

What should we call 'Junior Doctors'?

Report by Mrs Scarlett McNally

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Cover Illustration: A ward round: Doctors (yellow lanyards), medical student (blue lanyard) and Doctors' Assistants (green lanyards) at East Sussex Healthcare NHS Trust

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Phrases in inverted commas are direct quotes from a survey responder or task-and-finish group member.

Executive summary

This report is the cumulation of three years of discussion and consideration of multiple views. A suite of terms is needed to cope with multiple situations. The term 'Junior Doctor' was traditionally applied to doctors after qualifying, whilst working through a series of posts with on-going training on their way to Consultant or GP roles. There are 62,000 doctors in approved training posts, of whom 4,248 are over age 40 and all spend most of their time providing NHS service during their training contracts.

Large numbers of doctors do not follow a linear path. 62% of doctors completing their Foundation years do not continue immediately into approved training posts (UKFPO, 2018). Aside from Consultants and GPs, there are now almost as many doctors who are not in training (49,798) as those who are in training (61,592) (GMC, 2019). These other doctors are working as SAS Doctors or as locally employed doctors. Within hospitals and clinical areas, all doctors should be valued primarily for doing the job they are doing now and the skills they have obtained already rather than for their future educational potential. **It is recommended that they should all be called 'Doctors' in workplace settings.**

Most doctors in their first few years are on shifts, changing posts every 4 months, interacting with large numbers of other staff and patients and undertaking very intense work. Unconscious bias from patients, relatives, visitors and other staff means doctors are mistaken for other staff, students, newly-qualified or highly experienced doctors on the basis of what they look like. This may affect how medical advice is interpreted, may reduce training opportunities and may introduce embarrassment. The training system introduced in 2007, with a different term for every year of training, works for educational purposes but is too detailed for use in the workplace. Many hospitals and clinical settings still use the old terms to delineate the two main rota tiers with 'SHO' for the first few years and 'Registrar' for more senior doctors in a specialty. This is similar to imperial and metric still being in common parlance, for example a person's height may be stated as 6'2" rather than 187cm. The task and finish group favoured a return to the old terms, but this report shies away from this because the term 'SHO' has its own negative connotations. The term 'Registrar', however, was particularly popular in surveys. Multiple options were considered. A new term of 'Central Doctors' is recommended to directly replace the term SHO for this broad tier and to include those within and outside formal training posts. Most Central doctors will be within the first five years after graduation. **It is recommended that the broad ranks of Foundation Year 1 (FY1), Central Doctor, Registrar and Consultant are used.** This fits with four RCP 'Tiers' for workforce in acute hospitals. It should be noted that SAS doctors are trained doctors with national terms and conditions of service, usually working within specialties at a senior level, often providing a skilled contribution to the Registrar rota or Consultant rota.

Every doctor's name badge should have the title Dr or word Doctor on it (or surgeon if they identify as a surgeon, have passed exams and are operating). There are many different audiences. Introductions should be clear and tailored to every person or group, including by those introducing others. There are many useful initiatives around name and role emphasising both the individual and their general healthcare role, including: 'HelloMyNames', 'SignUpToSafety' and 'TheatreCapChallenge'.

Each doctor's annual training grade and educational needs will still exist as an extra layer when required, for example within departments.

It is recommended that the terms 'Junior Doctor' and 'trainee' should not be used as these terms are felt to be pejorative. From our survey with 1,948 respondents, 88% thought 'Junior Doctor' was inappropriate and 47% also thought 'trainee' should be avoided. The evidence section and appendices include free text from the survey detailing multiple instances and opinions. Other terms that can cause offence are 'middle grade', 'Career Grade', 'non-Consultant' and 'sub-' and these should also be avoided. Many felt strongly. Being treated in a belittling way (such as when a trainee or junior tag has been used in the past) can be part of a culture where bullying persists; this can be changed.

A different term is required to replace the very specific group term meaning 'all doctors who are in a training post'. The organisational term 'Doctors in training' is not favoured by patients or other staff as it seeps into the lexicon in acute areas and may be misinterpreted as 'student'. Patients dislike acronyms. I offer a final pragmatic solution that the word 'training' should only be acceptable in a title alongside an appropriate adjective. I recommend that groups of doctors in Foundation, Core and Specialty Training posts may be referred to as 'Doctors in Postgraduate Training' when a formal term is needed, unless another adjective is possible, usually signifying specialty eg 'Doctors in Paediatric training' or 'Doctors in foundation training'. In the workplace, I recommend that this is shortened to 'Postgraduate Doctors' or 'Postgrad Doctors' only for those in training posts when needed. This has some flexibility, removes the need for the terms 'trainee' and 'junior doctor' and is respectful. In most instances involving work or scheduling, the term Doctors is better as it includes those not in training. **The term 'Postgraduate doctor' is recommended to replace 'Junior doctor' meaning doctor in a training post.**

Any changes would require an educational exercise for the different audiences of doctors, other staff, the public and patients.

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Introduction

1.1 What is a Junior Doctor?

A Junior Doctor is a qualified doctor working in an accredited post-graduate training post. Although contracts and national terms and conditions of service refer to 'Junior Doctor' as being synonymous with 'doctor in a training post', the term does not appear to have been used as an official term. The Medical Act (1983) stipulates the training programmes that are overseen by the General Medical Council (GMC).

1.2 Why is the term 'Junior Doctor' controversial?

The term 'Junior Doctor' is often considered demeaning as it refers to qualified adults with experience, skills and responsibilities. In the UK, doctors work while learning for many years, often commuting to sequential posts and adapting their needs to what is required for the service. There are unprecedented problems with the availability of training opportunities and morale.

Unconscious bias is important. If a person's role is unclear, other people may make assumptions based on first impressions, so a doctor who does not fit the stereotype for their role may be treated differently (RCS, 2016a). There are anecdotal reports of nurses assuming a doctor giving critical advice was a surgical Registrar because they had the demeanour expected; many women doctors report regularly being mistaken for other staff or being given antiquated careers advice. Unconscious bias affects all of us. For those in training, every potential lost educational opportunity is a waste.

This is not about what 'Junior Doctors' wish to be called, but how others (patients, the public and other staff) understand their role, so that patients receive the best care both now and in the future.

1.3 There are three key issues:

Valuing people: Each staff member should be recognised for their experience and qualifications. Those who do not look like doctors are less likely to be respected and/or supported for training opportunities. Those who look young or inexperienced may get treated as if they are junior. The lowly title 'junior doctor' may reinforce the idea that they are not good enough. There is often lack of clarity about who is a doctor. There is lack of understanding about roles. Sometimes a patient may not realise the importance of any advice given if the messenger's seniority is unclear.

Patient safety: A staff member's role is not always clear to other staff, who may not wish to ask to avoid embarrassment. Unconscious bias means people make assumptions based on what the person looks like. There has been a welcome increase in diversity of staff, so such guesswork is unhelpful. Other staff should be aware of how experienced a doctor is. This includes clinical staff and administrative staff such as those organising a rota. There is the most dislike of the term 'Junior Doctor' in acute and emergency areas with shift working across hours and specialties, where staff are working in constantly changing teams and may not know each other.

Many doctors are not in training: There are thousands of doctors who are not in training posts, who do not fit into the role of 'Junior doctor'.

1.4 What statements have been made about the term 'Junior Doctor'?

- The Royal College of Surgeons of Edinburgh public letter: "We also believe that another term needs to be found to describe 'junior' or 'trainee' doctors. These are highly skilled and committed professionals and should be recognised as such." (RCSEdin, 9.8.16)
- The Royal College of Surgeons of England open letter: "One of the challenges facing doctors in training is the respect they receive in the workplace and the national media. For a long time there have been concerns that the term 'Junior Doctor' is inappropriate" (16.9.16; RCSEng, 2016b)
- The Royal College of Physicians of Edinburgh: "This College has long supported proposals to change the term 'Junior Doctor' to something that more adequately reflects the experience and training that these healthcare professionals have undertaken. We, therefore, welcome the Oxford Health Alliance's campaign to change the title and Dame Sally Davies' support for it. Doctors in training are fully-qualified doctors often with many years of experience after graduation. It is essential that this group of doctors are recognised for their contribution to the NHS and the vital role that they play in healthcare teams across the country. Changing their title would also provide more clarity to patients. Doctors in training are the future of medicine and their wellbeing and morale are important not just at an individual level but as a reflection of a functioning, sustainable and valued workforce that makes up the NHS." (RCPEd, 10.10.17)
- The Royal College of Surgeons of Edinburgh responded to our call for evidence: "It is positive to see a new term for 'Junior Doctors' is being discussed as it is an issue which has previously been raised by the Royal College of Surgeons of Edinburgh. The term 'Junior Doctor' doesn't communicate the vast amount of experience and knowledge built up by doctors prior to becoming consultants. Despite passing graduate exams and undergoing years of training doctors still retain the title 'junior'. This does not accurately represent their role and does not reflect their level of expertise. Distinguishing between doctors according to their level of expertise would ensure clarity for other clinicians within a team as well as for patients." 11.10.18
- The previous Chief Medical Officer for England, Professor Dame Sally Davies: "We need modern names for a modern NHS. The current terms of 'trainee' and 'junior' doctors have been in place for a decade, covering clinicians with a wide range of experience and expertise. These titles do not seem to work for either the staff or the patients. There is no easy solution to this, but I think it is important that all healthcare workers get the respect they deserve – and this should include how their jobs are described." (The Times, 10.10.17)

1. Process of this work and tensions

I was invited to lead the work on what we should call 'Junior Doctors' on behalf of the NHS, independent but with administrative support from Health Education England (HEE).

I invited a large task-and-finish group, which met on 9th July 2018 and 21st September 2018, with email communication around this. The group had clear rules of engagement including: no attribution of ideas to any individual or organisation after the event, encouragement to consider others' views in creating a workable solution and respect for others' contribution. Presentations were invited from those who had done research in this area.

A survey was constructed to gauge views of the public, doctors and other NHS staff. Many survey questions were written to assess the mood around controversial issues. A blog hosted by HEE invited readers to respond. There were press reports in the Times and the BMJ.

This is not a simple re-branding exercise. It started with a deliberate attempt to tease out difficulties. The hope was to find some compromise that could work for the most stressed patient or member of staff. Several issues were identified at the outset:

- Difficulties included that 'Junior Doctor' means different things. It is supposed to mean those with a National Training Number (NTN) or Reference number occupying an approved post within a training programme. Within hospitals, however, it is often used as shorthand for 'all Doctors who are not Consultants' yet now 45% of such doctors are not in training. Data was collected on this.
- Furthermore, only 38% of doctors go straight from Foundation into training posts (UKFPO, 2018). Many do a non-training 'FY3' year, locum work as a doctor or travel. They still identify as being in a training role, as this is the level at which they are working. Many decide to apply to training rotations in the future. Terms are needed that include them.
- There are different audiences, principally the public and other staff. There is a balance between respect for an individual and needing to know their level of experience. Even amongst other staff, there is a balance between exact definitions and broad categories. Some doctors within training grades are keen that their own level of training and experience is highlighted. This may conflict with the simplicity and clarity needed by others.
- There has always been tension between service delivery and learning. Most education is through practice. Over 50% of some doctors' time is on administrative tasks (RCS, 2016b) and on work that could be delegated to Doctors' Assistants or others with short training (McNally & Huber, 2018).
- The terms for doctors should identify that a doctor is doing work, rather than implying that they are there for their own educational benefit.

