apprenticeship — the ‘firm structure’ — has been lost in modern medical training, due to the change in shift patterns, restrictions on working hours and frequent rotation of trainees. Described by Harold Ellis as ‘being like a family’, the firm provided professional and emotional support for its members. There were, of course, disadvantages with this system. Trainees often lived on site and were expected to be omnipresent and, in addition to the misery of a dysfunctional firm or in-firm bullying, this would sometimes impact upon personal lives and career progression. It is also recognized that the firm structure provided variable and inconsistent learning experiences, which may be mitigated by the contemporary system of rotational working with a number of different supervisors.

After the introduction of the Modernising Medical Careers (MMC) programme in 2005, trainees began rotating more frequently across broad geographical regions. 2013 saw the publication of the ‘Shape of Training’ review, with a key theme addressing service versus training requirements. Although service should not be wholly dependent on trainees for the delivery of care, it is an integral part of training. In 2017, an initiative from Health Education England and the surgical Royal Colleges called ‘Improving Surgical Training’ conducted its pilot programme, with the hope of reducing the long service hours and frequent on calls.

The introduction of the European Working Time Directive (EWTD)
The aim of the EWTD is to promote the health and safety of workers. The EWTD now stipulates a maximum working week of 48 hours, averaged over 6 months. A number of key issues with EWTD have been recognized, not least the effect of rota gaps.

The implementation of a maximum hours contract leads to rota gaps, meaning fallow training opportunities: in the 2019 GMC survey, a quarter of trainees regularly experienced lost 48 hours, averaged over 6 months. A number of key issues with EWTD have been recognized, not least the effect of rota gaps.

Trainees are expected to cover brief periods (48–72 hours) of unplanned rota shortages. Any longer or predictable rota gaps should be covered by locums. In reality, this is not always the case and many trainees work hours exceeding EWTD regulations which may leave them vulnerable to medicolegal and clinical governance issues.

A move to the shift system also means that daytime training opportunities (such as consultant-supervised elective theatre lists) are lost more frequently, leading to a reduction in the overall breadth of clinical experience. We must recognize that
these are all stressors to someone embarking on their medical career, particularly as there is no commensurate increase in training time, and trainees are often self-conscious about their perceived lack of experience when compared to predecessors. Conversely, a reduction in maximum working hours allows time for a better quality of life and improved working lives. Further, trainees have increased supervision and are encouraged to recognize and work within their own limitations. Training programmes have changed to reflect this, and aim to produce well-trained consultants who can deliver the required excellent care according to the needs of the specialty and patient population.

The loss of the doctors’ mess and on-call rooms
With the move to a partial shift system and off-site living for junior doctors, many hospitals have removed on-call rooms and the doctors’ mess. In the recent GMC survey, one in ten junior doctors said they had no access to a junior doctors’ common room and only a third would describe their mess as very good or good, reporting poor or no catering facilities when on call. Where once a doctors’ mess was an area for junior doctors to socialize, find basic sustenance, relax and share clinical problems (i.e. all the strategies we now recognize for instilling resilience in the workforce), this has been eroded over time in many places. On-call rooms have also been removed in many hospitals on the justification that a partial shift system does not allow for sleep while on shift. There has been a recent move by the BMA to bring back rest facilities and on-call rooms, partially in response to media attention surrounding a number of junior doctor fatalities due to driving while tired, as well as survey responses.

Work–life balance and ‘Drexit’
One study of >130 participants concluded that postgraduate training was characterized by poor work–life balance (long hours, compounded with revision for exams and completion of e-portfolio or equivalent). The survey found that regular rotations often disrupted personal lives and sometimes meant that trainees had to live apart from their families, leading to low morale. These concerns were particularly prevalent in women with children. In the search for a better work–life balance, it has become common for junior doctors to take time out of training to move away from the UK to countries such as Australia or New Zealand where doctors are paid better and anecdotaly have a much better quality of life than their UK counterparts, or to pursue interests other than medicine (the so-called doctor exit or ‘Drexit’). While this represents an opportunity for trainees to experience a different way of working before returning to the UK to take up specialty training posts, it has also resulted in a considerable ‘brain drain’, with almost half of UK junior doctors admitting that they have considered leaving the NHS due to concerns about pay reduction, changes in working hours, and scrolling incessantly.

Burnout
Burnout is described as ‘a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed and characterized by three domains: feelings of energy depletion or exhaustion; increased mental distance from one’s job, or feelings of negativism or cynicism relating to one’s job; and reduced personal efficacy’. Questions about burnout amongst junior doctors have featured heavily in surveys over the past few years. Almost a quarter of all UK trainees reported feeling burnt out to a high or very high degree, with over half feeling always or often worn out at the end of the day.

