FROM TRADITION TO TRANSITION

NAVIGATING THROUGH THE HEALTHCARE WORKFORCE CRISIS

JUNIOR DOCTORS' EXPERIENCES AND PROPOSALS FOR THE FUTURE

EUROPEAN JUNIOR DOCTORS

EJD

ON BEHALF OF THE EUROPEAN JUNIOR DOCTORS ASSOCIATION

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We extend our deepest gratitude to the National Member Associations whose unwavering commitment and collaborative spirit have been instrumental in bringing this work to completion. Furthermore, we reserve special appreciation for junior doctors throughout Europe. Over the past decades, they have shown extraordinary resilience, enduring immensely challenging conditions. Their experiences and tenacity not only inform this report but also inspire a brighter, collaborative future for healthcare across the continent.

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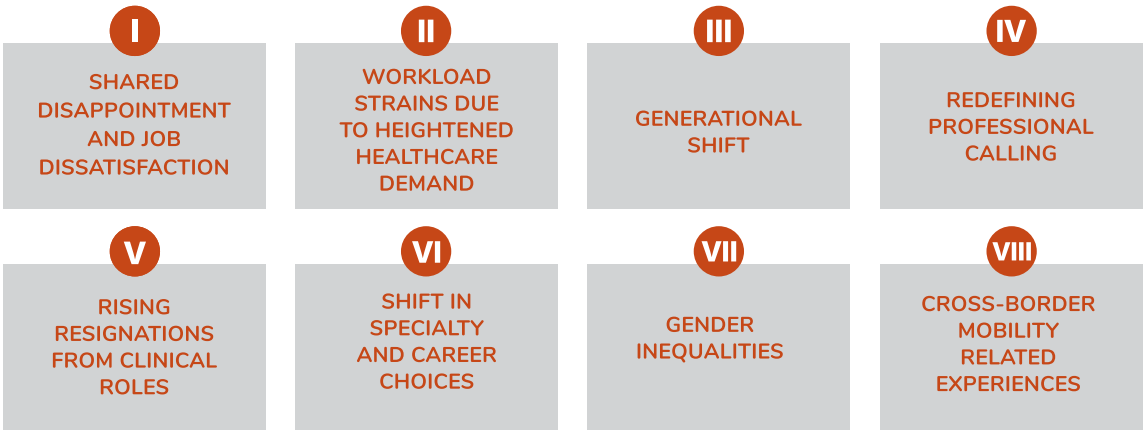
Executive Summary

The **European Junior Doctors Association** (EJD), in collaboration with the **APLICA cooperative**, undertook a qualitative study to explore the work-related experiences of junior doctors (JD) in Europe, focusing on the impact of those experiences on their professional and personal lives. It also aimed to present their ideas for improving junior doctors' working lives and increasing JD job satisfaction. Seventeen semi-structured interviews were conducted with representatives from 24 National Medical Associations and a thematic analysis of the content of the interviews was carried out. The study aimed not to collect aspects of divergence but relatively common experiences and proposals from the participating countries. European countries showcase differences in their healthcare systems, training structures, remuneration, and cultural values, such as work culture and family dynamics. These differences inevitably shape the perspectives of interviewees. **However, a notable discovery from this report is that regardless of these varied backgrounds, there is remarkable consistency and agreement among study participants regarding the central concerns and issues.**

1. Overview of Junior Doctors' situation in Europe



Despite wide variability among European countries, a significant consensus emerged:

I. SHARED DISAPPOINTMENT AND JOB DISSATISFACTION › Regardless of the countries' specifics, junior doctors across Europe share a sense of unease and dissatisfaction with their jobs.

II. **WORKLOAD STRAINS DUE TO HEIGHTENED HEALTHCARE DEMAND ›** Junior doctors struggle with an excessive workload due to rising demand in healthcare systems. Handling more patients than feasible in the given time may compel them to make hasty decisions, often without adequate supervision or reflection. This situation, combined with their relative inexperience, creates insecurity about the quality of care they provide. Many feel they can't deliver the best patient care, leading to pronounced frustration.

III. **GENERATIONAL SHIFT ›** Today's junior doctors seek a balance between their personal and professional life. Unlike previous generations that placed work at the centre of their identity, contemporary junior doctors prioritise their families, personal time and personal and professional development. This shift in perspective, coupled with the current medical workforce shortages, allows them more agency in job selection and the specialties they pursue.

IV. **REDEFINING PROFESSIONAL CALLING ›** While junior doctors are deeply passionate about their profession, they demand fair compensation and respect for their time. They no longer accept overworking as merely a part of the "vocational" motivation.

V. **RISING RESIGNATIONS FROM CLINICAL ROLES ›** Many junior doctors, over-burdened by the challenges and conditions in the clinical field, are choosing to resign from their positions. They are increasingly drawn to opportunities outside of direct patient care and even outside the medical profession. This trend not only highlights the depth of dissatisfaction but also raises significant concerns about the sustainability of the future medical workforce.

VI. **SHIFT IN SPECIALTY AND CAREER CHOICES ›** Due to workplace dynamics, junior doctors are drawn to specialties offering better working conditions that can lead to medicine becoming less attractive for some potential entrants. In turn, this could exacerbate existing workforce problems.

VII. **GENDER INEQUALITIES ›** Junior doctors face disparities shaped by both gender and migration experiences. Female junior doctors, influenced by traditional gender norms, often face career interruptions, part-time work biases, specialty segregation, pay gaps, and exposure to specific workplace violence.

VIII. **CROSS-BORDER MOBILITY RELATED EXPERIENCES ›** Migrant junior doctors, confront restricted professional growth, limited training, and challenges in social integration.

2. Factors Influencing Job Satisfaction

The study has identified three cross-cutting elements which affect junior doctors' job satisfaction: work-related experiences, training-related experiences, and difficulties in work-life balance.

A. WORK-RELATED EXPERIENCES

- **Work overload** › This is unanimously recognized as a dominant concern. A disproportionate number of patients relative to the available time, increased bureaucratic tasks, a rapid pace, lack of strategic resource planning, and the continual need to "put out fires" results in physical and mental exhaustion.
- **Poor working environment** › A tense, pressurised, and stressful atmosphere prevails in the healthcare sector; this negatively affects inter-professional relationships. Junior doctors often face a lack of recognition for their efforts and are particularly vulnerable to mistreatment due to their dependent positions.
- **Compensation concerns** › Relative to their workload, work hours and professional responsibilities, many junior doctors find their remuneration inadequate.
- **Lack of flexibility** › prevents junior doctors from dedicating their efforts to academic tasks that are fundamental for their training, limits their participation in educational activities and makes it difficult for them to reconcile work and caregiving responsibilities such as childcare.

- **Mobility and employment concerns** › The need for frequent relocations and a surge in temporary employment opportunities have raised dissatisfaction.

B. TRAINING-RELATED EXPERIENCES › While postgraduate training programmes have been praised, there are clear areas of concern:

- High workloads overshadow training requirements. The overarching work stress compromises the quality of training received by junior doctors.
- Lack of adequate supervision and feedback mechanisms.
- Lack of time for academic activities
- Sense of insufficient progress and inadequate clinical skills.

C. WORK-LIFE BALANCE › A lack of flexibility and rotating timetables often clash with many personal activities, especially those related to care-taking responsibilities as well as significant difficulties in planning one's personal life. A lack of opportunities to achieve this equilibrium may be a reason for making decisions which may have a negative impact on career advancement.

3. Proposals and Recommendations

The participants have presented strategies to boost job satisfaction and retention. These suggestions aim to revitalise the healthcare sector, particularly focusing on the needs and aspirations of junior doctors.

1 Governance

- Medical workforce must be considered a central issue in national and European health policy agendas.
- Implementation of robust medical workforce planning and forecasting systems.
- Increase health workforce investment.
- Align workforce strategies and healthcare policies with the evolving work values of new generations of doctors.

2 Working Conditions

- Increased flexibility in the workplace.
- Strategies to improve working environments.
- Monitoring and reducing workloads.
- Limiting and monitoring of working hours, compliance with EWTD and ensuring rest periods.
- Fair and adequate remuneration.

3 Work & Work-life Balance

- Offer greater work flexibility and autonomy.
- Rethink shifting and scheduling.
- Increase job stability and career progression.

4 Occupational Wellbeing

- Increase research and available indicators on junior doctors' wellbeing.
- Promote professional networking and bonding for a better work atmosphere.
- Monitoring and increasing professional satisfaction.

5 Training

- Safeguard structured, competency-based training programs.
- Standardise training across Europe and allocate time for professional development.
- Allocate sufficient quality training time for both trainees and supervisors.

6 Addressing Inequalities

- Promote gender diversity and reduce discrimination.
- Advocate for gender parity in leadership and initiate policies to diminish pay gaps.
- Provide knowledge and skills directed at all health professionals regarding gender and migration inequalities.

Amidst the pressing challenges of the medical workforce, this document unveils critical insights into junior doctors' European experiences. By shedding light on their concerns, ranging from overwhelming workloads to changing generational values and systemic inequalities, we emphasise the urgent need for reform. Addressing these issues is not merely improving individual job satisfaction but safeguarding the very fabric of healthcare systems that rely on the dedication and expertise of these early-career physicians. Understanding and acting upon these insights becomes paramount to ensuring a resilient, effective, and compassionate healthcare future in a time of workforce scarcity.

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ABBREVIATIONS AND ACRONYMS

TEXT, TABLES AND FIGURES

List of abbreviations and acronyms in the report's text, tables and figures

ECS — Early Career Specialist

EJD — European Junior Doctors Association

EWTD — European Working Time Directive

JD — Junior Doctor

MWF — Medical Workforce

PGT — Postgraduate Training Program

VERBATIM QUOTES

List of abbreviations in the report's verbatim quotes

I — Interviewer

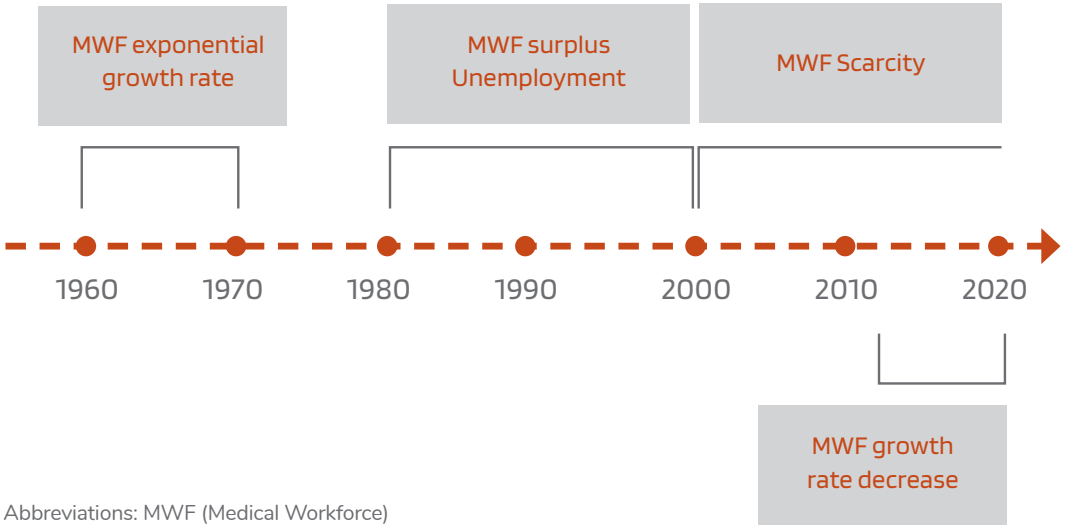
P — Participant

Introduction and objectives

INTRODUCTION

Since the 1960s, there has been growth in the number of active health care workers in the European Union countries. This growth has been steady but oscillating, increasing at a slower rate between the periods of 2013 to 2020 due to the effect of the 2008 financial crisis and austerity policies[1] Figure 1. Despite the oscillations, the number of active physicians increased in the European Union between 2015 and 2020: in 2020, there were 1.75 million physicians in this region, a figure that was approximately 1.3 million in 1990. This increase in the number of professionals is explained not only by the growth of the European population but also by anticipation and planning of the increase in the demand for health care due to the ageing of the population and the existing trends of offering medical care at the consumer's convenience[1].