- Confusion must be prevented with other roles:
 - Clinicians - Traditional roles of others are usually clear, including nurses, physiotherapists, pharmacists and dieticians who have a qualification and a register with a regulating body (eg Registered nurse). They start at NHS pay band 5.
 - Practitioners – may be used for clinical staff with advanced or autonomous practice
 - 'Assistants' or 'Support Workers' - do not have professional or registerable qualifications. Most work at NHS pay bands 1 - 4. All should be valued.
- Acute specialties with multiple interactions have most challenges. Some specialties report few issues but still feel understanding towards other areas where terminology creates friction. For example, "the term GP trainee is actually correct, because they are training to be a GP", whereas patients may not realise that a 'Trainee Anaesthetist' may have a great deal of experience and is often giving the anaesthetic and a 'Trainee surgeon' will be operating with an appropriate level of support.

It was very helpful to have ideas from a wide range of stakeholders and to feedback survey responses to them. These clarified the different audiences. The dialogue continued over six months but no final agreement could be reached on the term for all those within training programmes, so I have recommended the pragmatic solution of 'Postgraduate Doctors'.

Draft versions of the report highlighted other tensions. The task-and-finish group supported the need for other health staff to be aware of broad categories and favoured House Officer (for Foundation Year 1), SHO, Registrar and Consultant. Other organisations expressed particular disquiet over consideration of reintroducing the term 'SHO'. For many, 'SHO' has historical and contractual connotations. A number of other terms were considered (**see Appendix 6**). Possible terms included reference to their status, their workload or attributes. Many terms were rejected as they implied a linear training trajectory or an excessive expectation of their workload. Since this is for use in the workplace, the term should reflect their current level of working, rather than their educational potential. A possible term of RQ (Registered Qualified Doctors) for SHOs was rejected as risking adding to confusion over who was registered, qualified or licenced to work by the GMC. Doctors receive their full registration at the end of Foundation Year 1 (FY1). Many hospitals and clinical areas have the doctors between FY1 and Registrar as a separate rota tier. This report was delayed due to difficulty in timings with contract negotiations, a general election and a global pandemic. For me, this meant organisations who had contributed to the task-and-finish group were represented by different individuals who no longer had the collective understanding of the group. No clear agreement was possible. In the interests of working through the impasse of naming the SHO tier, I have decided on introducing the term 'Central Doctor' to replace 'SHO'. This term is similar to Core doctors (which it includes). Most Central doctors will be within the first 5 years of graduation. Future initiatives are being considered on how best to support doctors in this phase of their career. There were further issues of personal or global importance. I spent 2019 undergoing chemotherapy for Myeloma and cardiac Amyloidosis, still able to write this report, but hopefully using my experience as a patient to cement the importance of considering multiple audiences in this work. 2020 heralded a global pandemic during which doctors of all grades have worked together, truly as 'Doctors'. The pandemic will have an immense impact on future training for this cohort of Postgraduate doctors. It will be more important than ever that every doctor and every moment is valued, to ensure that current and future patients receive the best possible healthcare.

2. EVIDENCE - concepts:

It was felt useful to include a brief section on the history of doctors' training posts. Many roles, responsibilities and numbers of each post have changed (Health Select Committee, 2008). The context in which doctors work is hugely different from just a few decades ago. A further section on the total numbers of doctors with each type of registration is included as the numbers of doctors doing identical roles has not been widely appreciated.

2.1 Historical and legislative

Each doctor in a training post has a National Training Number (NTN) or Reference number; each must maintain a portfolio and undergo Annual Review of Competence Progression (ARCP). Most are undertaking a linked series of posts - a rotation. Similarly, each post with training approval is numbered and monitored.

There has always been a period of apprenticeship after qualification as a doctor. Training programmes are enshrined in legislation. The Medical Act (1983) mandates that doctors in their first year after graduation undertake an 'acceptable programme for provisionally registered doctors' with Provisional Registration with the General Medical Council (GMC). This first year after graduation has been known as Resident Officer, Houseman, 'House Officer', or House Surgeon and House Physician and more recently 'Foundation Year 1' or 'FY1'.

Those undergoing training in a specialty historically undertook a series of posts as a 'Registrar'. In the 1980s, the grade between House Officer and Registrar became more established with several 'Senior House Officer' (SHO) posts, often each of six-months' duration. Then, training posts were linked to form training rotations. A network of 'Training Programme Directors' oversees the specialty programme and competitive selection into it. Each Local Education Provider (eg an NHS Trust) has a governance structure to oversee the educational value of each post. Part of the salary funding for training posts comes from a central HEE education fund; the remainder is funded by the NHS Trust to account for the service aspect of the role.

There have been many reports and attempts to change the postgraduate training structure over the last 25 years:

- Specialist Registrar rotations started in 1996 with explicit curricula and assessments after Calman's 1993 report *Hospital Doctors—Training for the Future*. This also introduced an end point for training, now the CCT (Certificate of Completion of Training).
- Foundation started as a two-year programme across the UK in 2005, replacing House Officer with FY1 and the first year of SHO with FY2. This followed Donaldson's 2002 report *Unfinished business* that described the SHO grade as the 'Lost Tribe' (Collins, 2010).
- For doctors outside training, the Specialty Doctor contract was introduced in 2008. Staff Grade and Associate Specialist contracts were no longer offered following the 2003 report: *Choice and opportunity: Modernising medical careers for Non-Consultant Career Grade doctors*. This identified 12,500 doctors in Staff grade and Associate Specialist (SAS) posts, describing some as a 'professional cul de sac'. It recommended clear criteria and progression.

- Modernising Medical Careers (MMC) started in 2007, aiming to 'see all those emerging from Foundation Programmes entering a training Programme leading directly to the award of a CCT'. MMC and its recruitment system 'MTAS' had many faults, detailed by the Tooke review (Tooke, 2008) and affecting many doctors.
- Doctors have been actively discouraged from using the term SHO beyond 2007. Educational bodies tried to insist upon the new terms, including initiatives such as #SayNOtoSHO (Bradley, 2017)
- Shape of Training has suggested more generalism (Shape, 2013).

Figure 1. Current grades for 'Junior Doctors' since 2007, only applying to those in approved training posts

Equivalent years of training after graduation	Training path for specialties with 'core' phase (admission into CT1 and again at ST3)	Training path for 'run-through' specialties (admission at ST1)	Training path for GP	Rotas in Acute hospitals
1	FY1	FY1	FY1	House Officer = FY1
2	FY2	FY2	FY2	First on-call or Generic rota often still termed ' SHO ' New term Central Doctors is recommended
3	CT1 'core'	ST1	ST1	
4	CT2 'core'	ST2	ST2	
5	ST3	ST3	GP	Rota for a specialty or more specialist 'Registrar'
6	ST4	ST4		
7	ST5	ST5		
8	ST6	ST6		
9	ST7	ST7		
10	ST8	ST8		

NB:

FY = Foundation Year: FY1 = Foundation Year 1. FY2 = Foundation Year 2

CT1 or CT2 = Core trainee

ST3 = Specialty Trainee year 3

Psychiatry has 'core' including ST3

Some specialties have shorter programmes than others.

2.2 Changes to the context in which doctors work

The context of postgraduate medical training has changed a great deal over the last 20 years.

Many changes make the use of the term 'Junior Doctor' seem anachronistic. These changes include:

- Many training rotations used to be very highly competitive (McNally, 2012). Now, around 1000 training posts are unfilled every year (HEE, 2018). Between 8% (HEE, 2018) and 20% (BMA, 2017) of training posts are unfilled and 12% of posts are undertaken on a Less Than Full Time (LTFT) basis (GMC, 2018).

- 52% of medical departments report gaps on the rota (RCP, 2017). Around 30% of doctors in training regularly lose training opportunities due to gaps on the rota (GMC, 2018; BMA, 2018).
- Only 38% of Foundation Doctors continue straight from Foundation into a training rotation (UKFPO, 2018). Around 18% work as a doctor in a post not approved for training, often termed 'FY3 posts'.
- Many doctors in training posts had traditionally worked very long hours. The European Working Time Regulations (EWTR) limited work in all specialties to 48 hours per week from 2009 (Datta & Davies, 2014). Most doctors were arranged in a collective 'firm' with a consultant at the head, a registrar and a variable number of other doctors. It was considered supportive as the 'firm' cross covered and learnt together. This 'firm' structure has been eroded due to EWTR as most doctors are on shifts and do not meet as often (BMA, 2018). Many doctors are on shifts with long commutes. The provision of free accommodation for the first post-graduate year living in was removed in 2007 (Gajendragadkar et al, 2009).
- The complexity of patient care has increased (GMC, 2016). Patients are increasingly elderly, with far more medical conditions and multiple medications. There is insufficient time and focus on working with patients on prevention (AoMRC, 2015). Each step of assessment, discussion and prescription takes more time for each patient.
- The increasing computerisation of health records can greatly increase doctors' workload and burnout (Gawande, 2018).
- 50% of a doctor's time may be spent on administrative tasks (RCS, 2016c) or tasks of low educational value. In many areas, 99% of doctors miss educational opportunities due to poor Trust organisation or overwork (ASiT/BOTA, 2018).
- There is a burgeoning number of other roles fulfilled by nurses or Allied Health Professionals. These may be autonomous or specialised, as 'Practitioners'. Roles include Surgical Care Practitioners, Physician Associates, Specialist Nurses, Extended Nurse Practitioners, Advanced Physiotherapy Practitioners and Prescribing Pharmacy Practitioners.
- There are also new 'Healthcare Support Workers' such as 'Doctors' Assistants' who do not work autonomously. They can take the pressure off postgraduate doctors by doing administrative or simple clinical duties as delegated (McNally & Huber, 2018).

2.3 Numbers of Doctors involved - Data on Doctors by type of GMC Registration

The General Medical Council (GMC) licenses doctors for practice and maintains four different registers for doctors: Provisional, Full, Specialist and GP Registration. There are 250,000 registered doctors licensed to work in the UK as at July 2019. There are around 110,000 doctors licensed to work in the UK who are not on the GP or Specialist Register. Of these, 49,798 are not in training, which is almost as many as the 61,592 who are in training (Fig 2). 6,453 of the doctors in training, have Provisional Registration, most working in their first year after graduation (NHS workforce, 2020). 4,248 doctors in training (7%) are over age 40 (GMC, 2019).

Figure 2: GMC Registered Licenced Doctors (GMC, 2019)

On GP Register	61,015
On Specialist Register (i.e. eligible for Consultant appointment)	77,683
SAS (Staff Grade, Associate Specialists & Specialty Doctors) and LE (Locally Employed) Doctors. [Doctors not in training posts]	49,798
In Training	61,592
On both GP and Specialist Registers	1,231
Total Licenced Doctors	251,319

2.3.1 SAS Doctors

There are around 20,000 doctors in SAS posts, with national terms and conditions of service: 77% are Specialty Doctors, 20% are Associate Specialists and 3% are Staff Grades (NHS workforce, 2020). These latter two categories were closed in 2008, so doctors in these grades now are highly experienced. There is a process whereby SAS Doctors can be admitted to the Specialist Register, known as Certificate of Eligibility for Specialist Registration (CESR). CESR is bureaucratic, lengthy and costly; it requires demonstrating recent supervised experience in the generality of the specialty equivalent to a new Consultant. Only 600 apply each year across all specialties, with around 50% success rate (GMC, 2017b). SAS doctors are an essential part of the NHS workforce and for most this is the role in which they want to remain and develop their career. All SAS Doctors provide great continuity within a department. It may also be more attractive as a career option to future doctors with other interests or commitments.

