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Medical students' attitudes and expectations for future working conditions

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BACKGROUND

The doctors' strike in 2016 highlighted an ongoing debate on the tightening of working conditions for doctors. With this strike as a backdrop, we wanted to investigate the attitudes and expectations for future working conditions among medical students.

MATERIAL AND METHOD

Four focus-group interviews with a total of 21 medical students (48 % women, age 21–38 years) in their third to sixth year of study were conducted and analysed with the aid of systematic text condensation.

RESULTS

The students described how the doctors' efforts to help each other had a positive effect on the working environment, but might also paradoxically worsen the working conditions of the collegial community. They highlighted the importance of consensus around public health services, a good professional community and idealism, but perceived that these aspects could be threatened by competition for positions and distrust in political governance processes. The need to be competent and succeed in competing for temporary jobs, as well as a strong motivation to become a doctor, made the students vulnerable to accepting tough working conditions. The students' attitudes and expectations had mainly been formed through work placement experience and by family members, but the strike had impacted particularly the older cohorts' assessment of their future working situation.

INTERPRETATION

Medical students express concerns about accepting entry into a system that they are not immediately able to change, and where safeguarding their own needs and a favourable work-life balance might be difficult. This has implications for raising awareness of these issues during the medical studies and developing an organisational culture that ensures justifiable and sustainable working conditions for doctors.

Norwegian hospital doctors have long reported a persistently high level of job satisfaction (1), but also long average working hours where hectic days, long shifts and exemptions from the Working Environment Act are the norm (2, 3). The doctors are being charged with an increasing number of new tasks to be addressed, and little time is scheduled for rest during the on-call shifts (4). Many refer to the health enterprise model as problematic, with its long lines of decision-making authority, absence of a local management and activity-based funding (5). A survey of working hours conducted by the Norwegian Medical Association showed that hospital doctors work three hours of unpaid overtime per week on average, equivalent to 924 FTEs (6), despite the increase in the number of FTEs for doctors in the specialist health service in recent years. In addition to increasing external demands, professional norms among doctors may require them to yield their own personal needs to the needs of patients and workplaces, and thus mean that doctors go to great lengths to meet the requirements of their patients and colleagues (7). In parallel we can see that the doctor's role, which has previously been described as a lifestyle, is increasingly seen as a job by younger doctors (8).

This change can be interpreted in light of *self-determination theory* (SDT) (9). This theory describes various types of motivations, of which intrinsic motivation is the strongest driving force. Intrinsic motivation is described as wanting to do something because it is interesting and satisfying in itself and in line with one's own values and convictions. This contrasts with doing something in order to obtain a reward (extrinsic motivation). However, external motivation factors can gradually become internalised by being transformed into personal values and thus into intrinsic motivation. The change from regarding the medical profession as an identity to seeing it more as a job can illustrate this kind of transformation. Traditionally doctors have been motivated by providing patients with good and sufficient treatment – whereby the perception has been that for the sake of patients, one's colleagues and oneself, one needed to be a doctor nearly around the clock and work beyond the stipulated working hours. External regulations, such as compliance with agreed working hours, may gradually have turned into a more intrinsic form of

motivation. Younger doctors are still motivated by providing patients with good and sufficient treatment, but they also underscore the importance of a sound work-life balance for healthcare personnel as a key element in order to provide sustainable healthcare services. When both male and female medical students highlight a good work-life balance as one of the main values in their future working life (10), this may point to this kind of 'new' intrinsic motivation.

In 2016, disagreement arose between the employers' association Spekter and the Akademikerne trade union regarding the employers' right to regulate the work schedules for doctors. The doctors were concerned that individuals could be subjected to greater pressure by their employer to accept more unfavourable working hours. In the autumn of 2016 this conflict resulted in the doctors' strike, which was brought to a halt by compulsory arbitration (11, 12). Despite possibly unsettling trends in the working conditions of doctors, the number of applicants for medical studies in Norway has never been higher (13). In the wake of the strike, we as medical students were curious about the possible explanation for the apparent discrepancy between the increasing popularity of medical studies and the media reports of poor working conditions for doctors. We therefore wanted to investigate the prevailing attitudes and expectations for future working conditions among medical students.