Burnout is of course not a trait exclusive to junior doctors. A survey of over 500 NHS hospital consultants found that almost 40% reported emotional exhaustion or depressive symptoms, a fifth experienced depersonalization and almost 45% felt anxiety symptoms. Surgeons experienced the highest level of depersonalization of all specialties surveyed. When compared to estimated levels of burnout in the general population of around 10–15%, this is a very worrying picture. Burnout is associated with significant adverse personal behaviours such as excessive alcohol intake, drug misuse and relationship breakdown, in addition to the knock-on effects on patient care and doctors who experience symptoms of burnout are more likely to be involved in adverse patient incidents. If burnout were a disease we would have an epidemic on our hands. If you set out to design a system to induce burn out, you would probably design something very like parts of our healthcare system. Improving personal resilience may in part reduce some of the stressors leading to burn out, but it should be emphasized that ‘it is not the fault of individual staff for not being up to the job’.

Doctors in the digital age
Another potential source of external pressure on junior doctors is the omnipresence of work in the digital age. With instant access to emails, the rise of social media and increasing media attention, it has become increasingly difficult to ‘switch off’. Social media has become a particular source of ever-present work engagement after hours. This has the advantages of providing easily accessible platforms for education, collaboration and networking, but also brings drawbacks of feeling compelled to be present, vocal and scrolling incessantly.

There has also been increasing mainstream media attention towards doctors, particularly during the junior doctor pay strike against changes to contracts and pay conditions in 2016, as well as the more recent consultant pension dispute. It is disheartening for junior doctors to be branded ‘Moet medics’, to be criticized for raising concerns about pay reduction, changes in working hours and pay progression scales that have a particularly detrimental effect on trainees taking time out for maternity leave, training less than full time or pursuing an academic degree.

During the COVID-19 pandemic, the public and media is now rallying around NHS workers, extolling their hard work and branding them national heroes. While it is undoubtedly refreshing for NHS staff to feel valued at a time of national emergency, it is this fickleness of the media towards the profession that may be a source of anxiety and insecurity.

Financial remuneration
Junior doctors have experienced a significant relative pay reduction over the last few decades. The Review Board on Doctors’ and Dentists’ Remuneration (DDRBR) of 2019 reported that ‘a long period of real-terms pay decline over the last decade is starting to have a significant impact’. With the rising cost of childcare, house prices and cost of mandatory exams and...
educational courses, the issue of financial remuneration plays a part in the poor morale of our junior doctor workforce.

Added to this, with the removal of consultant pay uplifts such as merit awards and discretionary points and the recent reduction in pension allowance with increasing pensionable age, the financial rewards at the end of training are also diminishing.

**Strategies to enhance junior doctors' working lives**

While there are clearly many things that negatively affect junior doctors' working lives, there is also a concerted drive to improve them.

**National campaigns – improving rest facilities and promoting safe travel**

Sleep deprivation leads to poor performance at work, causing a reduction in psychomotor performance, difficulty in decision making and increased clinical error. With increasing acknowledgement of this, many national bodies are campaigning to improve wellbeing, including improving rest facilities. Individual hospitals are also tackling this, such as the Guy’s and St Thomas’ HALT (Hungry, Angry, Late, Tired) campaign, which encourages staff to take frequent breaks to improve their wellbeing and patient care; however, it is certainly not widespread.

The BMA have also promoted initiatives such as the provision of 'care boxes' in Scotland, providing essential supplies for healthcare staff. The GMC has commissioned a UK wide review of wellbeing and the RCSEd has produced a number of recommendations for improving the working environment.

In addition, hospitals need to provide easily accessible drinking water in clinical areas and provide 24-hour access to healthy food and facilities to warm food in staff-only areas. This was a focus of a recent NHS England CQUIN, however, it is currently not widespread.

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**Mentorship, enhanced roles and resilience training**

Up to 80% of doctors say that their job causes excessive stress, which may lead to poor productivity, increased sickness absence and little time for personal and professional development. However, the use of mentorship and resilience training may go some way to counter this.

Surgery is, by nature, a specialty demanding an element of mentorship; operative techniques must be taught in the operating theatre and cannot be learnt adequately from a book or in entirety from simulation. The technical mentorship engrained in the surgical specialties should be matched by non-technical mentorship, allowing personalized support for junior doctors when navigating the many challenges of their training. Allocated educational supervisors provide continuity during a surgical placement, however more formalized mentorship programmes should be encouraged on a wider scale.

A number of enhanced non-clinical roles for junior doctors are being developed across the country, including the ‘Chief Registrar’ role, which is thought to improve morale and engagement amongst senior trainees, and posts to develop leadership and management skills, such as the Scottish Clinical Leadership Fellowship. Such schemes provide an opportunity for trainees to develop their non-clinical skills, to engage with management and governmental organizations and may help boost morale.