2.3.2 Locally Employed Doctors (LE Doctors)

There are around 50,000 licensed registered doctors in the UK who are not on the Specialist or GP Register and are not in training (see fig 2). Only 20,000 of these are SAS Doctors. Around 30,000 other doctors work as locally employed doctors in Trust-appointed positions or locums with job titles including Trust Registrar, Trust Doctor, Junior Clinical Fellow, FY3 or similar. It is not generally known that large numbers of doctors occupy posts that look similar to posts with training approval. Many of these posts were introduced when the European Working Time Regulations (EWTR) applied to doctors' rotas from 2009. Even in 2012, as organisations prepared for revalidation, data collected for England identified 12,167 SAS Doctors and 9,661 'Temporary or short-term contract holders', adding 'No figures [existed prior to 2012] for doctors in this group as it is a new category' and a further 2,983 Doctors were categorised as 'other' (ORSA, 2012). This means 24,811 doctors were working in categories that had not been counted or acknowledged well before 2012 and did not fit the binary 'junior doctor' or Consultant model for acute and secondary care.

2.3.3 The implication for the term 'Junior Doctors':

The term Junior Doctor has traditionally applied to those doctors undertaking an approved training programme prior to becoming a GP or Consultant. Within hospitals and clinical settings, the term 'Junior Doctor' is used more loosely by administrative and managerial staff, and often by Nurses, Allied Health Professionals, patients and relatives, to mean any doctor who is not a Consultant but working under a Consultant's supervision. Although this report is about 'Junior Doctors', 45% of the doctors working alongside Consultants are in SAS or locally employed posts, rather than training posts and it is important not to exclude them. There is separate work being done to support and develop SAS doctors and review their career structure.

2.4 The title Doctor and Academic medical staff

2.4.1 Regulatory framework around titles

There are few terms protected in law. The title 'Registered Medical Practitioner' is a protected term. Similarly, the titles 'Registered nurse' and 'Registered midwife' are protected and require the post-holder to be on the appropriate national register following their qualification. Most of these clinical roles require qualification, registration and adherence to a code of practice. Further, it is an offence to masquerade as a qualified registered medical practitioner, under the Medical Act 1983 or the Fraud Act 2006. Some doctors write or stamp their GMC number next to their signature.

The Medical Act 1983 states: "Any person who wilfully and falsely pretends to be or takes or uses the name or title of physician, doctor of medicine, surgeon, general practitioner, or any name title addition or description implying that he [sic] is registered under any provision of this Act, or that he is recognised by law as a physician or surgeon...shall be liable..."

There are over 100 clinical job titles across the NHS. These have often evolved locally. There is a need for clarity between multi-professional teams with regards to roles and titles as well as understanding their respective responsibilities, accountability and ways of working to ensure safe and effective care together rather than relying on apparent hierarchies. Role titles are not clearly standardised, including Advanced or Specialist roles across health professions.

2.4.2 The title Doctor

The award of a doctorate, a higher research degree, in any field confers the honorary title of Doctor. The higher degree is usually a PhD (Doctor of Philosophy) but other doctorates are available in the UK and beyond, including DPhil, DBA and DEd. Medical practitioners, dentists and veterinary surgeons are also allowed to use the courtesy title 'Doctor', despite most not having a doctorate. In clinical settings, having two different types of 'Doctor' (medical and academic) is unlikely to cause confusion as there are so few staff with doctorates working in clinical settings. Any clinical staff with a PhD will be very specialised in their field, hence functioning at a high level and clearly identified (eg Dr C, Consultant Physiotherapist).

2.4.3 Academic medical staff

Many clinical staff have an additional academic role. This involves a commitment to a university with research, learning, teaching and organisational aspects balanced alongside their NHS clinical work. Typically, these are experienced doctors with a formal university contract and sessions and a role as 'Senior Clinical Lecturer' or 'Professor' in addition to their clinical role as Registrar, Consultant or Associate Specialist. Those with a near full-time university commitment may undertake their clinical work as an 'Honorary Consultant'. For some senior NHS doctors with busy clinical workloads, the link with the university is unpaid, but the university recognises their academic work with the role 'Honorary Senior Clinical Lecturer' or 'Honorary Professor'. A professorship may also be referred to as a 'Chair'. 'Emeritus Professor' usually means retired professor, retaining some teaching or research interest. In the clinical setting, there is seldom confusion as these staff usually use their NHS role, eg 'Prof B, Consultant Cardiac Surgeon'.

For those in training grades, formalised academic training programmes can be applied for (HEE, 2019). In the Foundation programme, 5% of posts are on an 'Academic Foundation Programme', with one 4-month block (or equivalent) of research and learning out of the two-year Foundation programme (FY1 and FY2). 'Academic Clinical fellowships' can be applied for alongside core training or ST1 or ST2 with several days out of clinical work per month. At ST3 and beyond (at Registrar level) there are funded 'Clinical Lectureships' which run alongside the doctor's specialty training programme. There is competitive entry to these posts, all of which count towards training with no extra clinical time required.

Many doctors also study for PGCert, Diplomas, Masters or PhD programmes in different fields, such as Medical Education, on a part-time basis.

2.5 EVIDENCE – reports from others

The task-and-finish group invited presentations of research from those in this field, paraphrased here:

2.5.1 Patient data, Mr Christopher Macdonald ST7 Plastic surgery

- This surveyed 200 people: 100 patients within a hospital and 100 members of the public in a shopping centre:
 - 70% of patients understood the term Registrar. Only 10% of public understood it. This suggests that the term 'Registrar' is not in universal use with the public but is used easily and understood by those who have become patients.
 - No patients or public could identify 'FY1'.
 - Fewer than half could explain 'Doctors in training'. Many thought that these were students, in training to become doctors.
 - Fewer than half could explain the role 'Associate Specialist'
- A separate study noted unsatisfactory oral introductions eg "I'm only an ST3". This suggests that doctors are using terms that would be familiar to other doctors but have no relevance to patients. Furthermore, many doctors do not project or value their own experience as they are apologising for their perceived lowly position in the hierarchy of training rather than being positive about their role, skills and experience working as a doctor.

2.5.2 Oxford data presented by Professor David Matthews

- This reported an electronic survey with 430 responses, including 258 Junior Doctors. Most felt the terms 'Junior Doctor' and 'trainee' were detrimental to morale (56%); affected how the role was perceived (76%) and had had a negative effect on their clinical practice (60%). 69% favoured the old terms 'Senior House Officer' (SHO) and 'Registrar'.
- This made recommendations around abolishing the terms 'Junior Doctor' and 'Trainee' and ensuring that 'Doctor' or the abbreviation 'Dr' should always be used, with a rank. This was suggested as a fundamental change to attitudes and a very low-cost intervention.
- They reported some free text comments:
 - "On multiple occasions patients have been surprised that a 'trainee' is a qualified doctor with a degree. They thought it was work experience or a medical student. So depressing."
 - "This terminology hugely undermines clinicians who have more than a decade of experience. It is needlessly patronising."
 - "I don't feel very junior in terms of my responsibilities as a registrar. I am the most senior doctor in charge of my hospital on site out of hours and look after some sick and complicated patients. The term Junior Doctor is demeaning."

- "Although use of the term Junior Doctor may not have an effect on your clinical practice it almost certainly impacts on your doctor-patient relationship as the patient seems to have less trust in a 'Junior Doctor'."

2.5.3 RCSEng and ASiT survey

A survey at the Association of Surgeons in Training (ASiT) conference and on-line via the Royal College of Surgeons of England attracted 997 responses from surgeons and students:

- For a term for the public: 76% 'Doctors', 13% 'Junior Doctors' and 12% 'Trainees'.
- For collective terms to aid staff:
 - 100% agreement that Consultants should be identified as such
 - 97% of respondents approved of a version of the term Registrar
 - 84% supported use of a version of SHO (eg 'surgical SHO') although few choices were offered.

Why this is of particular concern in surgery

Surgery has the longest training programmes. Hence many 'Junior Doctors' are in their 30s, doing highly responsible work alongside other responsibilities. Surgery is a craft requiring practice and experience. Surgeons early in training should be exposed to sufficient supervised operative experience. The terms 'trainee surgeon' or 'Junior Doctor' can sound as if all those who are not Consultants are inexperienced. Unconscious bias (RCS, 2016a) leads patients and staff to make assumptions. Many surgeons, especially women, are mistaken for other staff and this limits their role and experience (RACS, 2016; Peters et al, 2011). Surgeons' tendency to revert to 'Mr/Miss/Ms/Mrs/Mx' on obtaining MRCS exams can add confusion but may persist because it is a noticeable marker at the key stage when acquisition of practical skills

is greatest. Other staff recognising that they have achieved academic hurdles and are committed to a surgical trajectory can be empowering. Surgery remains 86% male (NHS Digital, 2018). People who do not feel they fit in are less likely to continue with surgical training (Peters et al, 2011). Having clear labels would allow medical students and potential surgeons to recognise a wide range of surgeons with whom they might identify or role models. Large numbers of surgeons are neither Consultants nor in formal training programmes, including many in SAS posts who should also be valued. Other specialties, including Gastroenterology and Cardiology have similar issues, with a need to obtain craft skills during training, and the lowest numbers of women of the medical specialties. These specialties also risk unconscious bias limiting opportunities.

Suggestions from surgery included support for one term while the doctor is pluripotential (such as the historical term 'SHO'), followed by Registrar once they have "planted their flag in the specialty" as an ST3. Once they are operating and have passed surgical exams, they may call themselves a surgeon. Clear terminology can help with unconscious bias (RCSEng, 2016a). Using the terms 'surgeon', Miss, Mrs, Ms, Mx or Mr is useful to signify a level of experience and qualification.

2.5.4 #HammerItOut Mr Simon Fleming @OrthopodReg <http://www.bota.org.uk/hammer-it-out/>

This work was invited to shed light on bullying, expectations and respect. The aim is to produce clarity, so that each person's name and work role is understood. There has been increasing awareness of the need for holistic self-care and respect for each person, especially at work. The Japanese term 'Ikigai' means passion/mission/love/needs. Undermining is behaviour that makes people feel small. Bullying involves use of power. Perception is everything, not what was intended.

- In Orthopaedics
 - 70% report being undermined
 - 37% witnessed harassment
 - 73% witnessed a colleague being undermined, bullied or harassed
 - 43% have witnessed a colleague being bullied
 - 71% of Less Than Full Time Trainees (LTFT) have experienced bullying or undermining
 - Only 59% felt valued by their manager

This affects morale. The answer includes role modelling good behaviour and treating each person as their role requires. There is a campaign across medical Royal Colleges to reduce bullying (RCSEd, 2018). We should also call out poor behaviour. The Australasians have built a programme of 'respect' (RACS, 2016). Every health worker can make a change by changing yourself first, then a small team, then the specialty, then the NHS.

2.5.5 #CivilitySavesLives Dr Chris Turner (did not present, concept discussed)

The work around naming Junior Doctors has occurred at the same time as other work on www.civilitysaveslives.com. Rudeness causes:

For the recipient:

- 80% lose time worrying about rudeness
- 78% reduce their commitment to work
- 63% lose time avoiding the offender
- 48% reduce their time at work
- 38% reduce the quality of their work
- 25% take it out on customers/patients

For the staff looking on:

- 20% decrease in performance
- 50% reduction in willingness to help others

For the patient/relative:

- 75% less enthusiasm for the organisation
- 66% feel anxious dealing with the staff

2.5.6 #HelloMyNameIs

The general concept of #HelloMyNameIs is that each person should introduce themselves with their name and role towards patients. Name badges have become popular, often with a yellow background to improve visibility. www.hellomynameis.org.uk

Their key values are:

- COMMUNICATION. Timely and effective communication which is bespoke to the patient makes a huge difference and starts with a simple introduction.
- THE LITTLE THINGS are important. This could be someone sitting down next to you rather than looming over you or holding the door open for someone coming through.
- PATIENT AT THE HEART OF ALL DECISIONS: 'No decision about me without me'. The most important person is the patient.
- SEE ME: as a person first and foremost before disease or bed number.