Material and method

We chose to use qualitative methods in the form of focus-group interviews, since these are suitable for studying experiences, motivations, attitudes and expectations (14, 15). Four focus-group interviews with medical students at the University of Bergen – one group from each cohort from the third to the sixth year of study (five or six persons in each group, duration from 46 to 73 minutes) – were conducted in the period September 2017–February 2018. The participants were recruited through one person who had been informed about the study in each cohort. We informed them that the participants should vary in terms of sex and age, and that not only their close associates should be included. The University of Bergen trains 165 medical students each year, out of a total of 636 in Norway. We included a strategic sample with variation in terms of sex, age and geographic affiliation/place of origin, and only students with clinical experience. A total of 21 persons (48 % women) participated, with geographic variation south of Trøndelag county (southern Norway). The interview guide included questions about the students' ideas about their future working life and situation, and what issues, including the strike referred to above, had influenced them. Fimland and Kjenås acted as moderators and Schaufel as secretary during the interviews. Audio recordings of the focus-group interviews were transcribed and subsequently analysed with the aid of systematic text condensation by Fimland, Kjenås and Schaufel in collaboration (16). This is a thematic method of analysis, and consisted of the following four steps: 1) a read-through of the material to obtain a general overview; 2) identification of meaning units that represented different aspects of the participants' attitudes and expectations for future working conditions, with definition of codes for each; 3) condensation and summarising of the content in each group of codes; and 4) synthetisation of the content in each group of codes into generalised descriptions and concepts that reflect key experiences from the students' narratives. The analysis and recruitment were done in stages, and the dataset could thus be supplemented with different perspectives and experiences in successive interview rounds. The analytical process and the development of categories were documented in an analysis log (17). The project was assessed by the Regional Committee for Medical and Health Research Ethics (REK), which found that it was outside their remit, and approved by the Norwegian Centre for Research Data (NSD) (ref. no. 57452). The participants have provided written, informed consent to participation in the study.

Results

COLLEGIALITY AND REQUIREMENTS

Socialisation into a paradoxical collegiality and production culture may hinder standing up for good working conditions. The students described how the doctors' attempts to help each other out and be a good colleague was favourable for the working environment, but may have the paradoxical effect of worsening the working conditions for the collegial community. It appeared impossible for the students to arrive as novices and help change a well-established system where nobody goes home before all their work has been completed, thus to avoid offloading work onto their colleagues on the next shift. They described how during their studies they had increasingly come to recognise the compromises that would be involved in their future working life, and that their choice to become doctors might imply resigning themselves to the prevailing culture. However, the participants saw that the service that the doctors were doing the next colleague to come on shift might be a disservice in the wider context:

'I feel that it's part of the collegial relationship. You don't go home before you have done all you need to do, because that'll be hard on the next guy. And the threshold to asking for overtime, I feel… No, I think it's a bad culture. That is, your collegial behaviour means that you shoot yourself in the foot.' (Woman, interview no. 2).

The students saw that avoiding unpaid overtime was difficult, and described how they felt expected to turn up and work overtime, and not to record it. If they did, they might be regarded as an 'uncool' colleague, and nobody wanted to be the only one to insist on their rights and go home with work unfinished. Some pointed out that the strike might highlight the conflict around the documentation of overtime and give rise to conflicts between colleagues. The consequences of this undocumented overtime were seen as follows:

'When you don't record overtime, you're telling the finance staff that you are working for eight hours instead of twelve. They will then say that this department does fine with ten doctors, when it really needs fifteen. It's self-reinforcing – if you fail to record overtime, you end up by having to work even more.' (Man, interview no. 3).

They also expressed concern for the balance between working directly with patients and doing paperwork. One student referred to expectations that the doctor's presence should be part of the medicine provided to the patient, that 'perhaps some patients may need more doctor and less medicine'. However, the students observed that the doctors did what they could to avoid touching upon 'irrelevant matters' in their conversations with patients, and concluded the consultation as quickly as possible. Some students had been advised against choosing the medical profession by colleagues who were disappointed in the requirements for lots of paperwork to the detriment of time spent with patients. This was interpreted as part of resource scarcity and a production-oriented culture in the hospitals and described as negative framework conditions that the students nevertheless were prepared to accept:

'When doctors talk about how things have developed in recent years, they describe how you need to run faster and do more and more in a short time. There are always calls for more efficiency. That somehow, all arrows point downwards. I'm also prepared for this to continue in the same direction in the years to come.' (Man, interview no. 1).

CONSENSUS AND OPPOSING INTERESTS

The consensus around public health services, good professional communities and idealism could be threatened by competition for positions and distrust in the political leadership. The students agreed that public ownership was the cornerstone of the health services and highlighted the importance of endorsing it. Professional communities, research and repaying for their studies were pointed out as key factors. They expressed concern about the future of public health services, and the development towards more privatisation was referred to as 'a trend that needs to be reversed'. To them, the strike highlighted how concern for the collective ought to take precedence over personal gain:

'And it will solve nothing to take a job at Volvat [a private medical centre]. This is a matter of trying to pull together. It solves nothing to go into private practice in order to have a better personal situation. It's more serious than that, it's not very health-promoting if everybody else needs to shoulder that burden. In addition, we have been given a free education by the state, so it will not be an option for the next 30 years at least.' (Man, interview no. 1).