Figure 1. Medical workforce growth rate timeline



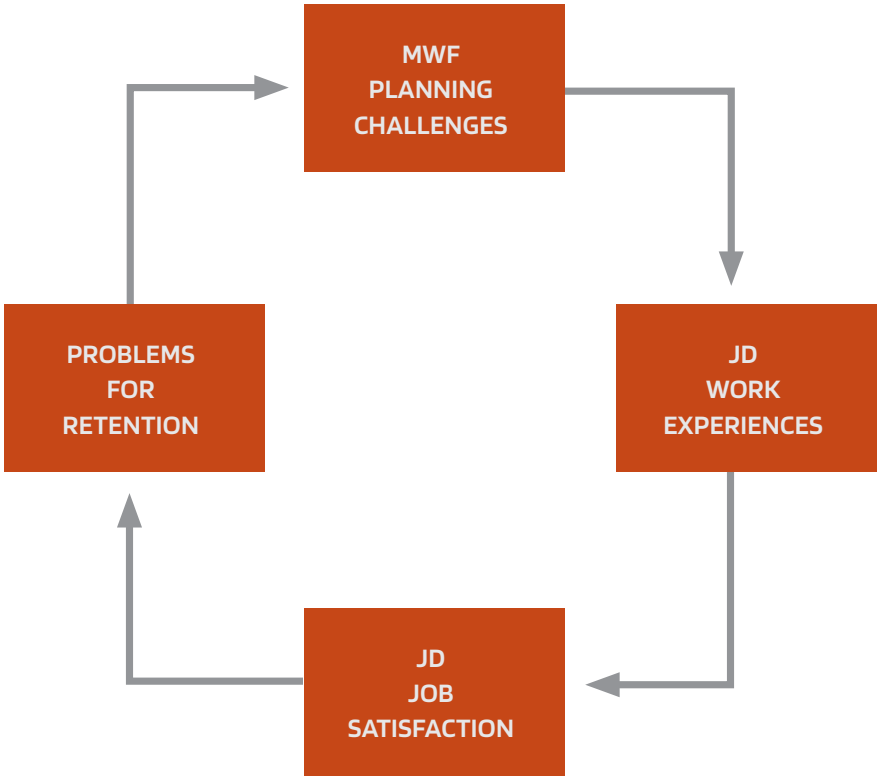
Abbreviations: MWF (Medical Workforce)

Despite the growth in the number of working professionals, all countries in the WHO European Region are currently facing significant challenges related to medical workforce (MWF) planning[2], which have been exacerbated after the effects of the COVID-19 pandemic on health care systems[3]. These challenges include a long-term shortage of professionals; insufficient recruitment in certain sectors (such as primary care and mental health); and problems of retention and difficulties in attracting and retaining personnel in rural and remote areas, with the consequent appearance of "medical deserts" or areas whose population has inadequate access to health care[2]. In addition, the inadequate investment in workforce development is widespread in Europe, making it difficult to address these problems efficiently[2].

Among the problems mentioned, the retention of health care personnel has recently gained prominence in MWF planning[Figure 2]. According to Mobley's 1977 model, there is a significant correlation between job dissatisfaction and intention to quit[4] [5].

In addition, the negative self-perceptions and poor evaluations of the work done by health professionals, which indicate job dissatisfaction, are associated with the appearance of psychological discomfort, with burnout syndrome being one of its most frequent expression[6]. It is therefore not surprising that the retention of personnel has been difficult in recent years[7] due to tough working conditions and their impact on the psychosocial well-being of professionals.

Figure 2. **Relationship between the work experiences of JD and MWF planning challenges**



Abbreviations: MWF (Medical Workforce); JD (Junior Doctors)

Junior doctors are highly affected by burnout syndrome; therefore, it is important to assess their situation specifically[8]. A meta-regression by Naji et al. in 2021 estimates that, in residents, the aggregate prevalence of burnout is 47.3%[8]. Occupational burnout syndrome is also associated with the intention to quit a medical career, according to the findings of a 2019 systematic review, which focused specifically on the young physician

population[9]. According to the systematic review by Zhou et *al*., in 2020, work-related factors have a greater impact on the occurrence of burnout and stress in residents than other nonmodifiable factors (such as age)[10]. Thus, the authors conclude that work overload increases residents' odds of burnout approximately three times followed by patient care concerns, poor work environment and work-life balance issues[10]. Some of these risk factors were identified as problems commonly affecting junior doctors by a survey conducted by the Medical Workforce working group of the European Junior Doctors Association (EJD) in 2022, such as work overload and the difficulties (or bottlenecks) they encounter in moving from stage to stage of their working lives[11]. Therefore, it seems important to delve into the work-related experiences of this group of professionals to identify the possible factors that are contributing to the difficulties for their retention.

Another element of growing importance for MWF planning is the substantial change in the demographic profile of medical professionals. In recent decades, we have witnessed the ageing of the medical population pyramid. Approximately 30% of active professionals in the European region are over 60 years of age and, therefore, will retire in the next 5 years[2], making it necessary to ensure the generational replacement of human resources that will be needed. Moreover, the profession has gradually become more feminised over the past decades, with the percentage of women increasing from 43% in 2010 to 48% in 2020[2]. The health care sector, like many others, reproduces gender inequalities: the wage gap for health care professionals is approximately 20% (estimated at 12% in other sectors), and there is a glass ceiling (underrepresentation of women in leadership positions)[12], with existing equality policies in the European framework being insufficient to combat these inequalities[2]. Similarly, the above-cited meta-analysis by Zhou et al. concludes that female gender is a risk factor for the appearance of burnout in young professionals[10].

As stated above, to address the problems of MWF planning, we must consider not only the lack of personnel but also the problems of retention, paying special attention to the group of junior doctors and addressing the problem from a gender perspective. Thus, it is important to consider the work-related experiences of European junior doctors, their impact on junior doctors' professional and personal lives and the proposals of the junior doctor collective to increase their job satisfaction, taking into account their perspectives and priorities.

OBJECTIVES

General objective

To explore European junior doctors' work-related experiences and the impact of those experiences on their personal and professional lives.

Specific objectives

- To identify similarities in junior doctors' work-related experiences in the different member countries of the European Junior Doctors Association.
- To collect proposals from European junior doctors for increasing their job satisfaction and thereby contributing to the retention of personnel within this group.

Methodology

Design

Study based on **semi structured interviews**, with a **thematic analysis** of the data collected. The study was conducted between **January and June 2023** with the **with representatives of the national medical associations which are members of the European Junior Doctors Association** (Table 3).

EJD National Members			
Austria	France	Latvia	Portugal
Croatia	Germany	Lithuania	Slovenia
Czech Republic	Greece	Luxembourg	Spain
Denmark	Hungary	Malta	Sweden
Estonia	Ireland	Netherlands	Turkey
Finland	Italy	Norway	United Kingdom

Table 3. **EJD's National Medical Associations**

Participants and sample

Because they are closely related to the research problem and have representative functions for the group of junior doctors in their country, **representatives from each of the member states of EJD** were selected to participate in the study. Gender was used as a **criterion for the sample configuration** to ensure parity or overrepresentation of people who identify with the female gender, which was achieved.

As this study was based on qualitative techniques, **purposive sampling** was used, and participants were selected based on specific characteristics relevant to this particular project (country of origin and gender), with the aim of gathering in-depth and valuable data to achieve the study's objectives. For the **selection of participants**, EJD provided the research team with the contact details of the representatives of each country previously selected by the members of each of the Association's delegations. The research team then contacted the chosen representatives to participate through messaging channels or email.

All EJD member countries were represented in the **sample**, which consisted of 25 people, 10 male and 15 female, between 25 and 47 years old, with 16 of them in their postgraduate training programme (PGT) and 9 in early career specialist years (ECS). The main sociodemographic characteristics of the sample are described in Table 4.

Gender		
Male	10	40%
Female	15	60%
Age		
25-30	10	40%
31-35	9	36%
36-40	5	20%
41-50	1	4%
Part of JD's journey		
PGT	16	64%
ECS	9	36%
Specialisations		
1	22	88%
>1	3	12%
Total participants	**25**	**100%**

Table 4. **Description of the sample's sociodemographic variables of interest**

A total of 17 interviews were conducted, 8 double and 9 individual, based on feasibility criteria. One of the topics explored during the interviews was the gender inequities that might affect the MWF. For this reason, those countries with greater implementation of measures to reduce such inequalities among health personnel were grouped to explore gender-related issues. In a preanalysis carried out by the research team, it was considered necessary to complete the information on this topic. Thus, a group was convened to focus on this issue, with the group's women participants selected based on their experience and knowledge of gender-related issues. This justifies Finland's double representation in the study.

Data collection process and dimensions to be explored

For data collection, the elected technique was the **semistructured interview**. The interviews were **moderated by professionals** with experience in qualitative research and were conducted in English, as this was the common language for all participants. The interviews were conducted **online,** and their duration was approximately 1 h 30 min when they were double and 1 h when they were individual.

In consensus with EJD, a **script** was developed to serve as a reference for conducting the semistructured interviews. However, the interviews were developed with the flexibility inherent in this type of research technique to explore the maximum diversity of ideas and opinions of the participants.

Based on the literature review, the **dimensions to be explored** during the interviews were selected in relation to the topic of study, and they are summarised in Table 5.

Name	Definition
Job satisfaction	Opinions of JD on the collective's job satisfaction
Wellbeing	Impact of work on JD's wellbeing, emotions and psychosocial sphere
Job resignations	Opinions on job resignations of JD
Working experiences	JD's work-related experiences and their impact (e.g., working conditions, working hours, workload)
Quality of training	Impact of work on JD's skills acquisition, supervision by mentors, PGT programs' quality
Personal lives	Impact of work on JD's personal lives
Gender inequalities	Gender inequalities experienced by JD regarding work, wellbeing, quality of training
Proposals	EJD's proposals or recommendations to improve JD professional satisfaction and wellbeing
Specific issues	Experiences or impacts related to certain contexts (country, postgraduate training programme, early career specialist or specialty)

Table 5. **Summary of the dimensions to be explored during the project**

The interviews were **recorded** (after the participants' consent was obtained) and **transcribed verbatim**.

Data analysis

A **thematic analysis** of the data from the interviews was carried out. This method of analysis was used to delimit and organise the representative themes of the verbatim transcripts, facilitating their interpretation according to the theoretical framework. The analysis was supported by the 9th version of the ATLAS.ti qualitative research software.

The themes under which the analysis was structured were built on the basis of the dimensions to be explored, described in the previous section, and relevant information from the participants' discourses (emerging dimensions).

Ethical and legal aspects

An **informed consent process** was carried out with all participants, which ended with the signing of a form.

The personal data of the participants were processed in accordance with **Regulation (EU) 2016/679** of the European Parliament and of the Council of 27 April 2016, General Data Protection. For reasons of validity and representativeness, a list of the organizations which provided with designated representatives can be found at the end of the document. **Confidentiality** in data processing, which is a fundamental principle, was guaranteed. To reduce the effect of the published list on the privacy of the participants, none of the quotes in this report are directly associated with data that could facilitate the identification of the person from whom they were obtained. Thus, none of the verbatim quotes are associated with the country of origin of the person who provided them, except for those from Turkey due to the unusual events affecting that country.

Results

There is wide variability among European countries in terms of their health care systems and organisational cultures. This means that their realities may differ in terms of issues such as access to and organisation of training programmes and remuneration. In addition, there are sociological and/or political differences in EJD member countries such as work culture, family values and economic context. This variability should affect the discourse of the interviewees, whose ideas emerge from the contexts with which they are familiar.

This study does not intend to address these aspects of divergence but rather to focus on the experiences and proposals that are common to all or most of the people interviewed. These are the elements that will be included in the following section. With the exception of some particular aspects of certain contexts, which will be duly indicated in the text, the rest of the results should be understood as the common positions of the majority of the people interviewed.

In this sense, it is worth mentioning as a first finding of this report that, despite the variability between countries, there is **a high degree of consensus around the ideas** expressed by the people participating in the study. A shared unease and job dissatisfaction are identified among the JD, despite the differences and particularities of the countries where they work. These feelings will be described in the first section of the results chapter of this report. The causes of those feelings will be presented in the second section, and the proposals for improvement will be considered in the third and final section.

1. Overview of European junior doctors' situation

How are junior doctors feeling?