2.5.7 #TheatreCapChallenge Names and roles on theatre caps – a global patient safety initiative

Presented by Dr Zoë Burton, ST7 Anaesthesia; on work originally by Alison Brindle, student midwife London and Dr Rob Hackett, Australian Anaesthetist. This is an initiative aimed at those working in theatres or delivery where head covering is used. Staff may write their name and role on their hat to improve team-working. Some have fabric hats with their name and role embroidered or applied.

- Using names gives a better exchange of information, better trust and brain activation pattern – we pay more attention. The 'cocktail party effect' is tuning in to the use of your own name.
- More effective teams improve patient safety.
- The adult short-term memory capacity is finite at around four units, eg names.
- Humans only recall 30%-50% of names after first introductions in different studies.

- In Portsmouth, only 52% - 77% recall of names. (Study of 88 staff, 26 theatres, 51% Consultants) with recall poorest in emergency theatres when staff density is highest.
- Patients also welcomed the named caps.
- First names were preferred for use within a team.

2.5.8 www.signuptosafety.org.uk (concept discussed, not presented)

This involves having respect for every individual team member. Their tenet is:

'My patients are safe when I feel safe myself. This applies not only to good clinical support from seniors, but also to good pastoral support from my colleagues. This pastoral support can be created by a few things:

- A team with a collective goal:
 - Individuals working together to achieve a common goal and support each other especially when one or more is struggling.
- Encouraging each other to share who we really are:
 - Each member of staff, each patient, is a completely unique person with other things outside of the hospital. They feel safer knowing colleagues for who they are.
- Small acts of kindness:
 - These contribute to a sense of collective support and safety.'

2.5.9 RCP workforce survey

The Royal College of Physicians of London (RCP, 2018) report on workforce was published in July 2018, just as we were compiling our survey. Their concept of 'tiers' mirrors discussion about having broad grades to aid understanding by other staff (eg if giving an opinion on a ward). Our survey was amended to include questions on this. RCP kindly presented to our task and finish group. The RCP tiers allow for better workforce planning. It suggests how many individuals are needed at which tier at different times of the week, weekend or night, by type of medical setting (RCP, 2018). Their 'Tier 1B' comprises the current 'SHO rota' grade, which our report is recommending as Central Doctors.

Figure 3: Aligning to RCP (2018) 'Safe medical staffing' tiers

RCP Tiers 1 2 and 3		RCP explanation of tiers	Terms Recommended in this report, to replace 'Junior Doctor' tiers
Tier 1	Tier 1: Competent clinical decision makers – clinicians who can make an initial assessment of a patient	Tier 1A: Foundation year 1 doctors (FY1), who are not yet on the medical register. As they are not yet independently competent clinical decision makers, they must work under close supervision at all times.	Foundation Year 1 (FY1)
		Tier 1B: Independently competent clinical decision makers, fully registered doctors (including FY2s, CMTs, GPVTS and ACCS trainees) and non-medical staff with equivalent capabilities, all of whom require a lesser degree of supervision than a Tier 1A clinician.	Central Doctors
Tier 2	Tier 2: Senior clinical decision makers – the 'medical registrars' – clinicians who are capable of making a prompt clinical diagnosis and deciding the need for specific investigations and treatment... We have used the term 'medical registrar' for all staff who are working in Tier 2, irrespective of whether they are doctors in training or not. Tier 2 doctors are able to manage the medical issues of the hospital out of hours as the most senior medical presence on site.	Passing all parts of the MRCP(UK) examination would normally be a requirement to work at this level. Tier 2A: Some more experienced trainees who are at the end of core medical training or other equivalent training. Tier 2B: Specialist or specialty registrars in higher medical training programmes, or trainees in internal medicine Year 3. SAS doctors and trust doctors can work in Tier 2 at either level, according to their competencies, qualifications and experience.	Registrar
Tier 3	Tier 3: Expert clinical decision makers – clinicians who have overall responsibility for patient care.	Tier 3 clinicians have overall responsibility for the care of patients. They are currently consultants, associate specialists or specialty doctors above threshold 2.	Consultant

2.6 Suggestions from other settings

Terminology or branding from other settings has been suggested. Whilst these were considered helpful in allowing discussion of a range of options, none had sufficient support to warrant progression.

- In Northern Ireland, an institution may use lanyards with different colours denoting different levels of seniority, like judo belts.
- Lanyards are used in Portsmouth, although they initially did not allow for doctors in all roles. They are being modified to include doctors who are not in training programmes. Lanyards are currently in the following colours:
 - Green = Foundation Doctor
 - Orange = Core training doctor
 - Red = Specialist Registrar
 - Blue = Consultant
- In the Republic of Ireland, the term 'Non-Consultant Hospital Doctor' is in common use.
- In New Zealand, 'Training Registrar' and 'non-training Registrar' is used.
- In the American system, doctors progress through grades: 'intern, resident, attending'.

Lanyards have already been instituted in several hospitals, but there is no standardised colour scheme between them. Some have used colours to distinguish doctors by grade. In some examples, SAS Doctors and those not in training may not feel included. Other Trusts have lanyards including all types of staff (eg East Sussex has Estates in green, management in pink, doctor in yellow with Consultants and SAS Doctors in black). Some Trusts have resisted lanyards due to infection control concerns. It is likely that policies recommending that lanyards be laundered weekly or when visibly soiled are not fully adhered to. Whilst there is merit in the greater visible recognition of doctors that lanyards provide, there is no appetite to insist on a new scheme or to promote an existing scheme.

It was clear in the survey responses and in discussions that any term reliant on 'non-' should be avoided, so 'non-training' or Non-consultant' would not be a useful direction. Similarly, the term 'middle grade' has been viewed as pejorative and 37% of responders to the survey thought it should be avoided.

Considering the American terms: Intern, Resident and Attending, these were felt to be less clear and well-liked than the old UK term 'Registrar' for the more senior grade. 'Resident' was considered to be too similar to 'Registrar' and might reinforce the expectation that these doctors lived in their work. The term Intern has connotations of an unpaid post-holder only present to gain experience. The term 'Intern' was little used in the UK until shockingly associated with reporting of Monica Lewinsky and perceptions of power differential. Furthermore, these American terms only include those in training grades, rather than the UK situation where 45% of doctors working at these levels are not in training posts.

2.7 Survey results

2.7.1 Summer 2018 Survey Responses

An electronic survey was conducted via HEE over August 2018. There were questions for all, including the public, and specific questions for those working in Healthcare. 1,948 responses were received, 76% from doctors, 12% from patients/public and 11% from other health professionals. Over 1,500 items of free text were received (see appendices 1 and 2) some giving instances where use of terminology had caused a problem and others giving explanation.

88% felt the term 'Junior Doctor' was inappropriate, principally because it was too vague or not representative; 60% felt the term 'Junior Doctor' should be avoided altogether. 47% felt that the term 'Trainee' should be avoided. Other terms that should be avoided include: 'middle grade', 'Non-Consultant', 'Career grade' and 'Sub-' (see Fig 4).

Figure 4: Terms to avoid

Term	% Yes - term should be avoided (Responses received 1,571 – 1,724)
Middle grade	37%
Non-Consultant	63%
Career grade	53%
Trainee	47%
Junior Doctor	60%
Sub-	94%

Respondents thought it useful to know: what kind of healthcare professional is treating them (99.5%), whether this person is medically qualified (98.5%), or if the doctor is a Consultant (93.8%). 90.7% wanted to know the level of seniority if the doctor is not a Consultant.

Broad terms for ranks, such as 'Registrar' were welcomed by 70%. There was 88% support for the term Registrar and 66% for SHO. 67% preferred those in their first year to have a different term to signify that they are in their first pre-Registration year, for example House Officer or Foundation Year 1 (FY1). Some terms for the first tier might inadvertently confuse patients or other staff about the role of Foundation year 2 doctors. [Free text from other health professional]: "When somebody introduces themselves as a junior doctor, patients lose faith in their ability - I've heard complaints that they "weren't even seen by a real doctor, they sent a junior instead". Many don't know what foundation doctor or CT means in terms of experience. I think it also causes some self doubt among junior doctors, particularly FYs, who see themselves as 'just' a junior"

Suggested term for niche term of doctors in training programmes

Possible terms were offered to replace 'Junior Doctors' when used to mean the collective term for doctors in training posts, but none had overwhelming support. It is probable that many responders were keen to support the terms 'Doctor' or 'Registrar' but did not consider a niche term for a group of doctors in training as a priority.

Survey results were analysed by type of responder. Terms 'including NTN doctors', 'doctors with NTN' and 'doctors with Educational contract' did not have great support from any group. A scale of 1 = not

at all acceptable to 5 = completely acceptable was given. The term 'Postgraduate doctors' scored 4 or 5 (acceptable or completely acceptable) from 60% of patients/public, 51% from other health professionals, 45% from organisations and 38% from doctors.

2.7.2 Results of the survey from patient/public responders

The survey included 154 responders identified as the public or patients. These have been analysed separately (see Appendix 2). Some general questions had clear responses in figure 5:

Figure 5: Patient responses in survey:

Is it useful to know what kind of professional is treating you?	98% "yes"
Is it important to know whether someone is a consultant?	87% "yes"
If the Doctor treating you is not a consultant or GP, do you think it is important to know their level of seniority?	86% "yes"
Is Junior Doctor an acceptable term?	76% "no"
Should Doctors in their first year be named differently?	57% "yes"

Many questions had low response rates, but in general the public/patients recommended four tiers (69%). For two tiers, labels were clear: Consultant (88%) and Registrar (81%). The other two tiers were more contentious, with SHO (40%) or another term (60%) for the tier I have called 'Central doctors' and variations on foundation doctor (52%) or House Officer (33%) for the first year after qualifying. The term for the first year must avoid confusion with Foundation year 2 doctors.

56% agreed that the term 'Doctors' was acceptable or very acceptable for all doctors whether in training or not. For those in postgraduate training posts, terms deemed acceptable or completely acceptable were: Postgraduate doctors (60%), Doctors with educational contract (23%) or NTN doctors (22%). (See Appendix 2).

There were many free text comments. These elaborated on why the term junior doctor was unhelpful and many reiterated that the multiple terms and acronyms in the current system were confusing for patients and the public. There were helpful suggestions about name badges, lanyards, clarity of introductions and posters or education explaining ranks.

2.7.3 The Times

The Times ran a leader article and an electronic survey, with 200 replies. The most popular response was: "What's wrong with: House officer, Senior house officer, Registrar, Senior registrar, Consultant". The terms 'Registrar' and 'Doctor' were also popular (See Appendix 3).

2.7.4 Other feedback

Letters and emails were received from interested people. Professor Harold Ellis (retired) wrote: 'We cannot call people who have done 100 cholecystectomies a Junior Doctor...When I qualified in 1948, I was proud to be called a House Surgeon. I think we all tried to live up to our various labels.'