On the other hand, they pointed out that increasing pressure on public services could put such values under threat and induce some to take a more positive view of working in private health care. They recounted that specialty registrars in temporary positions were dissatisfied, and described how not being permanently employed made it difficult to address problems and openly criticise reprehensible working conditions. These problems were related to competition between colleagues, which gives rise to uncertainty about renewing temporary positions and permanent employment. They observed that in the contest for permanent jobs in public hospitals, the pressure might reach a level that could cause them to leave:

'I think that as long as there is competition, people will be willing to go to great lengths. And then it's clear that those who are most willing to accept a little extra will be the most popular among the employers as well. When thinking a little cynically, that is.' (Woman, interview no. 2).

The students felt sympathetic about their immediate superiors' need to comply with budgets and requirements, but expressed distrust in policies and systems when it came to being shown consideration as an employee. This eroded the enthusiasm for the profession and the discipline, and not least patient safety. The strike was described as an outcome of the distrust between doctors and employers. One student had observed the pressures placed on doctors when duty rosters were negotiated, when a woman who was pregnant in the third trimester was pressured into taking a vacant on-call shift.

MOTIVATION AND WORKING CONDITIONS

A strong motivation for the medical profession and the need to be good at their work made the students vulnerable to accepting tough working conditions. They were aware that the role might involve a lot of responsibility and long shifts, and that it occasionally could be an arduous and demanding profession, but they nevertheless expressed a deep-felt motivation to become a doctor. The students saw that many doctors felt so privileged to have such a meaningful position that they disregarded their own needs. It was important for them to prioritise the patients' needs, and they were willing to spend the time deemed necessary to provide the patients with what they felt was needed. A student with a temporary licence noted that making a difference for a single patient or working with an inspiring colleague compensated for an otherwise busy working day. The strong motivation to help others, combined with the need to be hard-working and do a good job in order to win the competition for temporary employment might imply that they would not pay attention to their own needs to the same extent. They accepted that tough conditions were to be expected by those who were permitted to become doctors, and saw it is a unique opportunity to enjoy an exciting and rewarding working life:

'It's the price to be paid for a high-status profession. People know that being a doctor is hard, and that there are demands to be faced – this is a fact we need to accept if we are to become doctors. (…) It's part of the game.' (Man, interview no. 1).

In contrast to this, some narratives described how great dedication and a lot of time spent working might have negative repercussions for family life and relationships, including divorces and children who say that 'mum is living at the hospital'. Some described colleagues around them as 'superhuman', while they themselves were left with a feeling of having limited work capacity, resulting in a guilty conscience. Such attitudes and expectations for one's own future career were mainly shaped by experience from work placement and by other family members. In the older cohorts, however, many students claimed that the strike had helped shape their ideas about daily life in medical practice, and

that this had helped them become better informed and more aware of the work situation. The strike was described as 'a bit of a wake-up call' in terms of what they were heading for and likely to meet in the medical profession. They were nevertheless concerned that the need to make a good impression by demonstrating a high work capacity would reduce their ability to accept their own limitations and need to rest:

'But perhaps it's difficult to envisage how one may tackle it oneself and how it will be felt first-hand. That these may not be priorities you want to set yourself, but you have sort of accepted that this is what being a doctor is like. Because you've seen others do it.' (Woman, interview no. 2).

Discussion

Medical students in all focus groups expressed both a strong motivation to become doctors and concern regarding their own professional future and development in the public healthcare sector in the wake of the strike. They were prepared to face a number of dilemmas, such as choosing between specialisation and time with the family, and seeing that they would have to work a lot of overtime that might make it difficult to prioritise their own needs. They saw few opportunities to influence the culture they observed. Below we discuss the implications of our findings, as well as the strengths and weaknesses of the study.