I'm physically and mentally not capable of working 100% in this job, I will get sick.

EJD representatives generally consider junior doctors to be a **motivated and enthusiastic group.** They express that they are people with a will to do their job well, with **high hopes** for their future career. Nevertheless, when discussing the situation of this group and responding to specific questions about their emotional state, the participants identify a multitude of **negative feelings and emotions**. These feelings are shown graphically in the word cloud in Figure 3, with the font size proportional to the number of times an emotion was mentioned during the interviews. Tiredness (including exhaustion), frustration, insecurity, stress and pressure stand out as the feelings most frequently repeated by the interviewees. In addition

to those feelings, some representatives report that **symptoms of psychological suffering** and syndromes affecting mental health appear more frequently among junior doctors, such as anxiety, depression, burnout and even suicidal ideation.

> *We have one junior doctor out of three with depression. Sixty percent have anxiety. We have 60% burnout during the postgraduate years, and we have 3 times more suicide in junior doctors than in other people of the same age.*

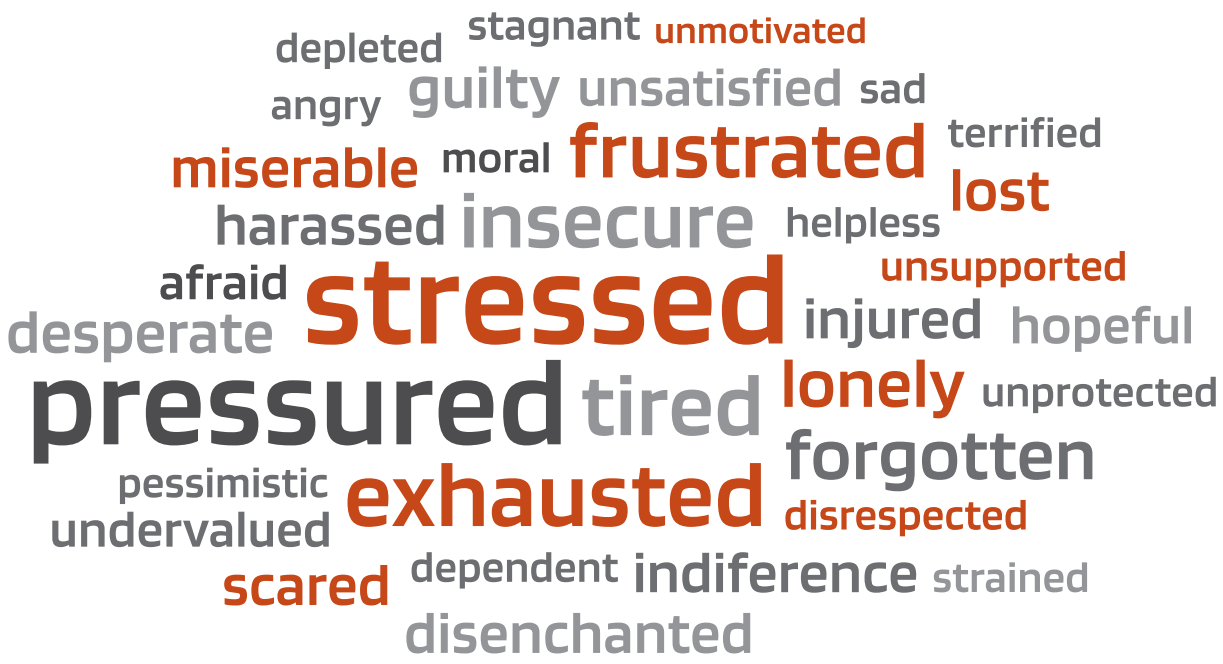


Figure 3. **Junior doctors' emotions and feelings: word cloud**

In addition, the participants identify that there is a **common feeling of professional dissatisfaction** among JD. Two main elements that make junior doctors particularly vulnerable within the health system can be extracted from the representatives' discourse: their relationship of dependence with their mentors and their lack of working experience.

The **relationship between residents and their mentors** was identified as an important source of dissatisfaction due to the "fragile" in which position it places junior doctors. This is because, in many contexts, mentors have a dual role: managing junior doctors' work and assessing their technical and academic performance. Mentors decide whether the residents will become specialists; thus, junior doctors' have a relationship of "dependence" on their superiors, which makes it difficult for them to express concerns or complaints about the management of important aspects (e.g., workload, schedules, holidays).

> *Things that affect our daily lives very personally are done by the same people that give us evaluations. So, that brings kind of a dependency on keeping our bosses happy, and if we're asked for extra shifts, or extra work, or very long hours, we don't really get to say no.*

One idea that was identified with broad consensus among the participants is that their **limited professional experience** makes residents especially **vulnerable** to discomfort, as their day-to-day work is particularly affected by uncertainty (e.g., about the competencies they must acquire, their knowledge and/or skills, and their future employment). Moreover, the health care environment is stressful, demanding and involving very high workloads and many responsibilities, especially since the COVID-19 crisis. Thus, there is often a great deal of tension on a daily basis. The participants emphasised that residents' entry into this complicated environment is often abrupt, with a lack of monitoring of the impact it may have on their mental health.

> *Initially, a lot of people feel like, well, I haven't been able to do my job properly. Why am I responsible for this? Why? Why can't I care for people properly? I am to blame.*

> *Sometimes the entry into the profession is very brutal because hospitals, they are not always prepared. […] Over-responsibility in the first months of training can also lead to frustration, because you don't feel confident, you don't have the experience, and you are also, in my opinion, not necessarily qualified in the first months of training.*

This vulnerability appears not only in residents but also in junior doctors who are in their first years as specialists, with the following problems particularly affecting them: a lack of fulfilment of their expectations of improved quality of life and working conditions upon becoming specialists and the sudden acquisition of great responsibility without supervision. Some professionals feel that the increase in responsibility upon becoming a specialist occurs too abruptly, which can lead to a feeling of abandonment and insecurity, even considering the lack of support they may have suffered during their residency.

> *When you become a specialist, you find out it's harder, even though you thought it would be easier.*

> *We know that, after graduation, the first couple of years are high risk for mental health problems because […] you're carrying the responsibility for the first time.*

The generational change regarding work

An idea that was repeated across the board in the participants' discourse is that there has been a **generational change in work-related values** that affects junior doctors. The participants evaluate junior doctors as hard-working people, eager to progress in their working life and enthusiastic about improving their skills and knowledge. However, they consider that for this group, work is not the only or the most important sphere of their lives, as it might have been for previous generations. The people interviewed indicate that for older generations, work played a central role in life, and held an important identity component, which was considered necessary to achieve satisfactory personal development. However, they point out that young people are not willing to sacrifice their time or personal development for the sake of professional or economic growth. Thus, they identify work as a potential source of discomfort when it cannot be combined with other activities they value more highly (e.g., leisure, creative activities, caring) or when it is performed without sufficient flexibility to meet their expectations for professional development (e.g., training, research).

> *Younger generations, they don't want to sacrifice as much as, maybe, older generations did. And I agree with them. It's perfectly normal to say: 'I don't want to work somewhere where I'm going to be burned out after a few years.'*

> *We have a shift in the generations, where the previous, the senior doctors, are used to having a lot of free time where they read up on patients and do other stuff. And we have a shift in the younger generation, who want to get paid for the work they're doing and want to have time off when they have time off.*

In the same vein, they report that they **do not feel identified with the idea of "vocational" work**. Despite feeling interest and passion for their profession, these feelings are not their only motivation for remaining in it. Junior doctors also expect financial remuneration for all the time they have worked, good working conditions and to feel valued for the effort they put into their work. The people interviewed report that they have noticed that, in their environment, junior doctors have begun to put limits on common practices in health systems that were covered under the concept of vocation or professional calling (e.g., working overtime or above permitted or safe hours, resting periods not respected).

> *But also working is now [...] seen a lot less as a vocation, or as your entire life. And a lot of people have an outside interest that is as strong as their work interest. And they want to do that. And they want to do that whilst they're young enough.*

> *Junior doctors have become more aware of how badly they've been treated in the past. And so, they are not putting up with it anymore, and they're more vocal about it. So, maybe in the past people would've said, 'Oh, I'll work my eight-hour shift.' And then there's nobody in the next shift. They'll be like, 'Oh, I'll just work my next eight-hour shift." And junior doctors now are saying, 'No, that's not safe, and that's not correct.*

Some participants point out that, as this change occurs in a situation of medical workforce shortages, younger generations feel more **confident in setting limits** than they were before. For example, there are junior doctors who do not accept jobs with precarious or inflexible conditions, whereas years ago they might have been compelled to do so because of the difficulties in finding a job in certain contexts. One of the factors identified as driving this change in work-related values is the feminisation of the medical workforce. In the past, the profession was mainly performed by men, whose professional careers were prioritised. However, women have verbalised that they are not willing to accept this hierarchisation of the spheres of life, and their male colleagues have joined in this way of thinking.

> *In these days, juniors are way more aware of the options, of their value, of their... And they're way less willing, I will put it bluntly, to ruin their personal lives for the job anymore.*

> *I: Do you think this generational leap is a gender issue?*
> *P: I think it's not just gender, but I think it started as a gender issue. And I think when it started as a gender issue, people perceived it. Women complaining and then actually men have realised, wait a minute.... They're right! [Laughs]. And now it's equal.*

A frequently mentioned idea is that this generational change has had an impact on the type of specialties chosen by junior doctors: some people prefer those that allow them a higher degree of personal development due to better working conditions (e.g., an absence of on-call shifts, the possibility of self-managing their schedules). They further indicate that this also affects the student body, so that the career of medicine is becoming less attractive in certain contexts due to its competitiveness, its demands and the prospect of a working life with conditions that are worse than those in similar sectors.

> *There are those programmes like family medicine or dermatology, which have been so much more popular now, because there are fixed working times, and this is now becoming more and more important for the younger ones, and they choose those programmes where they know that they will have their own life as well.*