2.7.5 Recent on-line survey from Brighton (See Appendix 4):

An online survey of UK doctors in April 2020, conducted by Dr Ramy Saad and Dr Robert Galloway received 473 responses. Results are pending publication. Highlights include:

- Significant proportions of doctors believe the term 'Junior Doctor' is misleading to patients and has undermined doctors, or their abilities, in the past.
- The term 'Junior Doctor' is frequently misinterpreted to mean medical student.
- A significant proportion of doctors feel it is not a beneficial term and should be changed.
- Opinions differ by grade and there is a mismatch between consultant perceptions of this issue and those who are referred to as a 'junior doctor'.

3.0 Discussion:

It has been fascinating and humbling to delve into reasons why 'Junior Doctor' is a poor term and how it might be replaced. The task and finish group was an excellent way of harnessing multiple viewpoints, all seeking to find a pragmatic solution. The survey gained almost 2000 responders, many providing detail from their own experience as a doctor, health professional, patient or relative in the NHS. Responders were very clear that the term 'Junior Doctor' must be avoided. Not only can this have a negative effect on the doctor's morale, but also on their education and the care of their patients. The term 'trainee' was also strongly disliked. This implies that the person is there for their own training, not for their job capabilities. The free text responses (Appendices 1 and 2) give a flavour of views.

Three different ways of seeing the issue are required. Firstly, Doctors are doing service work while in an educational post, so their label needs to reflect their current skills and experience rather than their educational potential. Secondly, the large numbers of doctors (around 45%) who are not in training posts, but working alongside us, is not widely realised. Thirdly, within hospitals and clinical settings, the term 'Junior Doctors' is often used to refer to any doctors who are not Consultants, whereas in political and educational circles the term is only used to mean those in a training post usually with a National Training Number.

The term 'Junior Doctors' has been partially rehabilitated with strong public support following the contract dispute. It is still, however, felt by a large number to be pejorative. 78% in our survey felt it was not appropriate. The term 'Trainee' is also felt by some to suggest the doctor is not qualified or is present principally to further their own education. 47% of survey respondents thought 'trainee' is a term that should be avoided.

It is better to name people after what they are, rather than after what they are not. This means the Republic of Ireland option of 'Non-Consultant Hospital Doctor' would be unlikely to get used in the United Kingdom.

The recommended term for the workplace is 'Doctors'. It is more important to distinguish between doctors and others than between level of seniority; there are parallels with other professions "you don't know if the physio coming on the ward is a Band 5, 6 or 7, but you just know you are pleased to see them". The term 'Doctors' allows inclusion of those who are not in training, so they are valued. Flexibility is needed as people increasingly step in and out of careers and as Less Than Full Time Training or part-time working becomes more popular. Each worker should be valued for the hours they are present and the skills that they have. Many of the additional posts without training recognition were created to make up for reduced numbers of hours when EWTR newly applied to doctors in training from 2009. There are nearly 50,000 doctors working as SAS Doctors or Locally Employed Doctors who should be valued as a huge skilled aspect of the workforce. The global COVID-19 pandemic has seen doctors and other staff working tirelessly across hierarchies and specialties and some new aspects of team-working may persist.

Discussion included that most Consultants work principally delivering patient care and should be included in the term 'Doctors'. Surveys have been very clear that the term 'Consultant' is recognised and valued. Although there have been other calls for flattening hierarchy, the patient wants to know who is in charge. Similarly, although there are other clinical staff at all levels, the public are keen to know who is a doctor.

It is apparent that some form of ranking is needed, especially to help other staff or with opinions for patients. The 2007 training ladder with its annual terms has never really landed. The old term Registrar is very popular, featuring in 88% of survey respondents, 97% of a surgical survey and 70% of a patient survey. This has been described as similar to Imperial and Metric. For many specialties, an exam is required to move to a level equivalent to Registrar grade. Many documents delineating required standards for patient care use this as a distinct level for example stipulating 'ST3+ competencies'.

The need for a broad term for those in the years between first year and Registrar was strongly supported. The term SHO was supported by 66% of survey responders but had negative historical and contractual associations for training organisations. The downside is that there is a wide range of experience and capabilities within this band. Some doctors feel their own level of experience should be highlighted. **The recommendation is that a clear term is used for those in Postgraduate years 2-5. My recommended term is 'Central Doctors' to directly replace the historical term 'SHO'. The other more specific educational terms still exist when needed.**

Having a separate tier for those in the first year after qualification was considered useful by survey responders. The task and finish group agreed this, commenting also that it would also ensure support for new doctors at this time; it supported returning to the old broad terms, including SHO, with the term for the first year 'House Officer' giving internal consistency. On further deliberation, I have selected the term Central Doctors to directly replace the term SHO. Those in their first year can remain 'Foundation Year 1' doctors (FY1).

It should be noted that those in Foundation year 2 contribute a huge amount to the core-level rotas with other doctors in Postgraduate years 2-5. Considering them as part of the tier of Central doctors means they should be welcomed into the team at that level, which may improve their experience. Currently over half do not progress straight to a training programme after Foundation. Imposter syndrome and being mistaken for a newly qualified doctor may prevent them from working to their full potential. The actual educational rank would still be available "as an extra layer" when needed.

The RCP workforce report was published just as our survey was being launched and in time for questions to be added. There was support for acknowledging doctors by broad rota tiers rather than by annual change in training title. Our terms: Foundation Year 1 (FY1), Central Doctor, Registrar and Consultant fit with four RCP rota tiers (see Fig 3). The phrase 'Tier 2' can have visa connotations, so the term Registrar is better.

It has been useful to draw together other initiatives around communication, such as #HelloMyNames. The name badge to be read by patients and workplace staff should clearly state Doctor, or Dr, and name. Discussions highlighted that it is increasing common to have two or more badges, some with swipe card access or smart capabilities. In some cases, a swipe card with Doctor or Dr and name may be sufficient, with the caveat that "they [name badges] always rotate or some hang at groin level and have too many words".

Oral introductions should be clear and targeted at the audience. There was interesting discussion over use of first name or title and surname, with patients needing particular clarity when major decisions were being discussed. The extent of bullying within the NHS was presented. In some cases, supervisors do not realise how their own behaviour is perceived. Bullying is in the perception of the victim. Doctors who do not feel valued and who have not been given clear expectations enjoy their posts less. It is possible that a new attention to respecting each person's contribution and to being clear about name, role and expectation may improve experiences (RCSEd, 2018, RCSEng, 2016a).

There were debates about the specific situation of surgeons. Those who have been successful in surgical exams may refer to themselves as Mr, Mrs, Miss Ms or Mx or 'surgeon' if they wish. These titles are first permitted at the critical phase when the recipient is most in need of respect and practise to develop specialty skills. In a craft specialty, procedural skills need to be acquired. Unconscious bias otherwise means that other staff, patients and relatives may make assumptions depending on what they were expecting a surgeon to look like. This may inadvertently reduce the opportunities to develop skills. There are similar issues for those in training in Gastroenterology and Cardiology which are the least diverse of all medical specialties.

It is noted that the rota at core generic level may include non-medical personnel (Fig 3). A distinct future line of work could be to provide clarity over the increasing number of non-medical staff roles. For example, the term 'Practitioner' might be preserved for those with autonomous or Advanced practice, 'Registered' might be used for those in a traditional profession and 'Assistant' or 'Support Worker' retained for those doing delegated tasks without a registerable qualification.

The term 'Junior Doctors' can be replaced with 'Doctors' in a workplace setting. 'Junior Doctor' or 'Trainee' should not be used to refer to any doctor. Many of the survey responses and meeting comments were articulating a desire to return to simple old terms including 'Registrar' and 'Doctor'. Discussion was around being inclusive of all doctors in the workplace, especially those not in training posts.

The final decision on a collective term to replace 'Junior Doctors' when meaning 'doctors in training posts' could not be agreed within the task and finish group. Acronyms abound within medicine and elsewhere, but are not well liked by patients, nor always understood by other staff. There is a useful precedent for acronyms with SAS Doctors. The term SAS started as Staff Grade and Associate Specialists, then Specialty Doctors were included in this term once this contract commenced in 2008. There are many other helpful acronyms: LMIC (Low and Middle Income Countries, rather than 'Third World'), BME or BAME and LGBTQ (although there are variations of this). Every doctor who has an educational contract with a NTN or Reference number is employed as a Foundation Doctor, Core Trainee or Specialty Registrar. The final term required is the niche collective term purely for those in training posts as doctors in Foundation, Core or Specialty Training posts. FCS Doctors would be accurate but had little support. Over the six months following the meetings, further dialogue continued with stakeholders. A section has been added on the survey responses specific to patients (**Appendix 2**). This clarified that patients prefer simple terms. There is a polarisation of views: organisations want exact definitions whereas patients and the public prefer simpler terms. Staff, especially administrative staff, need a clear shorthand term. There are no simple terms that appeal to all (**see Appendix 5**). The term 'trainee' should be avoided; both 'trainee doctor' and the term 'doctor in training' can imply that the person is a student or in training to become a doctor. 'Training' could remain a possible term, particularly if combined with 'Postgraduate'.

'My final pragmatic recommendation is:

- Within organisations, the term 'Junior Doctor' referring to doctors in approved training posts should be replaced by 'Doctors in postgraduate training' unless another qualifying adjective is available, such as the specialty (eg 'Doctors in Paediatric training' or 'Doctors in Foundation training').
- At workplaces or wherever a simple term is needed purely for those in posts approved for training, 'Doctors in postgraduate training' could be shortened to 'Postgraduate doctors'. This removes the need for the terms 'trainees' or 'Junior doctors'. There is often a need to communicate eg "all trainers and postgraduate doctors need to complete the survey". As one survey responder put it: "Members of the public not involved in education with no knowledge of universities will understand the term post graduate".

This gives sufficient respect. It is a pragmatic option, replacing the intended original use of 'Junior Doctors' as slang for those in training posts. For those who would prefer an acronym, I light-heartedly offer a suggestion that 'Postgraduate' could be an acronym for 'Programme Of Specialist Training, GP [or] Related, Active Doctors Under Approved Training [and] Education'.

This work has involved a number of strands. It has heard patient expectations and initiatives to ensure that all staff are valued. It acknowledges the large numbers of doctors in different career pathways. Many of the responders to the survey were keen to support the use of the terms 'Registrar' and 'Doctors'. Further work would need education and explanation to the different audiences involved.

4.1 RECOMMENDATIONS – explanation

1. The terms: 'Junior Doctor', 'trainee', 'sub-' and 'middle grade' should all be avoided.

There is clear dislike of all these terms. The large survey found 78% of respondents thought the term Junior Doctor was inappropriate. Eg: 'Junior Doctors' and 'trainee doctors' should be stamped out of the language of the hospital by all staff. We are not training to be doctors. We ARE doctors...'

2. At work, all Doctors should be clearly identified as Doctors.

The term 'Doctor' recognises the skills and experience already achieved and their role in current patient care, rather than their educational potential after it. This term includes the large numbers of doctors who are not in training posts. This reflects the prominence doctors give to NHS service.

Although there is a move to flatten hierarchies, there is strong support to acknowledge the unique place of the doctor. 98.5% of our survey responders thought it important to know who is a doctor. As Tooke (2008) put it, 'the doctor's role as diagnostician and the handler of clinical uncertainty and ambiguity requires a profound educational base in science and evidence-based practice as well as research awareness'.

The title 'Doctor' is not a protected term but is well understood and respected by the public. 'Registered Medical Practitioner' is a protected term but since this is less well understood, the term 'Doctor' is recommended.