Resilience is described as 'the ability to succeed, to live and to develop in a positive way despite the stress or adversity that would normally involve the possibility of a negative outcome', i.e. maintaining personal wellbeing in the face of a challenge. Resilience is a desirable basic component of being a junior doctor, as they are given substantial responsibility for patients’ lives and wellbeing, tend to witness difficult situations, work long hours and try to balance personal and professional challenges. However, this attribute is not innate in us all and often needs to be fostered through positive and active behaviours, such as maintaining strong personal relationships, keeping good physical and mental health, recognizing and dissipating conflict and tension within the workplace and making the most of opportunities around us. While there are resilience programmes available to some NHS staff, this is not universal. Equipping trainees with coping strategies to improve their resilience will help enhance wellbeing, productivity and work–life balance.

**Increasing flexibility in training pathways**

There has been a move towards increasing the flexibility of training pathways, with increasing support for less than full time training and better support for the financial costs of training. With many trainees taking time out of training, it is important to recognize the effect on the individual returning to work after prolonged absence. This can be a challenging time for trainees and trainers alike. Depending on the indication and duration of out of programme activity, the trainee will have specific requirements that will need to be addressed in a supportive environment. The emphasis here should be good communication between trainee, TPD and training unit, with a structured, appropriate plan for return to work developed well in advance and agreed by all parties involved.

Formal refresher training and enhanced supervision is now available in some parts of the country, such as the SuppORTT programme run by HEE.

The introduction of ‘enhanced preferencing’ and ‘offer exchanges’ for specialty recruitment allows candidates to alter their programme or geographical preferences, which is useful for those who wish to remain in the same region as their partners. These interventions go some way towards improving the wellbeing of doctors in training.

**Improving surgical training pilot**

Following the Shape of Training Review in 2013, the RCS and HEE proposed a pilot for a new training strategy called Improving Surgical Training (IST). The GMC surveys in the years preceding this consistently reported surgical trainees to be the least satisfied
trainees in the NHS and there was recognition that the health service was increasingly reliant on junior doctors to provide service, often at the expense of training opportunities, and to perform tasks beyond their competence. At the heart of these issues lies the knock-on impact on patient safety. The IST pilot aims to maximize training opportunities through reduced service commitment, re-introduction of run-through training (allowing a more stable and predictable personal life for the duration of higher specialty training) and developing ‘professional trainers’ to deliver high-quality training and supervision, thus hoping to promote a good trainer/trainee relationship and create a ‘modern apprenticeship’.

However, there are concerns about the creation of a ‘two-tier’ training system, where the significant reduction in service provision by IST trainees may in turn increase the service provision expected of current non-IST trainees. The suggestion of a minimum level of staffing on a full shift rota and the statement that 60% of duty time must take place within daylight hours may not be sustainable, particularly in some of the smaller specialties. The suggested weekly dedicated trainer/trainee meetings may be a challenge to deliver in a busy workplace. This needs redressed via appropriate consultant job planning and appraisal, with trainers being recognized to be just as important as managerial, leadership and academic roles, as well as appropriate feedback to clinical and educational supervisors from the Annual Review of Competency Progression (ARCP) process. IST may provide the drive to improve staffing, both medical and non-medical, to improve training opportunities. We must be aware that increased levels of rota staffing may have a deleterious effect on training opportunities available for each individual trainee, with many units now looking to provide work support to junior members of the team via allied roles such as advanced nurse practitioners and physicians’ associates.

Nevertheless, initiatives such as IST are a sign of increasing recognition and concerted effort by national bodies to address the negative aspects of surgical training and junior doctor wellbeing and further work should be encouraged.

Lessons from the COVID-19 pandemic
As the COVID-19 pandemic unfolds, all of our lives have been affected in a significant way, both within and outwith the workplace. Many junior doctors have been redeployed to other specialties and almost all rota have been redesigned at short notice, sometimes more than once. The national lockdown and closure of schools and nurseries provides an additional obstacle to the smooth functioning of the healthcare workforce. Junior doctors are facing some of the most challenging personal and professional conditions of their careers such as working long hours in personal protective equipment (PPE), trying to protect themselves and those at home from potential illness, adapting to new and unfamiliar ways of working, replacing training opportunities with service provision and facing exam postponements and recruitment delays. These are all against a backdrop of increasing numbers of NHS worker illness and fatalities and resulting grief and anxiety, and being unable to offer non-COVID-19 patients the treatment they require due to capacity and risk of nosocomial infection. Despite this, however, there are many very positive lessons to learn from the COVID-19 crisis in terms of the increased support available for junior (all) doctors.