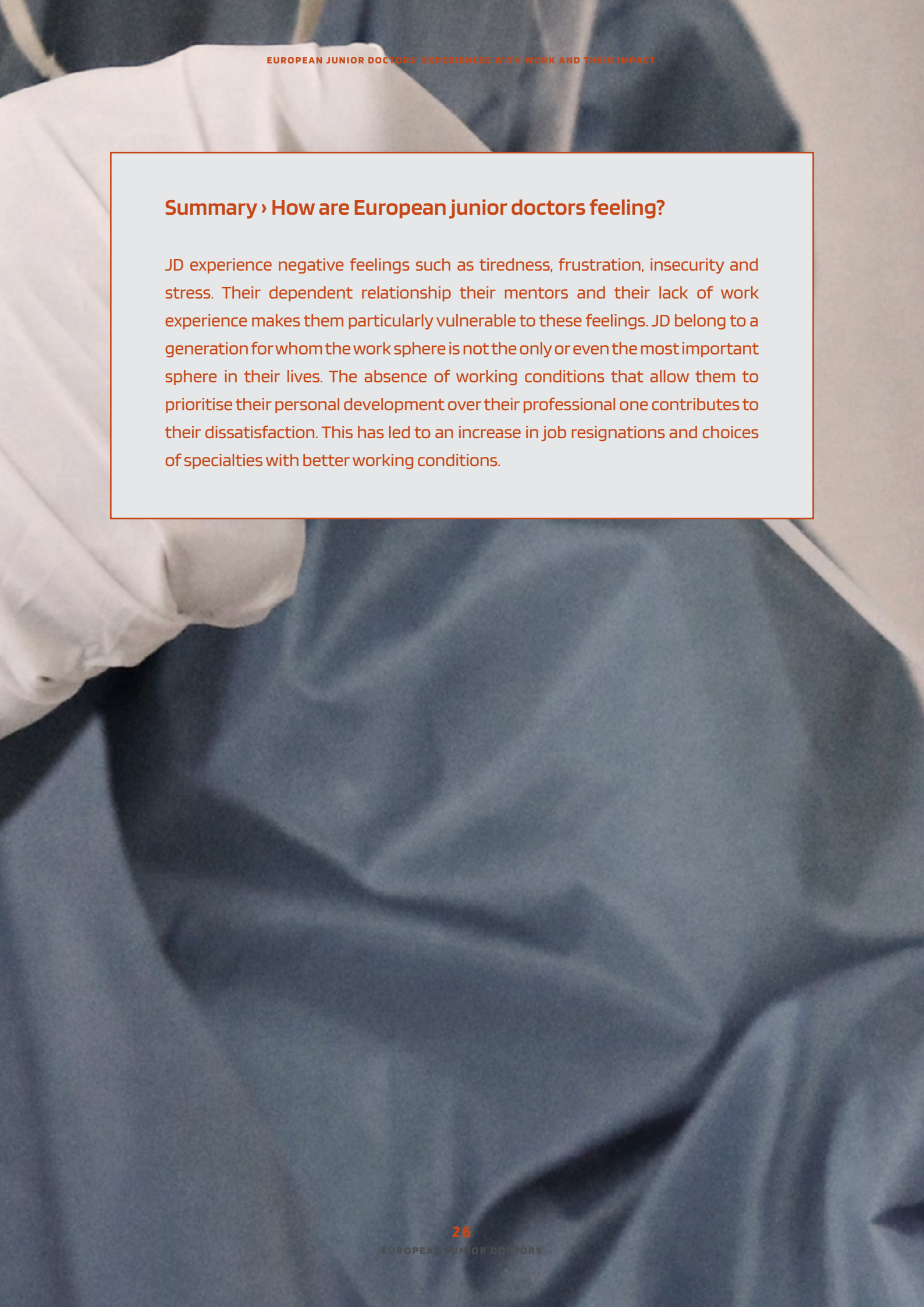
Job resignations

All participants, except for the representatives from some Nordic countries, reported that in recent years, there has been a **growing trend of job resignations** among junior doctors. Such resignations may occur before or at the end of postgraduate training programmes. They also point out that more specialists migrate from the country where they have been trained to work in places with better opportunities. Some people indicate that resignations also occur among recent medical graduates who choose to work outside the field of health care (e.g., pharmaceutical companies, consultancies). In some cases, they express concern about the possible impact of resignations on future medical workforce planning.

> *A lot of doctors leave the national health system. Especially as soon as they finish their junior doctor training, they leave. That's a growing trend.*
>
> *And we also see that students […] finish their medical school and then they disappear to, we don't know where. So not go to the hospital, but work somewhere else, because they know the pressure in the hospitals is too high, and they earn too little.*

Participants believe that the decision to resign from care work is **mainly motivated by the stressful and rigid working conditions** experienced by junior doctors, partly due to the stress that many health systems are under (e.g., increasing demand in a context of generalised workforce shortages). As discussed in the previous section, the younger generations attach great importance to working conditions that are good, safe and adapted to their requirements. Participants report that some junior doctors look for job options with such conditions, in other specialities, other sectors or other countries. Some of the participants point out that job resignations may result from the lack of continuity in professional careers within certain health systems (e.g., not having a guaranteed job at the end of postgraduate training programmes) and opportunities to move to and work in other EU countries.

> *So, when it comes down to being a junior in a situation where you have the financial pressure that comes down from the system, and you want to learn the specialty, […] and then you have the moral injury of not providing as high a level of care for your patient as you want to, with maybe a mental and physically straining working environment, this is the pot-pourri of something where you say, 'I don't want to work in medicine anymore.*



Summary › How are European junior doctors feeling?

JD experience negative feelings such as tiredness, frustration, insecurity and stress. Their dependent relationship their mentors and their lack of work experience makes them particularly vulnerable to these feelings. JD belong to a generation for whom the work sphere is not the only or even the most important sphere in their lives. The absence of working conditions that allow them to prioritise their personal development over their professional one contributes to their dissatisfaction. This has led to an increase in job resignations and choices of specialties with better working conditions.

2. Factors that influence European junior doctors' job satisfaction

Why are they feeling this way?

We have doctors being overworked, which leads to poor-quality training. And poor-quality training combined with overwork leads to exhaustion and burnout, and that leads to dropout. And increasing dropout leads to more overwork for the ones who stay, who then have poor training, have more burnout, more dropout.

EJD representatives interviewed for this study identified three cross-cutting elements that affect junior doctors' job dissatisfaction: work-related experiences, training-related experiences and difficulties in work-life balance. They also pointed out inequalities that occur within the group that also have a negative impact on it. In this section, we will present the discourse of the participants with regard to these four major issues.

Work-related experiences

European junior doctors report that their work-related experiences have a negative impact on their job satisfaction. They identify four main factors that affect them: poor working conditions, work overload, excessive working hours and a poor working environment. In the following, the participants' discourse on each of these aspects will be presented in detail.

Poor working conditions

Although there are significant differences in **working conditions** between the countries participating in the study and between residents and specialists in their first years of practice, there is a general consensus that working conditions are **unsatisfactory and do not meet the expectations** of junior doctors (see Section 1 of the Results chapter).

One of the main problems identified in almost all contexts is **a lack of flexibility at work** because it prevents junior professionals from dedicating their efforts to academic tasks that are fundamental for their training, limits their participation in educational activities and makes it difficult for them to reconcile work and responsibilities such as childcare. Flexibility is a crucial factor that makes it possible to adapt to the personal development demands of younger generations. For example, it allows for the development of professional profiles with different skills and the ability to change working hours or locations, if necessary.

> *When you come for an interview for a job and someone asks you, "Okay, if you want to work overtime, how do you want to be? Do you want it to be paid, do you want free time in exchange?" It's something that I want someone to ask me and not tell me you have to do this or that. Younger generations want choices.*

> *If you want to do research, go to a conference, present a poster… you know, you probably don't have time in your workday, so you need to spend a weekend doing that. […] That's a lot of time out of our life spent dealing with work-related matters or part of our career.*

Salary is also identified as a factor that negatively impacts junior doctors' satisfaction in many contexts. Compared to other professional groups, their salaries are often lower. The participants describe junior doctors' wages as insufficient for obtaining a comfortable financial situation in certain countries based on their assessment of their workload and responsibilities. This situation leads junior doctors to work longer hours to earn more. Despite its importance, several people point out that low pay is not the most important issue affecting job dissatisfaction.

> *Doctors in [country name] are aware that we will never be poor, but given the increase of pressure that juniors work in, given the expectancy that this pressure will rise, given that the demand will rise, and given the responsibility that you have every day, juniors feel we should make more money.*

The **need to move** frequently also negatively affects junior doctors' job satisfaction in many contexts. This problem affects the periods during and after postgraduate training programs, meaning that junior doctors must plan and carry out constant relocations. Although in most cases they are aware of this need to relocate, they receive little support to facilitate this task. This situation has a significant impact on their quality of life and their ability to obtain a good work-life balance.

> *A big issue with [country name] training overall is that you're made to move around the country quite a lot […]. So, that obviously comes with implications for, you know, your quality of life and [whether you can] have a home, have a family, etcetera.*

In some contexts, there is a **lack of career projection and a high level of temporary employment** for junior doctors. This situation particularly affects the first years of specialist practice, generating uncertainty. For some people, it may also contribute to their being less

involved in their work, a reduction in their opportunities for professional development and a diminished ability to plan their personal lives. A lack of job stability can limit junior doctors' ability to improve their quality of life, for example, by obtaining a mortgage. Moreover, it is noted that in some contexts, junior doctors have **university-type contracts** instead of labour contracts, which place them in limbo, with no clear employment rights.

> *To get a stable position where you actually have a job, like a stable job, it's not possible. It's very rare that you will get a stable position immediately after graduation.*
>
> *Legally, as we are not workers, we do not have a right to unionise, and we do not have a right to strike.*

Finally, in some contexts, junior doctors are **obliged to work for the state** in rural areas at the end of their residency. This situation has a strong impact on their satisfaction, as it limits their ability to develop their careers and personal lives in places of their choice. Moreover, these jobs are sometimes in remote areas, where junior doctors are far away and isolated from the rest of the health system, which generates feelings of insecurity and abandonment.

> *In my country, we call it slavery contracts. When you start your residency, you sign a contract. And when you become a specialist, you have to work the same amount of time in that hospital as you were in your residency, […] or you have to pay a lot.*

It is important to note that working conditions tend to improve somewhat when junior doctors become specialists, with the exception of temporariness or compulsory work for the state. Additionally, in Nordic countries, more favourable working conditions are observed, such as public support for relocation, training opportunities and greater flexibility.

Work overload

Significant work overload was noted by all the participants in the study as a very important element generating dissatisfaction. They believe their workload has increased over the last few years. The origin of this excessive workload is associated with the stress to which health systems have been subjected: there has been an increase in health care demand that has not been accompanied by a proportional increase in necessary resources. This situation, in addition to a transversal deficit in strategic planning for resources, has led to problems such as greater pressures in the workplace, difficulties in organising shifts, the need to work more hours than desired and overload.

> *We are increasingly providing care to people with greater complexity and greater demand to obtain health outcomes that you say, 'I just can't. […] Now, it's understood: 'He is 70, why should he die?' […] You carry elements that can affect your health.*
>
> *But then someone leaves, someone falls ill randomly […] and, all of a sudden, the clinic falls short and it gets really ugly for everyone, because everyone has to sort of step up. And then, when this becomes very frequent, that is really straining people.*

The interviewees reported that because of the overload, **they work at a very high pace**. The number of patients they have to attend to is often disproportionate to the time they have available for the task. This compels them to make decisions without thinking too much, **without taking time to consult with supervisors or within the literature.** Instead, they are forced to simply "put out fires". This pace, coupled with their lack of working experience, leads to insecurity and concerns regarding the work they are doing. All this makes them feel **they are not offering the best quality of care possible**, which leads to frustration.

Overload generates **work cycles** in which junior doctors finish their days exhausted, with the feeling that they could have performed their tasks better. As a result, they do not rest properly and return to work the next day with less energy. These cycles also make it difficult for them to have an adequate work-life balance because they return home with very little energy to devote to other aspects of life such as hobbies or caring for their family. Some interviewees pointed out that overload is an element that may favour some professionals' decision to leave their job.

> *So, I think there's, people are working at a pace they don't want to work at. They never quite finish any task, and then they go home and worry about it, just to do it again the next day and then worry about it more.*
>
> *The pressure per hour at work, it's kind of making it [so that] more and more young people [become] unsure [about] whether they wanna stay in the profession throughout their lives.*

The participants indicate that overload affects health systems across the board (albeit to varying degrees). However, they consider it to **especially affect junior doctors** for several reasons. There was a strong consensus regarding the idea that a lack of human resources means that many nonmedical tasks (e.g., bureaucratic, care) fall on junior doctors, which is detrimental to their satisfaction and the quality of training they receive. In addition, they point out that junior doctors have more difficulty changing jobs than senior doctors because

they are in the middle of their training programme or in periods particularly affected by temporariness. On the other hand, because of their dependent relationship with their mentors, they feel that they do not have the option of reducing their working hours if they need to, given that they are expected to work at full capacity. It is worth noting that some representatives from the Nordic countries and Northern and Central Europe have noticed a change in this tendency to overburden juniors compared to seniors: in their countries, there is a growing awareness that junior doctors cannot be treated as "cheap labour", and the work is shared equally among all members of medical teams.

> *If you are a senior doctor, […] you have the possibility to decide where and how you wanna work. And you don't have the possibility as a junior doctor because you have to finish your residency. Yeah.*
>
> *If you say 'I wanna work part-time', it's more accepted if you are already done with your training period. But if you are still in training, it's often like you lose a little bit of respect if you reduce the hours.*
>
> *We have a lot of problems with nurses' or administrative personnel's recruitment. So, the junior doctors are the ones doing this stuff because they can. So this is us.*

Some participants emphasise that although overload is a problem that cuts across all levels of the health systems, it affects some specialities more than others, with particular emphasis on surgical, medical-surgical and emergency departments. In some contexts, overload in primary care is also mentioned.

Working times

The implementation of the European Working Time Directive (EWTD) has improved working hours in many countries, as it is a legal framework which regulates and limits the number of hours that a person can work and sets forth the necessary breaks required to maintain the health and safety of workers. However, according to the participants' discourse, adherence to this norm varies depending on the country in which it is applied. The representatives from the Nordic countries interviewed reported that, in their countries, European regulation is usually complied with, as well as in several Central European and Northern European countries. Despite this, there was broad consensus in the discourse on the problems of working times and the issues arising from them: junior doctors still **work too long hours and sacrifice resting periods**. Several participants indicate that the shortage of doctors has worsened this problem in all contexts (e.g., there is a need to respond to the same demand for care or cover unforeseen vacancies with a smaller workforce). In contexts where EWTD

is complied with, mechanisms are used by the system to make workers available, such as postponing resting periods.