Respondents sought clarity. Without clarity, others may guess depending on the staff member's appearance or demeanour and 'Doctors [are] mistaken for nurses all the time, then patients don't realise they have seen a doctor'. The term 'Doctors' includes Consultants, those in training posts, SAS doctors and those in other roles, distinguishing them from other professions. There is huge overlap between the hands-on clinical work delivered at all levels, including by Consultants. Where there is a need to distinguish between grades of doctor, there are many options to use as occasion demands, including 'Doctors on the registrar rota', etc.

3. A doctor working at Consultant level should be identified.

All studies established that the vast majority of people want to know 'who is in charge'. The title 'Consultant' is not a protected term, but is felt to be clear enough in NHS circles. This also fits with inclusivity, in that there are a small number of 'Nurse Consultants' and 'Physiotherapy Consultants'. For general purposes, within an NHS team, the title 'Consultant' expresses a certain rank.

Within the SAS group, the grade of Associate Specialist carries the same right of autonomous practice as 'Consultant'. This is a closed grade, but there is appetite to re-introduce it. There are some doctors who are not employed in a Consultant post but who are on the Specialist Register, through CCT or CESR for which the standard of assessment is capability of Consultant practice.

4. It should be acknowledged that there are almost as many doctors working in SAS posts or Locally Employed posts as there are doctors working in training posts.

Continued use of the term 'Junior Doctors' should be stopped partly because it conflates 'Junior doctors' as the 61,592 doctors in approved postgraduate training programmes with 'Junior Doctors' as the

colloquial term for the 111,390 doctors who are not Consultants or GPs and who provide the bulk of NHS service. In the past, there has often been failure to know about, value or respect other doctors who are not in training posts whose numbers have increased. The numbers of such posts has increased. SAS Doctors (Specialty Doctors, Staff Grade Doctors and Associate Specialists) are trained doctors with national terms and conditions and often far more than the minimum of 4 years' of postgraduate training. Locally employed doctors include those in posts with various titles without formal training approval.

5. For practical purposes, particularly rota planning and team workload division, four broad categories of doctor are recommended:

- Foundation Year 1(FY1)
- Central Doctor
- Registrar
- Consultant

These broad categories are loose enough to encompass those in training posts and those in other posts.

There are different audiences, principally the public and other staff. For some, simply the title 'Doctor' will be sufficient. This is an acknowledgement that the current multiple levels of training grade are not easily remembered or used. Doctors can be ranked broadly as: Foundation Year 1 (FY1), Central Doctor, Registrar and Consultant, to understand their current skills, capabilities and experience for the current work, rather than whether they hold a training post. This mirrors terms from before 2007. The term 'Central Doctor' exactly replaces the historical term 'SHO'.

This fits with the RCP report on workforce planning, which has Tiers of capabilities. Of note, the RCP Tier 1B (the broad generic rota often covering multiple specialties, which we have termed the Central Doctor tier) may be populated by other clinical staff, not necessarily doctors (see Fig 3).

SAS doctors may contribute to the Registrar rota or the Consultant rota.

6. Doctors should keep their more specific title (eg ST4) for use as needed. Departments should be aware of each doctor's training status and requirements. Other staff may request the more detailed information as required. There is a difference between a label needed for administrative or workforce purposes and an individual's educational aspirations.

Although the four ranks of seniority are the pragmatic choice, every doctor retains their own contract or training grade. This is most useful at Departmental level, and best practice ideas include Departments updating 'who's who' boards before new staff rotate into their post or annotating rota sheets to ensure that senior staff are aware of the doctors' learning needs or grade. Other comments made in the task and finish groups included: 'there could be a Board for patients in a department. It should be easy to do with pictures, when every group of doctors changes over. Doctors can cover multiple wards, but where possible it is good to feel part of a team.' and 'Each department should know what level is expected of each doctor and who is in training.'

7. Those in GP training rotating through another specialty may be part of the 'Central Doctors rota' for that specialty.

Doctors training to become GPs typically follow a three-year programme often rotating through acute hospital specialties. They are frequently rostered onto the rota whilst in this acute specialty post, at the level that fits their skill within this specialty. 85% of survey responders felt that this situation was acceptable and members of the task and finish group agreed. This fits with the ethos of calling someone by the task they are doing, eg 'on the Central Doctors rota for Paediatrics' irrespective of whether they are also referred to as 'GP trainees', 'GP Registrar', 'GP on Vocational Training Scheme', 'GP VTS', 'GPST1' or 'GPST2'. No organisations or responders felt this would create a problem.

8. Name badges should be clear and visible, stating Doctor (or surgeon) or the title Dr with name and role.

Every doctor should have their name and role clearly visible. It is recommended that 'Doctor' or 'Dr' as a title is used. A further rank, or a specialty, may be added.

Many doctors change post every 4 months and only get a new badge every one or two years. Doctors changing this frequently are often involved in generic rotas, so their actual specialty is not essential on a name badge. Their role as a Doctor should, however, be clear.

9. Lanyards denoting rank may help where Trusts are doing this.

There is no appetite to introduce a new compulsory system for lanyards. Some Trusts have used lanyards in different colours to show either ranks of doctors or ranks of all staff. Where lanyards are in use, they should include all doctors, including those not in training posts (for example there may be one colour for all doctors, or one colour for Central Doctors and one for Registrars). There should also be a clear laundry policy (eg wash once per week or if soiled).

10. The 'Theatre Cap Challenge' is welcomed

The theatre cap challenge in an operating theatre or similar area involves staff having their name and role clearly displayed on their theatre hat (Burton et al, 2018). This is principally for communication between members of staff and can help with team expectations and bonding. Patients and students have also welcomed this initiative. Some doctors are a regular part of such theatre teams including anaesthetists, surgeons and obstetricians and their name badge is often not visible. Doctors participating in this with their own cloth hats stating name and role increase the inclusive ethos. Surgical Site Infections and bacterial shedding have been found to be lower with cloth hats than disposable (Markel et al, 2017a, 2017b, Farach et al, 2018). A clear laundry policy is needed, with each staff member having at least three hats, to permit a new theatre cap for each shift or more often if visibly soiled.

11. Oral introductions should be clear

Doctors should be clear about their name and role to each patient, relative and staff member. The oral introduction may need to change between different patients, 'the problem is the audience changes every moment, depending on the patient'.

Communication skills are already assessed as part of doctors' ARCP assessment process and postgraduate exams. The importance of speaking clearly and sufficiently loudly for the patient is

particularly important when giving a name and role. Clinicians should also be sympathetic to the fact that strong accents can be problematic for some.

12. Other staff introducing a doctor should be clear

Everyone introducing others should pause to ensure that the recipient is considered. Every worker should be treated with respect. "This is the surgical team" may be fine when introducing a group. If an individual will be doing specific work, they may need a specific clear introduction.

13. A doctor may use personal preference for first name or title and surname

Many staff members feel more comfortable with first names being used; others prefer a more formal name and title. When Doctors are involved in care or consequences over some time, a first name may not be enough: "You need to know their full name if something goes wrong or if someone is making a decision. It's fine until it goes wrong. Just to know someone is Dave is not enough if they are making a big decision."

14. If a doctor has passed surgical exams and is working in a surgical department:

- i. they may identify as 'Surgeon' rather than 'Doctor'

In this specific instance, where a doctor has passed surgical exams and is operating in a surgical department, they may prefer to introduce themselves as a 'Surgeon' rather than a 'Doctor'. This is particularly important for those who are mistaken for other staff or for those who are operating and gaining practical experience with supervision.

- ii. they may prefer to use the title Mr/Miss/Ms/Mrs/Mx after obtaining Membership of a surgical College if practising within surgery (eg as a Registrar)

There were some survey responses suggesting this would be a good opportunity to remove the UK anomaly of surgeons reverting to a title of Mr, Miss, Ms, Mrs or Mx on obtaining surgical exams. Eg "Members of the public do not understand the use of Mr etc for a surgeon vs Doctor"; "Whilst were on the subject, I think the time has come to call surgeons "Dr" as well. The distinction has never been understood by patients and, with consultant nurses, podiatric surgeons etc, it's even harder for patients to understand who they're being treated by" and "Mr, Mrs is old-fashioned"

It is felt, however, that this practice is useful for those who do not fit the traditional image of a surgeon. "If everyone called themselves Dr others would". The issue is that if everyone else is calling themselves 'Mr, Mrs, Miss Ms or Mx', the one person who does not may feel, or be perceived as if they are more junior by not doing so. Women surgeons, who are frequently mistaken for other staff, students or a less experienced doctor, may benefit from retaining this title as a recognisable label of their qualification. They become "part of that tribe". With any role, "you have a duty to explain".

15. 'Doctors in Postgraduate Training' is the recommended collective term for doctors whose post is on an educational training programme, unless another qualifying adjective is available (eg specialty).

This can be shortened to 'Postgraduate Doctors' or 'Postgrad doctors'.

The terms 'junior doctor', 'trainee' and 'doctor in training' should be avoided. All those working in a Foundation, Core or Specialty training post are in Postgraduate training. The recommended term is 'Doctors in Postgraduate training' unless a different qualifying adjective is available, such as 'Doctors in Paediatric training' or 'Doctors in Foundation training'. The term 'Postgraduate doctors' is recommended as a shortening of 'Doctors in Postgraduate Training' to aid communication about or with those in training posts. (In most clinical instances, the term 'Doctors' is better because it includes all doctors, whether in training or not.)

16. Any further work on this topic should include information for patients, relatives, visitors and other staff about the terms in use.

Information on the terminology for doctors and the need to respect their current experience and service should be designed with patient and staff representatives.

Figure 6. Recommendations on naming tiers of Doctors

- All Doctors are 'Doctors' in the workplace.
- Broad tiers or ranks (FY1, Central Doctor, Registrar) should only be needed in specific circumstances.
- Each Postgraduate Doctor also retains their training grade (eg ST4) as needed

'Doctors in Postgraduate Training' OR: 'Postgraduate Doctors'	Recommended broad tiers:	Includes Locally Employed Doctors (Eg 'FY3' or 'Trust Registrar')	Type of GMC Register (four options)
FY1	Foundation Year 1 (FY1)	Yes	Provisional
FY2 CT1 'core', ST1 CT2 'core', ST2	Central Doctor	Yes	Full
ST3 ST4 ST5 ST6 ST7 ST8	Registrar	Yes	Full
No	Consultant	Yes	Specialist
No	GP	Yes	GP

NB: SAS Doctors have national terms and conditions of service. Speciality Doctors require 4 years before entering the grade out of which 2 years should be in the speciality. Most work at the level of very experienced Registrars, with those beyond threshold 2 of the Specialty Doctor contract often working to a Consultant job plan and rota. Associate Specialists work autonomously at Consultant level.

** The GMC's Specialist Register comprises those who have CCT (Certificate of Completion of Training) and those who have CESR (Certificate of Eligibility for Specialist Registration).