In this time of immense change and uncertainty, there is a drive to keep staff well connected. There has been a major increase in online learning support for doctors redeployed to other specialties, or those navigating the changes to their own specialty as a result of the pandemic. As many doctors will face feelings of anxiety and fear, new online chat rooms and ‘safe spaces’ are being offered. Some therapeutic networks are offering free access to healthcare staff for therapy and listening services, and various apps are available to help with self-care. There are also regular newsletters, updates and online forums from educational bodies and many individual hospitals. The Joint Committee on Surgical Training (JCST) has worked in conjunction with the statutory bodies and the GMC, to rapidly develop processes to support trainee development via the ARCP. Some hospitals have opened new physical spaces to help support staff, such as ‘wobble rooms’ or ‘well-being suites’, and increased access to chaplaincy support.

The public support for healthcare workers has been remarkable. Many businesses have provided free food to NHS workers, a number of hotels are offering free rooms to healthcare staff and some transport companies are providing free transport. These expressions of solidarity will go far to raise the morale of junior doctors during this crisis, but whether this is sustained beyond the pandemic remains to be seen. There is no doubt that the psychological aftermath of the pandemic will be significant and we must ensure that there are strategies in place to offer support for our trainees (and the rest of the workforce) in the months and years to come. We must ensure that medical staff feel valued at all times.

Empowering junior doctors to engage and improve their working lives
There is little doubt that continued institutional change is required to enhance the working lives of our junior doctors. Trainees should also play their part in this journey and there are a number of strategies that may help junior doctors contribute to their own wellbeing.

Firstly, trainees should be encouraged to take an active approach to solving problems, by engaging with the medical hierarchy. This is already happening in some areas, with an increasing number of high-profile trainee committees and trainee representatives on professional society committees. For example, the RCSEd Anti-bullying and Undermining Campaign was endorsed by a number of trainee organizations and the trainee board members of specialty societies have been vocal in their own campaigns to raise awareness of junior doctor wellbeing issues. On a local level, trainees should be encouraged to bring their own concerns to their seniors, TPDs and Department of Medical Education and seek to carve out solutions, with escalation if the response is inadequate.

Suggestions to foster engagement between trainees and wider healthcare staff include reach-out programmes, including junior doctors shadowing hospital board members, and vice versa, with increasing presence of trainees on executive committees and corporate meetings. Trainees should be actively involved in the design of their rota and other organizational aspects of their training.

It is also important for junior doctors to identify time for activities to improve their physical and mental wellbeing. It is often difficult to feel motivated to find time for exercise and activities outside of work, however this should be encouraged and may be facilitated through hospital programmes such as the ‘cycle to work’ scheme, staff sports groups and provision of sports discounts.

Conclusion
There are a multitude of factors that contribute to the wellbeing of junior doctors and many national bodies are addressing the
mounting evidence of reduced satisfaction, low morale and poor wellbeing amongst our trainees. The responsibility lies not only with professional institutions, employers and senior colleagues, but also with the junior doctors themselves, to protect their own wellbeing while also protecting their patients and their profession. During the global COVID-19 pandemic, there have been some notable examples of improvements in support for trainees who are facing the most arduous time of their careers—the challenge now is to sustain and expand on these initiatives. There is much work still to be done, and we all have a part to play.

**Tips to enhance junior doctors’ working lives**

**Trainers**
- Manage trainee expectations appropriately
- Discuss aims of training placement with clear objectives
- Discuss training ‘needs’ versus training ‘wants’
- Be aware of non-clinical needs of trainees
- Look to other models of staffing delivery of patient care rather than relying solely on trainees
- Develop low tech simulation that is easily accessible
- Be familiar with return to work guidance
- Value your trainees
- Be familiar with return to work guidance
- Allow trainees to practise medicine within the confines of their limitations
- Recognize trainees require differing levels of supervision
- Recognize that trainees are here to be trained and should be supported throughout their mistakes
- Recognize that medicine is a long, hard but fulfilling career
- Realize that you will make mistakes and need to develop strategies for coping
- Recognize that you need resilience to practise medicine—it is not innate in us all and often needs to be fostered through positive and active behaviours
- Understand that resilience can be bolstered by acquiring the requisite knowledge, skills and competencies
- Be aware that training is a finite period of time—look for your training and do not wait for it to look for you
- Accept that service is an integral part of training
- Understand that trainers are learning too
- Pursue a ‘return to work’ process after periods of absence
- Find time for hobbies outside of work—exercise, socialize, spend time with family
- Avoid alcohol when tired or to relieve a stressful day
- Set a limit to time spent on social media
- Turn off emails when not at work—take joy in setting up ‘not at work’ replies

**Trainees**
- Avoid alcohol when tired or to relieve a stressful day
- Find time for hobbies outside of work—exercise, socialize, spend time with family
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