> *We don't follow the European working time directive. Clearly, we tend to exceed that in fair amount. So, between 60 and 80, 90 hours a week. That's something that's not for everyone, but for a lot of junior doctors, that's a normal working week.*
>
> *And the compensative rest is really like, it's negotiable when it'll be like, like the time where you can even out the lack of adequate rest and so forth. Like, yes, you will have it, but you won't have it yet. You will have it, you know, later.*

The people interviewed consider that working times have a significant impact on their job satisfaction and personal life. Thus, they point out that **overwork, night shifts and overload have negative consequences**: they increase the risk of exhaustion, stress and burnout; they affect the quality of training, which is carried out in a state of fatigue that makes it difficult to take advantage of learning opportunities; and they make it difficult to have a proper work-life balance due to the rotation of schedules.

> *There comes a time when the weeks become eternal if you have 2 or 3 on-call shifts, really. The impact of physical fatigue to withstand the dynamics of work, becomes very complex, doesn't it?*

Although excessive working hours affect many professionals, the participants share the idea that **this problem especially affects junior doctors** and, in particular, residents (although some participants commented on how this phenomenon is shared, to a lesser extent, by specialists in their first years of practice). They attribute the poorer schedules of this group to the pressure derived from the predominant culture in health systems (which undermines compliance with safety standards at the workplace), the need to comply with the training requirements of the residency and their desire to earn more money. They point out that in procedural specialties (especially in surgical or medical-surgical specialties), junior doctors feel pressured to exceed their schedules or not adhere to resting periods to be present when infrequently applied techniques are performed. In addition, the emergency department was also identified by some participants as particularly affected by this problem.

> *If you are still in training, it's often like you lose a little bit of respect if you reduce the hours, because everybody's saying, 'Yeah, well, you still have to learn and you can only learn if you are here and if you're at work, not if you're at home'. So, it's probably easier for senior doctors than for junior doctors to reduce hours.*

Most of resident doctors work in two or three other jobs, because the salary is really low […] and there are cases when people work 36 hours without rest, because if you work in two or three jobs at the same time it is the only chance to make it possible.

This is a common scenario where somebody will stay after their 24-hour shift to scrub in for that one surgery that, you know, you only see three or four of per year.

Poor working environment

The participants agree that the environment in which junior doctors work has a significant impact on their job satisfaction and mental health. Unfortunately, they point out that it is common for a **constant atmosphere of tension, pressure and stress** to exist in the health care work environment. Many people identify work overload and a shortage of resources as contributing to this poor environment.

P: It's always tense. It's always pressure, and it's always, yeah, tension between. I don't know. In the hospital.
I: Do you think that that has an impact on how you are like, living or feeling?
P: I think it has an impact on your mental health. Yeah, that's for sure.

This poor working environment **hampers relationships** between junior doctors as well as their relationships with senior doctors and other health professionals. As noted, this problem is transversal to the entire health system but **particularly affects junior doctors**, who are specifically vulnerable to being mistreated due to their dependent relationship with their mentors (see Section 1 of the Results chapter) and to the competitiveness that exists between them. Some of the participants believe that the origin of these competitive relationships is in the demanding nature of medical universities and postgraduate training programs. Others point out that junior doctors' exposure to poor working environments makes them feel **pessimistic about their future careers** (e.g., fear of burnout, fear of no change). Some interviewees think that this factor contributes to job resignations.

If there's a bitterness and a resentment from your senior colleagues, everybody mirrors that. And if your mentor or your supervisor, you almost feel like they'd be mocking your enthusiasm. […] You can deflate that enthusiasm almost immediately.

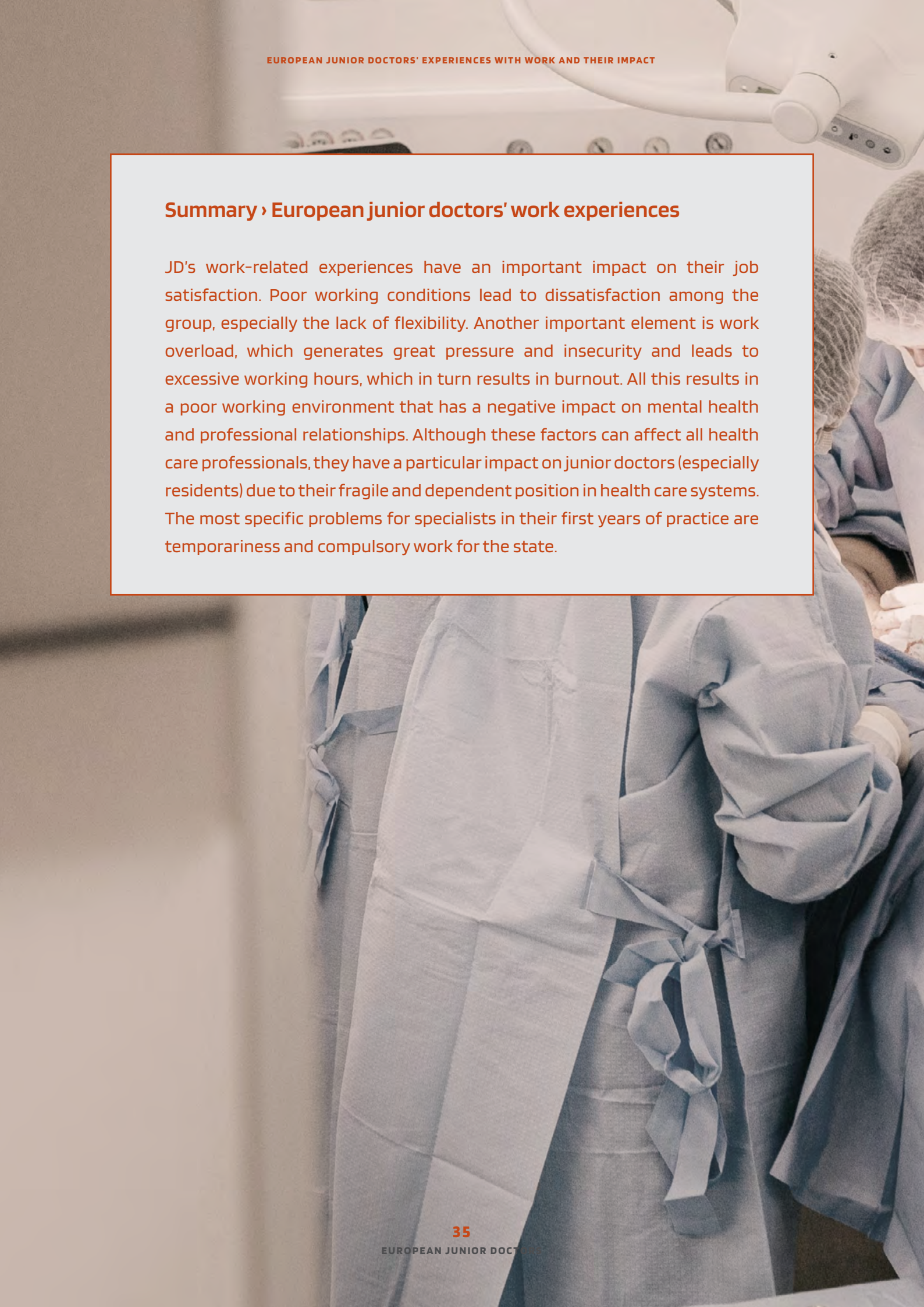
Medical school, it's not the most relaxed place to start with, […] you basically incentivize competition, and competition that is like mostly a way to prove to yourself that you're adequate for the job, to yourself and to others.

The **lack of recognition of the work done** by junior doctors was identified by some participants as a major problem. These interviewees state that junior doctors are put under a great deal of pressure and that their work is not recognised. This lack of recognition occurs in a work context with a lot of overload; therefore, they feel they are working to their maximum capacity, even putting themselves at risk, without their contributions being fairly valued.

> *If a junior feels appreciated for the work, and that's the same with motivation, if my attending says, 'Hey, thanks that you stayed longer yesterday so we could discharge the people this morning. Thank you that you did that.' Honestly, that's all a junior needs for a long time. But usually, it's only the opposite, it's more of bringing out the negative than the positive. And if you have leaders and supervisors that actually embrace this positive culture, there's a completely different working environment.*

Some respondents from Nordic countries and Central Europe point out that the working environment is receiving more attention and that the culture in the health care system is changing. In addition, participants indicate that there are places where the environment is generally friendlier (such as rural areas, smaller hospitals or primary care). Despite this, others feel demotivated due to the difficulties in changing the situation, as there is a prevailing vindictive culture among health care personnel: "I had a bad time, now it's your turn". Participants note that this attitude among older professionals causes them frustration, as it blocks potential changes in the health care work culture, which could lead to an improvement in the working conditions of all professionals in the system, not only junior doctors (e.g., compliance with working hours, respect for the breaks established by the EWTD, assertive communication and care for professionals). Some participants point out that, due to this "revanchist" culture, progress in the labour rights of health professionals is slower than in other similar sectors.

> *Our senior doctors, they always say, 'Why are you complaining? It was harder in my times. You can't complain because for me it was much worse. My boss was much worse. And now, I'm a better boss than my boss was. So, be happy because I'm a good boss'.*



Summary › European junior doctors' work experiences

JD's work-related experiences have an important impact on their job satisfaction. Poor working conditions lead to dissatisfaction among the group, especially the lack of flexibility. Another important element is work overload, which generates great pressure and insecurity and leads to excessive working hours, which in turn results in burnout. All this results in a poor working environment that has a negative impact on mental health and professional relationships. Although these factors can affect all health care professionals, they have a particular impact on junior doctors (especially residents) due to their fragile and dependent position in health care systems. The most specific problems for specialists in their first years of practice are temporariness and compulsory work for the state.

Training-related experiences

In general, postgraduate training programmes are considered to have positive aspects and to function well, with many participants finding them to be of good quality. However, there is a transversal discourse indicating that **the quality of postgraduate training programmes could be improved**, and the core problem is the overload and stress to which those who work in health care systems are subjected.

There is consensus that it is **not possible to dedicate sufficient time to training due to the work overload** of residents and mentors, even in settings where a schedule is established with time reserved for training. Work demands take precedence over training development, preventing residents from studying, consulting with supervisors or other activities necessary for their training. Instead, they devote their training time to bureaucratic or nonmedical work. In addition, it is transversally highlighted that mentors lack the time to carry out their teaching work due to overload. This situation has been noted as particularly problematic in contexts where training programmes are based on the acquisition of competencies, as residents find it difficult to complete all the required tasks due to overload.

> *I think the system sometimes forgets that we are in training and there's not enough time for training itself. So, I have the impression that junior doctors, they are just there to run the hospital, and sometimes their formation, their training, is neglected.*

> *Not getting time to reflect on your practice, or not getting time to study, or not getting time to progress yourself, it's also an issue here. We're told that we can take study leave, but whether we actually get that is a different story, because sometimes the amount of work to be done doesn't allow us to take this as leave.*

> *One big issue is that there has to be enough time for the senior doctors to teach the junior ones.*

A lack of time for academic activities (such as attending conferences, conducting research or developing practical skills) is a common concern of the participants. These activities often take place during residents' free time to the detriment of personal development. The shortage of opportunities to participate in training activities is exacerbated by overload, as well as by residents' fear of requesting time to engage in them due to their position of dependence on their mentors. A lack of time for **academic activities also affects one's first years as a specialist**, according to the participants. They assert that, in some countries there are difficulties in combining work with training or research during this period, although in others specialists have more time for these activities than during residency. Some participants noted

that qualifications and training increase one's chances of getting a good job, but not all people have the same opportunities to engage in these activities, which generates inequalities. It is also noted that the lack of importance given to academic aspects during residency has a negative impact on specialists' interest in these activities in their first years of practice.