4.1 RECOMMENDATIONS – list

1. The terms: 'Junior Doctor', 'trainee', 'sub-' and 'middle grade' should all be avoided.
2. At work, all Doctors should be clearly identified as Doctors.
3. A doctor working at Consultant level should be identified.
4. It should be acknowledged that there are almost as many doctors working in SAS posts or Locally Employed posts as there are doctors working in training posts.
5. For practical purposes, particularly rota planning and team workload division, four broad categories of doctor are recommended:
 - Foundation Year 1(FY1)
 - Central Doctor
 - Registrar
 - ConsultantThese broad categories are loose enough to encompass those in training posts and those in other posts.
6. Doctors should keep their more specific title (eg ST4) for use as needed. Departments should be aware of each doctor's training status and requirements. Other staff may request the more detailed information as required. There is a difference between a label needed for administrative or workforce purposes and an individual's educational aspirations.
7. Doctors in GP training rotating through another specialty may be part of the 'Central Doctors rota' for that specialty.
8. Name badges should be clear and visible, stating Doctor (or surgeon) or the title Dr with name and role.
9. Lanyards denoting rank may help where Trusts are doing this.
10. The 'Theatre Cap Challenge' is welcomed
11. Oral introductions should be clear
12. Other staff introducing a doctor should be clear
13. A doctor may use personal preference for first name or title and surname
14. If a doctor has passed surgical exams and is working in a surgical department:
 - i. they may identify as 'Surgeon' rather than 'Doctor'
 - ii. they may prefer to use the title Mr/Miss/Ms/Mrs/Mx after obtaining Membership of a surgical College if practising within surgery (eg as a Registrar)
15. 'Doctors in Postgraduate Training' is the recommended collective term for doctors whose post is on an educational training programme, unless another qualifying adjective is available (eg specialty). This can be shortened to 'Postgraduate Doctors' or 'Postgrad doctors'.
16. Any further work on this topic should include information for patients, relatives, visitors and other staff about the terms in use.

See also Appendix 7.

5: Members of Task and Finish group

These people and organisations were crucial to this work and contributed effort, expertise and ideas. Membership of the task-and-finish group does not imply agreement with report contents.

	Name	Organisation
1	Mrs Scarlett McNally	Lead
2	Mr Alastair Henderson	Academy of Medical Royal Colleges (AoMRC)
3	Dr Dev Chauhan	Academy of Medical Royal Colleges Clinical Fellow
4	Dr Jack Ross	National Medical Director's Clinical Fellow, AoMRC
5	Mr Graeme Larkin	BMA
6	Dr Donna Tooth	BMA GP Trainees Subcommittee
7	Dr Matthew Tuck	BMA Junior Doctors Committee
8	Ms Mita Dullipala	BMA Medical Student Rep
9	Dr Raj Kumar	BMA SAS Doctors
10	Dr Sethu Warriya	British Association of Physicians of Indian Origin (BAPIO)
11	Dr Ian Benton	Director of Medical Education, Countess of Chester Hospital
12	Prof David Oliver	Consultant Physician
13	Mr Mark Dexter	GMC Head of Policy (Education)
14	Mr Jonathan Howes	HEE (Health Education England)
15	Dr David Cox	HEE Clinical Fellow
16	Dr Hatim Abdulhuseein	National Medical Director's Clinical Fellow at HEE
17	Dr Katie Knight	HEE Clinical Fellow
18	Dr Tahreema Matin	National Medical Director's Clinical Fellow (2017-2018) at HEE
19	Dr Liz Carty	HEE Deputy Postgraduate Dean
20	Ms Rita Joshi	HEE Policy
21	Mr Andrew Matthewman	HEE Policy Manager
22	Dr Katie Petty-Saphon	Medical Schools Council
23	Dr Claire Mallinson	National Association of Clinical Tutors, Director of Medical Education and Deputy Medical Director, Guys & St Thomas; NHS Foundation Trust
24	Ms Ellie Atkins	National Medical Director's Clinical Fellow
25	Ms Ellie Pattinson	NHS Employers
26	Dr Michael Doris	NIMDA (Northern Ireland Dental and Medical Training Agency) - ADEPT (Achieve Develop Explore Programme for Trainees) Leadership Fellow
27	Ms Anne Trotter	Nursing & Midwifery Council
28	Mr Louis de Bernard	Patient Rep
29	Professor David Matthews	Presenter - data from work based at Oxford
30	Mr Christopher Macdonald	Presenter - patient and public data
31	Dr Zoe Burton	Presenter #TheatreCapChallenge
32	Mr Simon Fleming	Presenter #HammerItOut
33	Dr Philip Riddell	Presenter - unable to attend. FY2 Doctor, West Suffolk Hospital and writer for 'Sign Up for Safety' https://suzettewoodward.org/tag/patient-safety/
34	Dr Chris Turner	Presenter - unable to attend www.civilitysaveslives.com
35	Mrs Janet Down	Public & lay representative
36	Dr Nichola Ashby	Royal College of Nursing (RCN) – Professional Lead for Education
37	Dr Anne Corrin	RCN - Head of Professional learning & development
38	Dr Carol Postlethwaite	Royal College of Physicians London - Chair, Trainees Committee
39	Mr John Kell	The Patients Association

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Appendix 1:

Extracts from free text comments to Summer 2018 survey. 1500 received.

- I think dropping the term 'trainee' would be very helpful - it makes sense to doctors but frequently confuses patients (usually because they think trainees are students) and is also causing for other health professionals.
- I'm aware that I probably sound like a grumpy, neophobic luddite, but I think that names matter, I think that people who are ill are easily confused and need simple, clear and reassuring titles and uniforms that have a human quality ('Hi, I'm an ST4 in GI medicine' is jargon, and patients (and doctors) should be protected from it). The white coat issue was just sentiment until I read a persuasive article arguing that the case for white coats as transmitters of disease had been overstated. Thank you for the opportunity to contribute
- 'Trainee' is particularly odious and is used to demean the experience and skills of doctors with many years' experience and thousands of hours of dedicated service, to justify the worsening of employment conditions to a public who see that as synonymous with 'student'.
- I don't think it needs to be defined on a badge etc- all their department would know this info anyway
- I don't think most staff (or patients) care about this. So I don't think it should go on a badge.
- Highlight those out of training rather than those in training.
- Hospitals should update their websites when doctors rotate to include them in the departmental teams. ie Cardiology should list with pictures all their rotational doctors on the website (and ideally on each ward) so that they are included in the team
- All doctors are required to complete training/education for appraisal- this distinction is outdated
- Anyone who is attending and making a decision for a patient and communicating back to them is a DOCTOR, irrespective of how they make this decision, if they r doing a duty then they have a equal right to be identified as doctor, if they r not competent to make decision they can let the patient know about they needing a reference from senior colleague
- Badges/ identifications are for patient benefit, rather than for Junior Doctors themselves. It is important not to confuse patients with endless divisions/ tiers to stratify doctors. The id badge, in my opinion, should just say rank
- "Dear Trainee" from admin people needs to stop!
- "Junior" Doctor is an unsuitable name. There should be clear differences between nurses and doctors in terms of clothing and badges
- "Trainee" and "Junior" should be specifically avoided.
- 'Junior Doctor' should only apply to F1, the pre-registration year. Anybody else should be referred to as Doctor. ST3+ should be referred to as senior doctors. In any other profession at year 5 after graduation they would be considered "senior". When patients request to see a senior doctor - they expect an ST3+. It is a simple system.
- A major cause of confusion for patients (and frustration for doctors) is the array of vague and abbreviated terms on ID/name badges. House Officer (not HO/FY1 etc), Registrar (not SpR/StR) - patients have no clue what CTX or STX mean either, neither do they care about a few years here or there. Please provide name badge guidelines for all UK Trusts as part of this review. Please!

- All doctors must carry their name badges and must be mandatory
- All juniors should introduce themselves as doctors, and consultants as "consultants". If the patient wants to know what grade the junior is, they can ask. Posters or leaflets describing what each grade means may be helpful.
- As a GP I need to know (often via the phone) what level of expertise the doctor I am talking with has
- Colour coded lanyards or badges are useful to both patients and other staff, especially in emergencies or other situations where you might be working with people and teams you don't otherwise know.
- A doctor in training is more an employment description. He / she should know the limits of their competence. But they should be called Doctor.
- 'Junior Doctors' and "trainee doctors" should be stamped out of the language of the hospital by all staff. We are not training to be doctors. We ARE doctors, if anything we are training to be consultants and should be called trainee consultants. At the end of the day doctors will always be working within their competence and under a consultant so why would a distinction needs to be made between different levels of juniors? It should just be "doctor" and "consultant". What does it mean to a patient if the doctor is ST1 or ST3? It's only useful for other members of the medical team. We should just be able to introduce ourselves or refer to our colleagues as "the doctor working with Mr/Miss/Dr _____, the consultant in charge"
- Although I do not like lanyards they are less likely to be lost and they can be used to attach the multiple cards issued by each hospital (security card/ name badge + smart card). They are also easily worn, instead of trying to find a piece of clothing they can be attached too. I however fail to understand why lanyards are OK but ties are not (from an infection control point of view). I personally wonder if fitted scrub tops with the doctor's grade embroidered on can be issued. This would save doctors considerable money on clothing and be compatible with infection control. If they are nationally colour-coded then this would standardise grades (similar to the nursing uniform system).
- Colour-coded lanyards to indicate seniority to facilitate communication within the team but clear text stating DOCTOR for the benefit of patients, visitors etc.
- Delineating a doctor's experience level can be important for patients and colleagues alike. From a doctor's perspective, it can be useful to learn, in a glance, the experience level of a colleague - this can be helpful in emergency situations where a team (e.g. crash team) come together and are not completely familiar with one another. It might help nurses and allied health professionals with how they approach doctors - I recall the demands made of me being very similar in my first week to 5-6 years on because there was no way to differentiate my experience (particularly on-call, away from a familiar ward team).
- Doctors should present as a united profession; different colour name badges and lanyards would make it confusing for service users.
- I am shocked HEE are spending taxpayers' money commissioning a review, survey and someone's time to investigate this issue at such a critical time for the NHS. Our nomenclature will always be difficult - even my family can't always tell what my 'grade' is, but they know I am a doctor and that's all that really matters. Please don't waste significant time and resource on this. A number of places have overcome this issue by introducing badges and lanyards for FY1s, SHOs, Registrars and Consultants - these are helpful in avoiding embarrassment of role allocation and useful in emergency situations.

- I have been made to use a coloured lanyard as a medical student, I didn't like it as I thought they looked terrible (I'm aware that sounds daft, but people take pride in their professional appearance). As an F1, I wore a scrub top with 'Doctor' written on as per Trust policy. There were times when I would get answers directed to me, rather than the consultant with me directly introducing themselves. Sometimes even with a clear verbal introduction, patients will not listen or not recall your name/role. Even when wearing my 'Doctor' scrub top I would still be called 'nurse', so I don't know what else we could do!
- I think a non-consultant doctor should simply be referred to as a doctor. They are not 'junior' or 'in training'. Qualified nurses are not referred to in this manner. We should not be infantilising or belittling doctors in this manner.
- I think bring back the white coats with badges with name and rank
- they are capable of independently taking patient care decisions (consultants and sometimes registrars), need guidance (SHO or Registrar). Keep the message simple
- Bigger badges so patients can read them. Posters clearly visible with pictures and names.
- Doctor alone should suffice
- Create national scale that has years in training post that is constant for all grades/roles ie. Pg1 Pg2 Pg3 which makes all directly comparable.
- I am extremely concerned there may be an appetite to distinguish doctors in training posts from those in 'staff' or 'service' posts. This comes from someone with an NTN. Our rotas rely on staff doctors to function. It's not a gamble worth taking to try to highlight the fact they are 'different' - this could well be interpreted as making them feel 'second class,' we need to be more inclusive of our valuable colleagues.
- Don't think it should be on badge. Stigma to career grade drs
- I hate my "junior dr" badge and lanyard- I can consent a patient for surgery, perform said surgery independently and yet still they ask if I'm a student or ask when the dr will be coming. I think it would help me as a women who wears scrubs to be called a registrar as almost everyone knows who that is
- Please no more gimmicks - no lanyards, coloured scrubs, name badges. I want to wear my own clothes, look professional, and be capable of explaining my position to my patients.
- The RCP definitions are too broad. An F2 in surgery would not be expected to make the same decisions as a CST2 and therefore should not be grouped into the same category.

