

The junior doctor experience in Singapore through a temporal prism

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Junior doctor well-being has been a pressing topic for the national healthcare system in Singapore for several years,¹ with myriad implications on mental health, quality of life and work performance, and further follow-on effects on patient care and outcomes.² Cultural factors in the workplace have been strongly implicated in junior doctor well-being and work performance. A disconnect between senior and junior staff has been suggested as a significant source of mismatched expectations and hence tension.

Anecdotally, this disconnect is often attributed to the fact that senior doctors in the public healthcare system perceive that their own experiences as junior doctors were more challenging than those of the current generation. The refrain that things were more difficult “in my time” is perhaps a familiar one to many successive generations of doctors in Singapore. The practice of medicine has indubitably changed over the last few decades. In this issue of the *Annals*, O’Hara et al. aimed to shed light on the changes in the lived experiences of junior doctors in Singapore over the generations.³ This is a novel perspective that is distinct from previous work on this topic that has tended to be cross-sectional and relevant mainly to a single time period.

In this qualitative study, the authors interviewed 30 participants across 41 years of seniority of practice. This study focused solely on a description of participants’ lived experiences, followed by a discussion of the similarities and differences across the years. In their analysis, the authors relied on thematic analysis to derive factors that “improved” or “worsened” the experience. They then constructed a model based on the socioecological model (SEM)⁴ to classify these factors based on impact at the individual, interpersonal, institutional, community and policy levels, with an overarching category of time period as a modifier. They observed a large amount of overlap between the categories, and hence chose to describe an overlapping Venn diagram-based model instead of the typical onion-layered SEM.

Unsurprisingly, marked differences in working conditions were noted across the years. O’Hara et al.

incorporated anecdotal information on working conditions obtained from their interviews, with secondary sources to illustrate working conditions in 3 time periods—1970s, 2000s and 2020s. This roughly corresponded to the 3 cohorts that participants were banded into. Working and duty hours and workload as measured by patient load appeared to decrease, but non-clinical workload appeared to increase. More significantly, complexity of care was also perceived to have increased—a finding that has not been formally reported in Singapore before. At the same time, specialist training and career opportunities became more codified, as did supervision of junior doctors. This was on a background of structural changes and 2 generation-defining pandemics. Much of the extant literature on this topic focused on both pandemics⁵; but this work helps to fill in the gaps in between.

An interesting observation is that many of the structural milestones recorded, especially from the senior cohort, were anecdotal rather than based on independent sources. At the same time, participants in the study cited tangible measures to support learning, training and rest as significant factors that improved the junior doctor experience. Furthermore, having junior doctors involved in deliberations on improving conditions seemed to be a positive experience across cohorts. This may be a reminder to policymakers and organisations that while deliberations on changes to working conditions may often take place in committee settings, such as the recent National Wellness Committee for Junior Doctors, communicating the findings and recommendations could be important both for improving participation from the junior doctors as well as future understanding by observers.

Despite significant differences in the nature and conditions of practice across the more than 2 decades of experience captured in the study, there were striking similarities in the thematic factors identified. Strong camaraderie between team members, support from seniors and mentorship were factors that improved the experience of participants from all cohorts. It is heartening to see that a culture of peer support within the medical community has persisted over the

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generations. Organisational culture has been described as a key factor contributing to job satisfaction in junior doctors previously.⁶ Arguably, this culture is an under-recognised buttress against the myriad changes in working conditions highlighted across the years. This may be a potentially valuable resource that policy-makers and organisations should tap on in their future efforts to improve wellness.

Conversely, there also remained a consistent negative undercurrent of maladaptive coping strategies to stress across the cohorts, with some sobering anecdotes of potential self-harm shared. Previous studies in the Singapore context have suggested that senior doctors are more resilient than junior doctors⁷ and hence are less burnt out, with a higher quality of life.⁸ The findings from this study across time periods remind us that the current generation of senior doctors was perhaps no different during their time as juniors from the junior doctors of today; differences in observed measures of resilience may represent both learned behaviour as well as be affected by hindsight and survivor bias.

Finally, the effect of the changing nature of practice and consequent differences in professional agency is an important finding. Participants across cohorts appeared to agree that one such change is the rise of “defensive medicine”. One participant from the senior cohort shared that it caused them to leave practice, those from the middle cohort focused on the changes to how they approached and investigated patients, while those from the junior cohort focused on the effects on their workload. As professional development and fulfilment were strong fortifying themes across cohorts, changes to practice that affect how individuals see their roles and relationship with patients could undermine junior doctors’ sense of agency and progression towards professional self-actualisation.

This study has some limitations that may limit its generalisability. The authors sampled a small selection of 30 participants; with between 8 and 11 participants in each cohort, it is possible that respondents may not necessarily be representative of the overall population of junior doctors. It is striking that participating in advocacy for junior doctors was a consistent theme identified across generations, which may suggest some degree of selection bias for participants who are more engaged about junior doctor well-being or who may have their own entrenched viewpoints on the issue. Furthermore, there is the possibility of recall bias in senior doctors who may recollect their more “extreme” experiences (whether positive or negative) more vividly. Lastly, there is the possibility of survivor bias, as doctors with extremely negative experiences may have already left the profession and are not available for recruitment.

As this study used a phenomenological approach, which is primarily descriptive, further work can be done in this area to better understand the junior doctor experience and factors affecting well-being. Other contemporary approaches towards evaluating physician well-being have utilised the job demands-resources model developed by Bakker and Demerouti,⁹ with modifications for the Singapore context.¹⁰ While this model helps to illustrate relationships between factors better than the SEM, it still lacks a temporal dimension. Future studies should incorporate a temporal element into their analysis and model-building, to allow continued relevance to the succeeding generations of junior doctors through informing adaptive workforce policies.

To conclude, this study highlights some points that may be useful to policymakers. Involving junior doctors in policy-making committees and facilitating clear communication of findings are important to ensure relevance and support buy-in. Robust mechanisms should be put in place to monitor for maladaptive coping behaviours to stress. Changes in the nature and scope of practice need to be monitored for their impact on the professional agency and consequently self-actualisation of junior doctors.

A key development is the rise of digitisation and artificial intelligence (AI) in healthcare. This study concluded in 2022, prior to the emergence of generative AI models into the zeitgeist. Even then, increasing healthcare digitisation was already seen as a key developing challenge for junior doctors in this study. Since then, the development and implementation of AI tools have become a key direction of the Ministry of Health in Singapore.¹¹ It is likely that AI tools will disrupt current clinical workflows and have a transformative impact on the junior doctor experience. Such transformation may be beneficial through a reduction in workload but may also have risks such as cognitive offloading and de-skilling. Further in-depth study is warranted to explore the effect of these technologies on both well-being and professional identity development in junior doctors in Singapore.

Ethics statement

Not applicable.

Declaration

The authors declare there are no affiliations with or involvement in any organisation or entity with any financial interest in the subject matter or materials discussed in this manuscript.

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