> *All the research and papers I've done, and not just me, I do it in my free time at home.*
>
> *It's actually, when you're a senior doctor and you have a specialty. Actually, it is worse to get to learn something new because you have to find someone who will replace you and work when you work in hospital.*

Another training problem identified by many participants was the **lack of adequate supervision**, which generates a strong sense of insecurity and dissatisfaction among the residents. Mention was made of the lack of mechanisms for giving and receiving feedback from mentors, who sometimes lack communication and teaching skills due to their lack of formal teacher training. Furthermore, it is believed that this lack of supervision is exacerbated by the absence of incentive systems for mentors. This problem is particularly evident during on-call and night shifts, despite these being identified as more stressful and difficult to manage. It is also noted that this is an element that affects specialists across the board in their first years of practice, as they take on a great deal of responsibility without adequate progression.

> *P: We're struggling a lot to have this reform and to get enough time for supervision, guidance, procedures... There isn't enough time.*
> *I: You don't get enough time?*
> *P: No, there is not. No, because everyone is busy doing work.*

The poor quality of training, due to a lack of supervision and emphasis on academics, can lead to a **sense of insufficient progress** and contribute to the perception that the best quality care possible is not being provided. As a result, residents may experience feelings of guilt and insecurity about their professional performance.

> *I: Do you think this [not getting supervision] has an impact on junior doctors?*
> *P: Of course, because you wanna get better in your job, you wanna be able to do more things on your own, you wanna get more experience. And you depend on someone else who teaches you the technical skills, and this is often the problem, that there's nobody here who can supervise you. So yes, it has an impact.*

In addition to the general challenges mentioned above, there are also problems specific to some countries or organisational models. In some places, teaching hours are not included in residents' contracts, which makes it more difficult for them to fulfil academic requirements. In other contexts, there are no regulated competency acquisition plans, which leads to highly variable training depending on the centre where the residency is performed. The poor quality of training in some contexts is related to a lack of human resource planning (e.g., an excess of residents in one specialty, with not enough work for all of them; an insufficient number of centres with teaching capacity with respect to residents in training; or a lack of available mentors).

Summary › Training- related experiences of European junior doctors

There is consensus that the quality of postgraduate training programmes could be improved. Overload and stress in health systems are the main obstacles affecting the quality of programmes. A lack of time devoted to training, a lack of supervision and low emphasis on academic aspects contribute to the perception of insufficient training.

Work-life balance

In recent years, an interest in **work-life balance has gained more prominence** among European junior doctors. The participants believe that this is due to a generational change in the work-related values of junior doctors (personal development has become more important than professional development) associated with the feminisation of the medical workforce (see Section 1 of the Results chapter).

> *And I think this is something that employers are not yet ready to accept, how important your personal life has become in comparison to 10, 15 years ago. Juniors are not willing to put up with all that anymore.*

There is a broad consensus among the research participants regarding the numerous **difficulties faced by junior doctors concerning work-life balance**. Participants referred to obstacles in dedicating time to aspects such as their family life, personal relationships, leisure and free time activities and physical exercise. The lack of opportunities to achieve an adequate balance between work and personal life has a negative impact on the mental health and job satisfaction of these young professionals. Some participants express that the group has feelings of isolation and loneliness, which is identified as a risk for mental health problems.

> *And, in fact, we know that, I remember, 60% of the junior doctors said they feel alone. They are not alone, but when we ask them, 'How do you feel?', they say, 'I feel alone'.*

Participants consider these difficulties to be the **result of several factors,** discussed above in this report (see Section 2.1 of the Results chapter). A lack of flexibility and rotating timetables make participants' schedules incompatible with many personal activities, especially those related to care responsibilities. In addition, the high workload, the bad working environment and the long working hours generate exhaustion and make it difficult for junior doctors to devote energy to their personal lives. It is also noted that academic activities outside working hours limit their free time.

> *There's not really any flexibility like other people with an academic background have. And I think that is tough for a lot of postgraduate doctors. Yeah, because they have the family where sometimes they have to take the kids to the doctor or see us, go to the school, or whatever they have to do. And the flexibility isn't really there to do that.*

> *You can feel so depleted from work, and you feel like you've given so much of yourself to patients and colleagues that there's nothing left for your family, or for your friends, or for going out or, I suppose, importantly, pursuing your hobbies and things like that.*

For the participants, **personal life is not limited to family life alone**, encompassing a wide range of aspects that are increasingly relevant for younger generations. The interviewees point out that justifying the need for time for caring tasks may be more accepted than asking for time for social, leisure or creative activities.

> *I suppose when we talk about work-life balance, generally people will mention the fundamentals of like, you know, what we view to be a normal life, which is having kids and having a house. I suppose that's not the experience for everyone, that's not what everybody wants. Creative pursuits and these sort of things, […] that allows you to be a whole person to, you know, live. Live up to your potential outside of medicine as well.*

It is also noted that in many countries, there are significant **difficulties in planning one's personal life**. These difficulties occur on both a daily and long-term basis. The problems of daily organisation arise from the rotating schedules and long hours of unplanned work inherent in the medical profession. On the other hand, long-term planning difficulties are related to working conditions that limit junior doctors' ability to choose where to live. The need to move during residency, the lack of career planning, the obligation to work in a nonchosen location and the lack of flexibility to change location during postgraduate training programmes affect the possibility of settling down and creating a stable environment. These difficulties cause uncertainty and have an impact on junior doctors' satisfaction.

> *The working hours, they are hard to predict because sometimes you think that you will leave hospital at five or six, but at the end you leave at seven or eight. So, your daily day-to-day is always unpredictable, which also, I think it's a very negative.*

> *This is a real problem, because we have a lot of junior doctors that need to go away because their husband or their wife has to go for a job or anything else. Sometimes because their dad or mum [is] sick in another city, because the baby needs some medical help in another city, whatever you want. They need to move, and they can't.*

Another idea pointed out by some participants is that work-life balance is so important to junior doctors that the lack of opportunities to achieve it is a **reason for making work decisions** that may have a negative impact on their careers (e.g., working part-time). Some participants note that if given the choice, junior doctors would prefer to have flexibility rather than reduced hours. In addition, some participants express that the lack of possibilities for achieving work-life balance conditions junior doctors' choice of specialty (they sometimes prioritise specialties with better working conditions) and may also influence job resignations.

> *Some people choose specialties with no shifts because they want to have more time off and they don't want to work weekends. But that's not only because of children. I know people who don't have children, but they don't wanna work shifts.*
>
> *A lot of colleagues are thinking about reducing hours or sometimes also about switching jobs, because they can't find the time for free time or family.*

As noted, participants indicate that this problem **particularly affects junior doctors**, who are at a stage of life where it is common to have to devote much time to personal responsibilities, such as care, and where they also want to enjoy social and leisure activities. Additionally, they are particularly affected by poor working conditions that make it difficult to reconcile work and family life.

> *I think in general it affects both, but I think junior doctors a little bit more because, usually you like, wanna get kids, have a family in the time when you're a junior doctor.*

In most contexts, benefits and childbirth and breastfeeding leaves are viewed positively. However, benefits for childcare and other types of care are considered to be insufficient and difficult to obtain. It should be noted that in the Nordic countries, work-life balance is perceived as very good due to public benefits such as low-cost childcare services and extended hours of operation as well as financial and care allowances. Some representatives from these countries point out that part-time work is not common in these countries because it is possible to work full-time, which promotes gender equality in terms of career development and economic independence.

Summary › Work-life balance experiences of European junior doctors

JD face numerous difficulties in achieving work-life balance, which has a significant impact on their job satisfaction. These difficulties can lead them to make decisions that can have a negative impact on their careers and may influence them to resign from work. Work-life balance problems arise from the lack of workplace flexibility, rotating schedules, work overload and the poor working environment as well as the need to dedicate personal time to academic activities. The participants also highlight difficulties in planning their personal lives, in the short and long term. Both problems particularly affect junior doctors, who are more exposed to conditions that make work-life balance difficult.

Inequalities

JD's field of work is, like many others, affected by significant inequalities. During the interviews, gender inequalities were identified (specifically explored by the research team), as well as inequalities related to the migration experience. Both are discussed in more detail below.

Gender inequalities

Despite the increasing feminisation of the medical workforce, junior doctors continue to face significant gender inequalities. One, highlighted by all of the participants, is the **inequality in the active working careers** of men and women generated by **significant career breaks** for female junior doctors. These interruptions are usually made to dedicate themselves to care tasks (e.g., for children, dependent family members or close relatives), which affects women more than men due to the feminisation of care, which is motivated by patriarchal gender stereotypes and differences in the design of maternity/paternity benefits (in many countries, paternity leave is shorter and less used). Inequality in working careers results in a gap in terms of training, career development and, ultimately, career advancement for female junior doctors. In countries where there are difficulties in moving between the different phases of training programmes, these interruptions in working life can have a particularly negative effect, causing female junior doctors to become stagnate in their development.

> *Women have to take on the majority of those caring roles, and women take maternity leave, and women are breastfeeding, and women look after their older relatives. And women naturally take on those caring roles more than men.*

Another problem that is often mentioned is that **women work more part-time** than men due to caring responsibilities. Participants reported that in the health system, a perception persists that working part-time means less commitment to the job. Thus, they consider that women who decide to reduce their hours face a decrease not only in their opportunities for training and professional development but also in the appreciation of their performance.

> *The people working 50 or 60% tend to be the women and tend to be parents. […] And there is a perception from some of the specialists: […] 'they're less committed'.*

> *But if you are the one who says, 'Okay, I only wanna work 20 or 30 hours,' you often don't get like as much training as the others. You are like discriminated [against].*

Some participants also note the **negative impact of dedication to domestic or daily care tasks** on female junior doctors' professional development, even if they do not work reduced hours or have not taken maternity leave. Despite identifying that a general change in gender roles is taking place, they believe that domestic or daily care work (e.g., absence from work due to illness of a child, time for displacements or accompanying a child) still falls mainly on women. This means that female junior doctors do not have the same amount of time and energy as their male counterparts to devote to academic or work activities. These burdens affect both female senior and junior doctors, but the latter have worse working conditions (see Sections 2.1. and 2.4. of the Results chapter) and a dependent relationship with their superiors (see Section 1 of the Results chapter), which places them in a particularly vulnerable position with regard to these inequalities. Some participants highlight that in places where public care services are less accessible, these problems are magnified.

> *The girls, most likely they take time off to take care of the baby. I mean, even the sick leaves when your child is ill or something happens.*

Another problem identified with broad consensus is the perception of a **glass ceiling** for women in medicine, i.e., the lack of representation of women in positions of power and leadership in health care. Work interruptions and the daily tasks associated with caregiving have a particularly negative impact on the career advancement opportunities of female junior doctors. In addition, in some contexts, management or leadership responsibilities require extra time in addition to working time, which women cannot take on as well as men. Participants point out that these factors are in addition to the fact that women have fewer opportunities for career advancement than men, stemming from, among other things, patriarchal gender stereotypes that make it difficult for them to be seen as potential leaders.

> *If you look at the majority of people in leadership positions in the hospitals, most are men. Often because they have to add those in addition to the hours they work.*

> *P: In [country name], there are definitely more women in medicine, but guys are mostly in leading positions.*
> *I: Why do you think is that, do you have any clue?*
> *P: I don't know. Maybe because women go to maternity leave.*

Gender segregation in the choice of specialty is also a widespread problem. Women are underrepresented in surgical specialties, where patriarchal gender stereotypes that privilege the acceptance and promotion of men over women are still maintained. Women who opt for these specialties often face the need to earn the respect of their male colleagues. In

addition, it is noted that forms of gender-based violence, such as environmental or sexual harassment, occur more frequently in these specialties. Some participants suggest that this may be because these fields have evolved less in terms of work culture (e.g., working times and resting periods). It was also pointed out that this lesser evolution is due to the high demand for these specialties, which do not need to implement changes to make them more attractive, as they already receive enough residents.

> *Females are getting into traumatology, surgical residencies… But you have to fight against prejudices: 'You're female, what are you doing in this specialty?' That's common.*

> *In male dominated fields, we have had junior doctors approaching us because they have been discriminated [against] due to their gender in different situations. Like sexist 'jokes' and comments on their daily life in hospitals. And of course, the chiefs, they are all male, so you cannot approach them with these topics.*

The **pay gap** was also mentioned as a significant problem. Respondents point out that there is not officially a different salary between men and women, so there is not an obvious gap. However, it is noted that during residency or one's first years as a specialist, work interruptions (associated with gender, as discussed above) have an impact on career development and contribute to one's future pay gap. Some participants point out that male junior doctors have more opportunities for on-call duty, as they take on fewer caring responsibilities, which contributes to this pay gap that also affects women during the junior period. The existence of a pay gap is also identified in certain highly feminised specialties.