PROFESSIONAL AND ORGANISATIONAL CULTURE

The importance of well-being among health personnel is increasingly studied as a precondition for the quality of patient treatment (18, 19). Previous studies have shown that we are socialised into a culture with given premises for behaviour and conformity (20, 21), where it may be hard to strike a balance between the ethical and medical responsibility for the patient on the one hand and the prevailing frameworks and development of a professional identity on the other (22, 23). Descriptions show the importance of group conformity for the way in which each medical student adapts their behaviour and attitudes during the study programme (24). Combined with impressions from work placements during the programme and input from doctors engaged in clinical work, this may generate a shared perception of the values that a doctor should uphold. Our findings from the medical students' narratives elucidate how a gradual adaptation to the requirements of clinical practice may help explain the socialisation into a culture that involves a lot of overtime hours and a poor work-life balance, while the students are clearly critical of this trend. In light of self-determination theory, this could be understood as a transition between different forms of intrinsic motivation (9). The students recount how many of the colleagues whom they meet are motivated by providing their patients with good and sufficient care – in the sense that for the sake of the patients, colleagues and themselves they have to be doctors around the clock and work beyond the scheduled hours. On the other hand, the students' attitudes can be seen as reflecting a motivation to provide the patients with good and sufficient treatment, but that this also requires the doctor to enjoy a favourable work-life balance. They describe how the more traditional notion can be seen as inappropriate, and at worst give rise to poor working conditions for the medical profession as a whole.

TENSIONS IN THE DOCTOR'S LIFE

The students' attitudes to the medical profession and desire to enter it despite their awareness of the arduous nature of the working situation is a striking finding in this study. Many of them told us that their concerns and scepticism with regard to the heavy workload and exemptions from the Working Environment Act made them inclined to attempt to change the system. This notwithstanding, their confidence in the possibility of change was mixed with resignation, since the system is seen as large and difficult, if not impossible, to change.

In 1957, Festinger described a theory of cognitive dissonance: when one's own values and attitudes come into conflict with the environment, psychological discomfort arises. The human need to ease such inner conflicts manifests itself in attempts to change attitudes or avoid those particular environments (25). Going from being a medical student with attitudes to frameworks that have not yet been challenged to being a doctor who is embedded in the system and constantly perceives this dissonance may give rise to a change in values and increasing acceptance of the system of which the doctor is part. The students identify and express concern and dissatisfaction with a number of the compromises that have to be made. Accepting to do unpaid work to help out the next colleague to come on shift, or to choose to stay there for the patient or qualify in a desired specialty may be perceived as a threat to the ability to prioritise one's own needs, family and leisure time. On the other hand, it is important to point out that Norwegian specialty registrars report high levels of job satisfaction, despite working longer hours than the average, and we can see a trend towards more family-friendly working hours and a correlation between significantly shorter working hours and higher levels of well-being (26). To better prepare doctors to endure the tension between their intrinsic motivation and the prevailing working conditions, it is crucial that this be discussed and focused upon during medical study programmes and later in the health trusts.

VALIDITY AND TRANSFERABILITY

Qualitative methodology is suited for gaining access to personal experiences and narratives that can elucidate the research question in a richer and broader way than with standardised questionnaires (14). The study was undertaken in a single university in Norway, but a broad-based sample of informants will nevertheless help make the experiences and expectations transferable to and recognisable by medical students in other places of study. The interviews were moderated by fellow students at the same university, and we chose to conduct group interviews rather than individual interviews. This may have influenced the students' choice of what they wanted to share. Our impression was that this interview format created a setting characterised by trust and induced the participants to sincerely share their experiences and ideas, including feelings of uncertainty and vulnerability. The two first authors' motivation stemmed from their involvement in the doctors' strike and their perception of how Norwegian doctors are exposed to increasingly tough demands, as seen through the eyes of medical students. This may have influenced the research question and swayed the further interpretation of the interviews in a critical direction. The fact that the strike and the concomitant conflict with the employers served as the basis for the interviews may also have affected the data collection through its focus on negative framework conditions and by having attracted the most negatively inclined students as informants. However, the participants reported seeing the advantages of their choice of profession and positive expectations for their future working life, which underscores the nuanced and varied nature of their viewpoints. They also reported strongly varying experiences and impressions from the strike. The last authors, who are specialists in occupational medicine and cardiology respectively, have also followed up elements in the data collection and analysis that could elucidate the findings from a clinical point of view.

Conclusion

The medical students' strong motivation to become doctors is an important driving force, but it could also render them vulnerable to adapt to working situations with a lot of overtime and time constraints in order to remain competitive and meet the requirements of colleagues and employers. The students are concerned about having to accept and enter into a system they are not immediately able to change, where safeguarding their own needs and a favourable work-life balance may be difficult. This has implications in terms of raising the awareness of such issues during medical studies, and for developing an organisational culture that ensures appropriate and sustainable working conditions for doctors.

MAIN FINDINGS

Socialisation into a paradoxical collegiality and production culture hinder efforts to improve working conditions.

Consensus around public health services, good professional communities and idealism may be threatened by competition for jobs and distrust in the political leadership.

A strong motivation for entering the medical profession and a need to be seen as accomplished doctors made the students vulnerable to accepting tough working conditions.

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