> *Doctors will usually be paid the same. But then, you can say it's a bigger problem that some specialties generally have a little less pay. In gynaecology, we have a little less than surgery. And that might be because there's more females.*

Some participants also pointed out that female junior doctors are exposed to **gender-based violence,** such as environmental harassment or sexual harassment in the workplace. All women are exposed to this type of violence in health systems, but the participants pointed out that junior doctors are particularly exposed to it due to the "fragility" of the position they occupy.

> *We can see harassment or aggressions in the hospitals. I didn't talk about that, but this is a real issue too.*

Specialists in the first years of practice also face specific inequalities, such as those related to recruitment in case of pregnancy or in obtaining basic employment benefits during periods of job instability.

> *When you want to be pregnant as early career specialist, you expose yourself not to be hired, okay?*

Some participants highlight that there is a **particular resistance to addressing gender inequalities in health systems**. This is because leadership structures are still predominantly masculinised and, as public services, they are perceived as unchanging and highly equitable. However, they believe that this resistance will gradually be overcome due to the increasing presence of women in the medical workforce. Representatives from the Nordic and Central European countries note that in their countries, great progress has been made towards gender equity in health systems. Participants point out that this progress is supported by a strong public care network and positive actions and policies. Although gender inequalities still exist in these countries, they report significant improvements in areas such as the pay gap, maternity/paternity leave and part-time work for care reasons.

Inequities related to the experience of cross-border mobility

Some people reported that junior doctors working in countries other than their own suffer **inequities related to the migration experience.** These inequalities are of two types: those related to racism, which affects health systems as well as other institutional structures in host countries, and those related to the loneliness and isolation produced by migration. The participants point out that migrant junior doctors' experience **inequalities in opportunities for their professional development**. Interviewees state that migrant professionals play an increasingly important role in European health systems, given the workforce shortages in all of them and the increased frequency of migration in the sector. However, despite their important contribution, participants believe that these doctors are at a disadvantage in terms of training and employment opportunities. In addition, the language barrier is a challenge for foreign doctors, limiting their opportunities for communication in their social environment and successful social integration.

> *We have a lot of immigrant doctors from other countries. […] So, these doctors basically prop up our system, and they keep our health therapies going. They make up maybe 40 to 50% of the junior doctor workforce. But there is a massive feeling of disenfranchisement for them because I suppose they contribute so much to our service, but then they are disadvantaged when it comes to training positions and jobs.*

Summary › Inequalities impacting European junior doctors

There are gender and migration-related inequalities affecting JD. The enforcement of patriarchal gender stereotypes implies that a greater burden of domestic and care work falls on female junior doctors, which has a negative impact on their professional development. Several problems affecting female junior doctors have been identified: more interruptions in their working life, a greater frequency of part-time work, the glass ceiling, gender segregation in certain specialties, pay gaps and exposure to gender-based violence. These inequalities affect female junior and senior doctors; however, the former are in a fragile position in the health care system, which makes them more vulnerable to them. Migrant JD have fewer possibilities for professional development and training, as well as integration difficulties due to the language barrier.

The Turkish reality › polarisation and violence

In Turkey, the conditions for junior doctors differ considerably from those in other European contexts, which is why this issue is highlighted and addressed separately in this section of the report. In that country, health professionals face various forms of violence on a daily basis at work (e.g., threats, risk of physical violence, verbal violence) to the extent that they feel physically insecure in carrying out their work. The Turkish representative points out that this violence is fuelled by strong political polarisation in Turkey, making it a structural problem. The lack of security and the absence of protection measures further aggravate the situation. The representative also noted that an aggravating factor in this problem is that the National Medical Association from Turkey has been declared a terrorist organisation, which has led professionals to avoid joining to prevent being stigmatised.

> *We are under threat of violence and getting killed at work. And this happens very, very frequently, like, as physical violence, or threats, or abuse.*
>
> *Our organisation, Turkish Medical Association, was already declared as a terrorist organisation. So, nobody wants to be a part of our organization anymore because they don't want to be seen as a terrorist.*

3. Proposals

> ***What could help them improve?***
>
> *The workforce plan needs to take into account that people aren't working the way they used to.*

The participants' proposals for increasing job satisfaction and contributing to the retention of European junior doctors are summarised in Table 6 and are set out in more detail below.

The interviewees collected a series of proposals that would apply to the entire health care system and would have a positive impact both for junior doctors as well as other professional groups. In general, participants believe that improving working conditions would improve working environments, the quality of training and possibilities for achieving work-life balance, which would ultimately promote job satisfaction for JD and other health care professionals.

Representatives of EJD state that to achieve this goal, first and foremost the health workforce must be considered a top political priority in both national and European health policy agendas. In this regard, proper medical workforce planning and forecasting is necessary as well as building supply of the necessary physicians and specialists. It is vital to ameliorate the uneven distribution of health professionals, providing reinforcements in the places that need it most (e.g. medical deserts) and ultimately contributing to a better distribution of workloads. To this end, they propose the collection of health demographic data, strategic planning, and the implementation of mechanisms to increase the number of human resources in specialties or areas with the greatest shortages and providing the necessary incentives to achieve this goal.

In the wake of the immense challenges posed by the COVID-19 pandemic, the lingering financial strains from the 2008 economic crisis, and the evolving health demands of an ageing population, it's evident that a robust investment in healthcare systems is overdue. Prioritising the medical workforce is not just strategic, but essential, to ensure resilient and sustainable care for the generations to come.

Interviewees consider that, for medical workforce planning to be effective, it is necessary to consider the changes in values regarding work that have taken place in recent years. European junior doctors belong to a generation that have a different set of beliefs and expectations in comparison to previous generations. Therefore, it is necessary to implement innovative strategies that meet those evolving attitudes and values. Participants' proposals for improving job satisfaction and retention of JD have been grouped under the following headings: improve mental health; improve work, working conditions and work-life balance; boost the quality of training; and reduce the inequalities experienced by European junior doctors. The proposals in each of these blocks are set out below.

> *I think we need numbers. We don't know how many doctors we have. We don't know how many hours they work. We don't know how much work they do, actually, in their working hours. And we need this data to actually change the management.*

Group	Proposals
General	› Medical workforce must be considered a central issue in national and European health policy agendas. › Implementation of robust medical workforce planning and forecasting systems. › Increase health workforce investment › Considering junior doctors' values regarding work
Work, working conditions and work- life balance	› Increased flexibility in the workplace. › Strategies to improve working environment › Monitoring and reducing workloads › Limiting and monitoring of working hours, compliance with EWTD and ensuring rest periods › Fair and adequate remuneration. › Enhancing job stability
Occupational Wellbeing and mental health	› Increase research and availability of indicators on junior doctors' wellbeing. › Promote professional networking and bonding for a better work atmosphere. › Monitoring and increasing professional satisfaction › Institutional violence prevention strategies and protocols should be developed
Training	› Protecting the training of residents in times of increased healthcare demand. › Reducing variability in training › Ensuring time for training and supervision › Increasing accountability during residency › Supporting academic activities
Inequalities	› Reducing the gender gap in active professional careers › Achieving gender representation in positions of responsibility › Narrowing the pay gap › Increasing the recruitment of women in underrepresented specialities. › Educating health workers on inequalities

Table 6. **Summary of EJD's proposals to improve JD's job satisfaction and retention of personnel**

Work, working conditions and work-life balance

The participants state that the solutions to the employment problems of European junior doctors must be innovative, creative, and adapted to the values of this generation regarding work. In this sense, they propose the following:

- Increase the flexibility of working conditions. Junior doctors should be given more autonomy and flexibility to decide how they wish to work. It is proposed that measures be implemented to encourage part-time work; working hours be made more flexible; medical work be made compatible with other duties (e.g., research, training); and job transfers be requested when necessary.

- Improve the working environment. Health professionals should be provided with training focused at improving their interpersonal and soft skills. In addition, improving working conditions could contribute to solving professional team work problems. In this regard it would be interesting to focus and study best practices in human resources and retention from other sectors and fields.
- Implement strategies to monitor and reduce workloads. This will have a positive impact on the quality of training, work-life balance and, ultimately, job satisfaction. Specifically, the workforce should be increased according to the needs of each specific location (according to strategic planning), measures should be implemented to reduce bureaucracy (e.g., use of digital technologies, and more attention should be given to the contexts most affected by work overload (e.g., night shifts, certain specialities).
- Guarantee rest periods, limit working hours and ensure European Working Time Directive (EWTD) compliance. Strategies should be implemented for time control and payment of overtime hours worked. EWTD must be enforced and oversight mechanisms put into place.
- Fair and adequate remuneration. This proposal was voiced by participants from different European countries with varying economic contexts. Several stressed that this measure in isolation would not contribute sufficiently to job satisfaction.
- Implement strategies to increase job stability. This would increase opportunities for junior doctors to organise their personal lives. Measures such as long-term contracts and career planning were proposed.
- Institutions should provide adequate resting facilities and ensure breaks during shifts. Encouraging breaks and providing spaces to rest can help increase efficiency and productivity while also helping to avoid burnout. Fatigue management strategies should be implemented at the level of the department and take into account vulnerable workers.

Occupational Wellbeing and mental health

The interviewees proposed the following measures to contribute to improving the wellbeing and mental health of European junior doctors; **bearing in mind that the most effective interventions are the ones which aim to improve junior doctors' working conditions (primary prevention)**:

- It is proposed that research be promoted on the mental health problems of the group (e.g., prevalence studies) and that prevention and intervention measures be implemented according to the needs of each context (e.g., Balint groups, screening or treatment of mental health problems, screening or treatment of addictions).
- Promote the formation of professional associations and networks and encourage spaces for interaction between health care professionals in the working environment to improve the atmosphere and promote collective cohesion. This means setting aside worktime allocated for these networks and spaces to develop. The representatives note that there should be mechanisms for organisation and association between junior doctors from different contexts and countries, between junior doctors and senior doctors, and between medical professionals and professionals from other fields.
- Implement measures to monitor and promote job satisfaction, drawing on experiences from other sectors.
- Encourage voluntary clinical placements of residents and promote knowledge of diverse working environments. It is proposed that temporary changes be implemented in services, hospitals, regions and even countries.
- Institutional violence prevention strategies and protocols should be developed. In this regard they should not only consider patient violence (verbal or physical) but also workplace and institutional forms of violence.
- Clear policies and procedures must be in place to ensure all healthcare professionals feel able to take breaks and to take time off when ill. Institutions should accommodate for the needs and implement strategies directed at vulnerable junior doctors including those with mental health conditions and psychosocial disabilities, in line with international human rights principles.
- Senior staff and managers should have specific and adequate training to support their workers' mental health, which could improve their knowledge, attitudes, and behaviours in this area.
- Mental health literacy and awareness should be part of the Postgraduate Training (PGT) core curriculum to improve trainees' mental health-related knowledge and attitudes at work, including stigmatising attitudes.

Training

The participants propose the following strategies to improve the quality of training for European junior doctors:

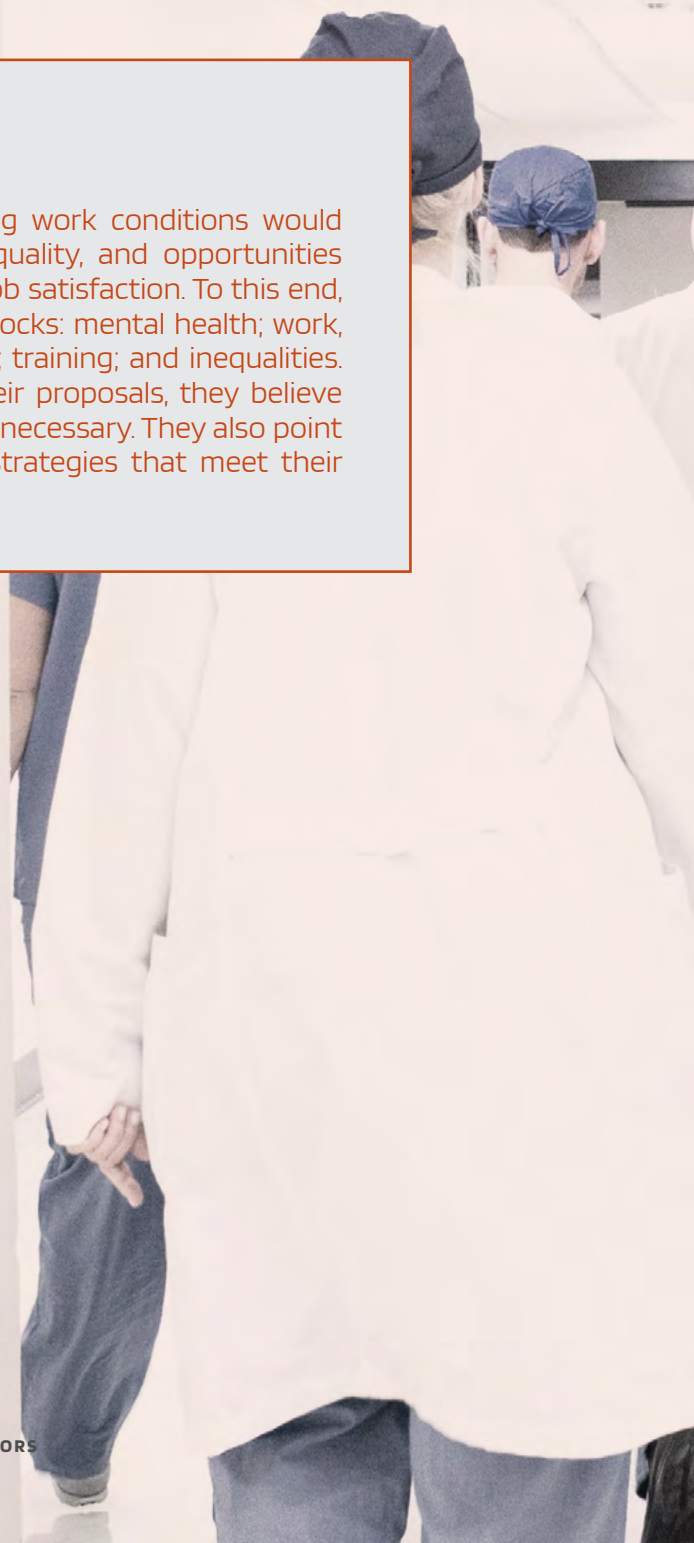
- Protect residents' training in times of constantly increasing demand for healthcare and growing pressures. Highly structured and well-planned training programs, based on competencies acquisition and provided by public and independent institutions, are positively valued. To protect training, it is also necessary to guarantee the preparation and involvement of supervisors as teachers, with strategies such as training programmes for this collective and financial incentives.
- Reduce variability in training by ensuring that programmes comply with European medical training standards.
- Implement strategies to guarantee training and supervision time. Measures should be implemented such as setting aside time in working hours for personal professional development (e.g., studying, preparing clinical sessions); programming mandatory tutorials or supervision times; or scheduling teaching activities.
- Increase accountability during residency. Mechanisms should be used such as the evaluation of residents, mentors and training institutions. Such evaluations should be independent and carried out at several points in time (not only at the end of clinical placements or residencies).
- Support the implementation of academic activities. Funding and time should be provided to pay for training activities, and time should be set aside for attending events (courses or congresses, for instance) or conducting research.

Inequalities

The participants believe that women will increasingly occupy increasingly diverse spaces within health care systems, thereby contributing to overcoming stereotypes and reducing discrimination. To this end, they state that government programmes in terms of a public care network, additional equitable employment benefits, and affirmative action policies, are essential to encourage change. Participants from the Nordic countries point out that the solution is not to work part-time to be able to perform caregiving tasks but to ensure that both parents can work full-time if they wish to do so. Thus, the study participants propose the following:

- Implement strategies to reduce differences in the active professional careers of men and women. Maternity/paternity leave should count as active working time, and policies should be implemented for men to take paternity leave.

- Design affirmative action policies to achieve gender parity in positions of responsibility and leadership, such as establishing a maximum percentage of persons of the same gender in such positions.
- Promote the implementation of strategies to reduce the pay gap, for example, by setting up pay gap monitoring units and allocating public funds to address identified inequalities.
- Promote the recruitment of women in underrepresented specialties.
- Provide training for all health professionals regarding inequalities in health systems, including education on gender and diversity.



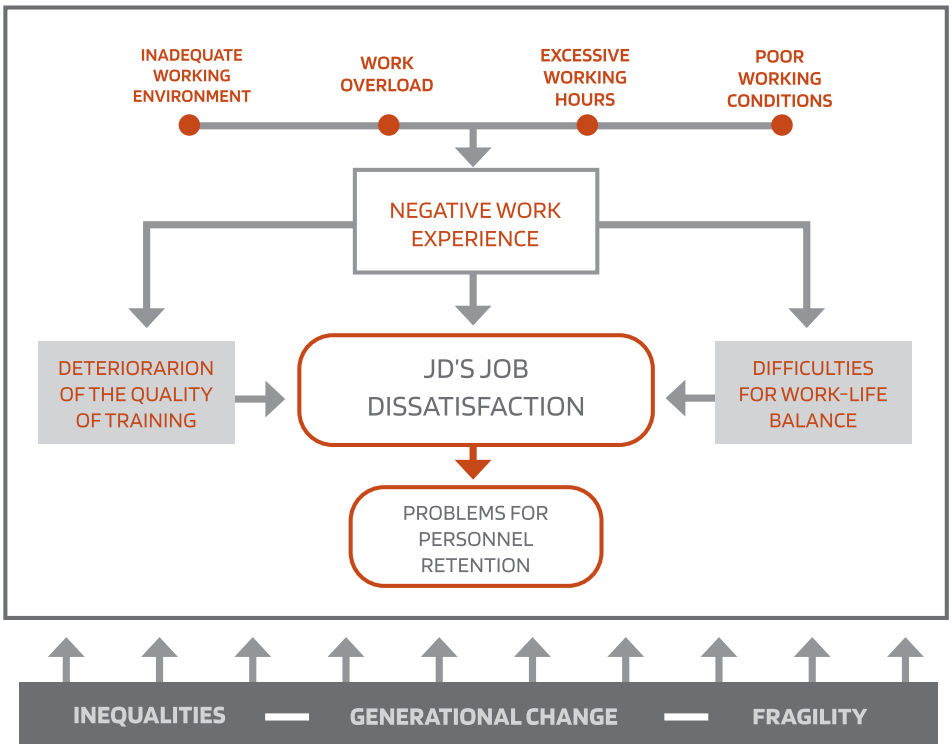
Summary › Proposals

The respondents suggest that enhancing work conditions would elevate the work atmosphere, training quality, and opportunities for work-life balance, thus boosting JD's job satisfaction. To this end, they make proposals grouped into four blocks: mental health; work, working conditions and work-life balance; training; and inequalities. For the successful implementation of their proposals, they believe that proper medical workforce planning is necessary. They also point out the need to implement innovative strategies that meet their generation's expectations.

Conclusions

To solve the medical workforce planning challenges that Europe is facing, it is essential to focus on the problems of retention for health care workers. To this end, it is necessary to deepen our knowledge of professionals' job satisfaction, particularly that of younger professionals, who have their whole working lives ahead of them. This study explored the work-related experiences of European junior doctors and the impact of those experiences on their professional and personal lives. The study's central finding is that these professionals show a **common feeling of job dissatisfaction**, the main causative factors of which are summarised in Figure 4.

Figure 4. **Summary of results: Factors influencing JD dissatisfaction**



Junior doctors' job dissatisfaction is influenced by **three main factors**: poor working conditions, deterioration in the quality of postgraduate training programmes and difficulties in achieving work-life balance. Poor working conditions, in turn, worsen training and worsen work-life balance. Junior doctors are particularly vulnerable to this feeling of dissatisfaction as a result of several **contextual elements** that can affect all related factors, which are discussed below. The fragile position junior doctors occupy at work due to their dependent relationship with their superiors, is one of those elements. In addition, junior doctors belong to a generation that gives equal or greater importance to personal development than career progression, which can lead them to feel limited by their work and thereby cause them frustration. Gender and migration-related inequalities are added to this context, which can lead to a worsening of any of the factors that influence dissatisfaction.

As mentioned above, poor working conditions are a central factor that has an impact on junior doctors' job satisfaction. Such conditions derive from the stress to which health systems have been subjected for a long time: there has been an increase in demands for care that has not been accompanied by a reinforcement of necessary resources. This situation means that work is carried out in precarious and stressful conditions, preventing the best possible quality of health care from being provided. **Providing safe, equitable and quality health care for the population** should be a central concern that may be the focus of health policies in the coming years. To this end, it is necessary to improve the working conditions of health professionals across the board. In the words of the study participants, without taking care of the older generations and other professional strata, it is not possible for the working conditions of junior doctors to improve.

The participants believe that there have been significant changes in junior doctors that mark a **rupture with the past**, especially in terms of how they approach the working culture and practices within health systems. This transformation has been underway for years, but the younger generations are the ones speaking out most clearly and forcefully about their expectations. Junior doctors, in the shortage of health care personnel situation, are increasingly aware of their own value and dare to express their dissatisfaction. They are unhappy because work and working conditions do not meet their expectations, and they want health systems and management to understand and address their concerns. This aspect is crucial because the solutions proposed to approach junior doctors' job dissatisfaction must take their expectations into account. To this end, it would be interesting to consider the implementation of **participatory mechanisms** that allow us to understand the needs of these young professionals. Furthermore, it is urgent to **focus on the dependent relationship** established between junior doctors and their mentors. Guaranteeing that young professionals have an independent and secure position in health systems is essential to ensure that they have the tools to ask for help if they need it.

From the discourse of the participants, it is clear that giving them **opportunities to make choices** is essential to increase their satisfaction: "*younger generations want choices*". Junior doctors give great importance to work flexibility, the protection of training and the implementation of measures to ensure a safe working environment, with priority being given to tackling work overload and excessive working hours. The participants assert that the implementation of these measures would allow them better opportunities for achieving work-life balance and improving their job satisfaction in the medium and long term. Thus, it is urgent to consider the discomfort reported by junior doctors and to propose strategies to address it in the short term.

Finally, it is crucial that work be continued **to overcome stereotypes and reduce discrimination** in European health care systems. All stakeholders must work together to create more equitable working environments and ensure that junior doctors can practice their profession on equal terms, regardless of their gender or other personal characteristics. Strong state support, including a public care network, more equitable maternity and care benefits, and positive action policies to drive change, are essential to achieve this.

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ANNEX I — LIST OF PARTICIPANTS

AUSTRIA • **Österreichische Ärztekammer**

CROATIA • **Hrvatska Lijecnicka Komora**

CZECH REPUBLIC • **Česká Lékařská Komora**

DENMARK • **Yngre Læger**

ESTONIA • **Eesti Arstide Liit**

FINLAND • **Suomen Lääkäriliitto**

FRANCE • **Intersyndicale Nationale des Internes (ISNI)**

GERMANY • **Marburger Bund**

GREECE • **Junior Doctors' Network-Hellas (JDN-Hellas)**

HUNGARY • **Magyar Rezidens Szövetség**

IRELAND • **Irish Medical Organisation**

ITALY • **ANAAO Assomed**

LATVIA • **Latvijas Jauno Ārstu Asociācija**

LITHUANIA • **Jaunųjų gydytojų asociacija**

LUXEMBURG • **Association Luxembourgeoise des Médecins en Voie de Spécialisation**

MALTA • **Medical Association of Malta**

NETHERLANDS • **Landelijke vereniging van Artsen in Dienstverband (LAD)**

NORWAY • **Den norske legeforening**

PORTUGAL • **Ordem dos Médicos**

SLOVENIA • **Zdravniska zbornica Slovenije**

SPAIN • **Consejo General de Colegios Oficiales de Médicos de España (CGCOM)**

SWEDEN • **Sveriges Yngre Läkares Förening**

TURKEY • **Türk Tabipleri Birliği**

UNITED KINGDOM • **British Medical Association (BMA)**

FROM TRADITION TO TRANSITION
NAVIGATING THROUGH THE HEALTHCARE WORKFORCE CRISIS

JUNIOR DOCTORS' EXPERIENCES AND PROPOSALS FOR THE FUTURE