Specific comments on whether GP trainees passing through a specialty would be a problem if listed as on the Central Doctors rota, previously often known as the 'SHO rota':

Most comments were supportive of considering them within the Central Doctors tier, with themes of: "The title should relate to the job they are doing" or "Titling them SHOs is clear and unambiguous when conveying their skills and responsibilities. Calling a doctor who has just finished Foundation Training a 'Registrar' in one speciality (GP) and a trainee in another (e.g. surgery) is potentially a cause of resentment. Most badges I have seen use GPVTS to designate 1st/2nd year trainees in GP and they refer to themselves as SHOs, referring to themselves as Registrars in Yr 3 after FY (to sync up with when that title is awarded to hospitalist specialities)"

- This is so confusing. Is it important? Do you really expect "man on the street" to remember we what all these terms mean?
- GP registrar then to be replaced by GP trainee with NTN for example to reduce confusion.
- Clearly whilst they are working in these departments, they are not Registrars.
- I think it's helpful for staff to know that they're a GP reg, but this may become more confusing for patients who feel that they're not being seen by a specialist. I think it's appropriate in this case to adopt the title of the equivalent tier" [other health professional]

Appendix 2: Survey results from patients/ public responders

The Summer electronic survey had a predominance of doctors and other health professionals responding, suggesting that this subject matters far more to doctors themselves than to the public or patients. 154 responses were from people identifying as 'public/patient' were analysed separately.

	% of those responding	Yes	No	No response
Is it useful to know what kind of professional is treating you?	98% "yes"	151	3	0
Is it important to know whether someone is a consultant?	87% "yes"	134	19	1
If the Doctor treating you is not a consultant or GP, do you think it is important to know their level of seniority?	86% "yes"	133	21	0
Is Junior Doctor an acceptable term?	76% "no"	16	52	86
Should Doctors in their first year be named differently?	57% "yes"	39	29	86

For those answering that junior Doctor is not an acceptable term, reasons (multiple were allowed):

Ambiguous – I do not understand who the term applies to	36
It may undermine the morale of these doctors	30
The term is not representative of doctors in training	32
The term is too vague	30
It may mean that a Doctor is not given responsibility or a training opportunity	15
Other	7

Free text included:

- Does not distinguish between Tier 1 (for whom 'Junior Doctor' is accurate) and experienced Tier 2s.
- It insinuates they have not completed their qualifications
- It is demeaning as the general public don't understand and want to be seen by a "proper" doctor
- Junior Doctor should be used for those who are junior in their position, just out of medical school.
- Makes them sound like students
- Many members of the public think junior doctors are unqualified. Huge gap from FY1 to ST4.

What should we call 'Junior Doctors'?

How many tiers of Doctor?	4 tiers	83	(69% of those responding)
	3 tiers	31	
	2 tiers	10	
	No response	21	
Name for Tier 3	Consultant	61	(88% of those responding)
	Attending	4	
	Other	4	
	No response	85	
Name for Tier 2	Registrar	56	(81% of those responding)
	Other	8	
	Resident	4	
	No response	85	
Name for Tier 1b	SHO	28	(40% of those responding)
	Post-Foundation Dr	23	
	FY2-CT2	10	
	Other	8	
	No response	85	

Name for Tier 1a [first year after qualification]:

House Officer	23	33% of those responding	15 responders over age 50 9 responders under age 50
FY1	5	52% of those responding to a variation of Foundation. * NB – This may add confusion with Foundation year 2 doctors.	17 responders over age 50 19 responders under age 50
Foundation*	20		
Foundation Year*	11		
Intern	2		
Other	8		
No response	85		

Names for all doctors, whether in training or not (offered a choice of terms):

56% of those who responded agreed Doctor was very acceptable

Names of doctors in postgraduate training posts:

This had a high non response rate. Options were: 1 = not at all acceptable to 5 = highly acceptable. Scores of 4 or 5 as percentage of those responding:

Postgraduate doctors	60%
Doctors with educational contract	23%
NTN Doctors	22%

Comments included:

- A lanyard bearing a name badge and photo is useful in theory but in practice the badges are seldom the right way round or at a suitable angle for patients or others to read.
- All trainee Dr's should have to spend a year before any medical training as a paid care assistant
- Clear explanation of different levels in any pre admission paperwork and information given
- Different coloured uniform with senior experienced wearing no uniform but more formal. Less of the casual wear
- I agree that the term "junior doctor" is unhelpful and potentially misleading. However, I have only heard it used by the medical community and the press, not by friends or relatives. My perception is that there is still good understanding of the terms "registrar" and "house officer" and would strongly advocate continuing to use these rather than introducing yet another set of new labels. I'm not sure anyone I know who is not a doctor actually ever says "specialty trainee". I feel strongly that it is helpful to badge 3 levels of seniority, so that I know whether someone is relatively newly qualified, has a good amount of experience, or has overall responsibility for my care. Adding additional categories makes the system unnecessarily complicated. It also emphasises 'time served' rather than actual skills / experience, which clearly are not always directly correlated.
- I think a distinction between F1s and other training grades at a minimum should be clear cut: a provisionally licensed driver has to have L plates - why should medicine be any different? Registrars, 'senior decision makers' should be clearly distinct from SHO grade doctors too. I am unconvinced that grades beyond F1, SHO, reg, and consultant need to be displayed to the public.
- I think that the designations of House Officer/Foundation Doctor, Senior House Officer, Registrar and Consultant are a good way to differentiate between doctors at different levels of seniority with different roles/responsibilities within the clinical team. It is important that it is clear to patients, families and other members of the multi-disciplinary team that 'Junior Doctors' are clinical professionals with a high level of training, qualification, experience and responsibility, even if they are not yet a consultant. I can empathise with doctors who may have low morale when patients think they are not qualified doctors if they are not a consultant.
- I would like to know what experience/knowledge a Doctor has when I am being treated
- I would prefer doctors to introduce themselves with a first name and also a surname
- I'd like to know which country a doctor is trained in and if they are a temp or hired just for a weekend cover from another country
- Important to ensure that staff introduce themselves AND have easily readable name badges.
- It is important to me that a doctor introduces him/herself to me, including their role/seniority.
- It would be nice to have a visual clue incase you aren't introduced to the doctor and told their position in the hospital but I do generally find a consultant will inform me of their title whereas other doctors don't.
- Junior Doctor should be used for those who are Junior for the first 2 years after medical school, then use Doctor. Identity of the doctors and who they are, seniority, training level and what in, is required for all, if they are agency staff we need to know, this should be shown in posters (or on the wall behind a perspex gallery/photo/job); on badges/lanyards/clothing. Patients and staff need to know.
- Just keep it simple!

- Make every doctor and CEO read Black Box Thinking by Mathew Syed so they lose the arrogance, blame culture and stop wasting millions of NHS money on compensation for unnecessary mistakes.
- maybe having different colour coded badges and lanyards, with the grade, will stop junior trainee doctors walking around with their stethoscopes around their neck to show people they are doctors (a habit that is unhygienic and looks stupid), also show (code/wording) if someone is temporary/ agency staff, and this goes for all staff including nursing/care assistants etc. I have been a patient mistook for a doctor on a ward quite a few times, and many patients mistook males for doctors, when they are care assistants/office staff, and female doctors as office staff/patients by male doctors ! large code and lettering saying doctor etc., junior doctor and grade would help !
- Name badges should use decent size print
- Often a patient will encounter a large number of staff from different disciplines and there is a lot of overlap in their input. It is important that healthcare professionals introduce themselves and say what their role is.
- patients just want clinicians that can give them answers, options or reasons in a way that provides assurance that what is being done is the best possible. When you sit in a plane, you are reassured that the pilot meets the criteria for flying plane and ensuring its passengers are safe. Likewise a clinician just needs to reassure the patient that the clinical journey they are going on is appropriate and being explained to them. The most senior clinician may not be the best person at taking the patient and explaining to them the journey along the clinical pathway
- Perhaps scrub colour. A poster will need to be present to inform the patients of the colour coding A consistent system, regardless of the hospital - this is vital, as it will then be nationwide
- Posters and little leaflets can explain the system. Doctors should introduce themselves - "Hello, I am Jane Smith and I am the Senior Registrar". There should also be name badges and lanyards for instant recognition. Please also include medical students in this system so it is clear immediately who is a student.
- Posters or leaflets showing hierarchy of medical titles and how roles related to each other would be useful to patients.
- The doctor's grade has to be communicated in a way that is understandable by those without expertise. The current system works for insiders but not for users.
- The eradication of uniforms and the general wearing of 'scrubs-type' dress is very confusing to many people .. No one looks professional any more, just scruffy.
- There should be Posters in the Clinical areas and name badges
- Too much detail is not in the public interest (e.g. the current system)
- When (if) the new nomenclature is introduced it will be important to signal it in as many ways as possible, especially in locations where doctors and patients meet.
- You need a degree to fill out this questionnaire...what a load of nonsense over nothing !

Appendix 3: Extracts from responses to a survey in the Times

The Times ran an article, with electronic response option. It received over 200 responses.

What term would you prefer instead of Junior Doctor? [Option to make only one choice:]

- Intern 12%
- House Officer 16%
- Doctor 35%
- Registrar 37%

Top response, with 41 likes:

"What's wrong with:

- House officer
- Senior house officer
- Registrar
- Senior registrar
- Consultant
- Senior consultant"

Other responses:

- 4 "Doc McDoc Face"
- As... this is just another example of snowflake nonsense. The term Junior Doctor is accurate in respect of both words and I have never experienced any lack of warmth or respect from any patient on account of the term. For goodness sake do something useful and stop wasting people's time.
- This is SO simple. Just drop the term 'Junior Doctor' completely as a group generic term. The BMA is the culprit for its widespread usage; old Sir Lancelot Spratt type consultants wanting to assert and maintain their unchallengeable superiority! The term Pre-Registration House Officer (PRHO) used for those in their first year after a five or six year undergraduate course was an accurate description of a doctor prior to receiving full GMC registration after 12 months. The current description Foundation Year 1 and Foundation Year 2 (FY1 and FY2) immediately tell colleagues and nursing staff what level of experience and expertise they might expect from the individual - vital in a large hospital where one could not expect to know all the medical staff personally. The badges are not primarily intended for patient information. Those who have attained Registrar status, usually after four or five years are badged as such and this can be taken as meaning "Consultant in Waiting" (for Dead Mens Shoes, often!). Then we have the "Nirvana" of Consultant. No, just resolve to drop the derogatory and self-imposed 'Junior Doctor' and all will be well.
- Why not just drop the "junior" and call them doctors?

- In other countries, a medical intern is usually someone who hasn't graduated. In the UK our "internship" happens as part of our medical schooling and also as the first part of our postgraduate medical training. Internship is not a directly transferable concept. Qualified Doctor - QD for short.
- Revert to pre MMC grades. It is, however, very common that a registrar is the most senior doctor physically in a hospital out of hours. They might have been practising as qualified for 15 years and very independent with their practice - this is why the "junior" title is up for debate.
- Just call them what they are: Doctors. Use shoulder boards, as with aircrew, to denote seniority. One, two three or four bars

Appendix 4: Responses to an on-line survey April 2020

An online survey of doctors in April 2020, conducted by Dr Ramy Saad and Dr Robert Galloway received 473 responses from across the UK. 202 responses were from doctors with over 10 years' experience, of whom 165 were consultants. Results are pending publication, but some notable highlights include:

- There are differing opinions amongst medical staff regarding who constitutes a 'junior doctor'.
- Significant proportions of doctors believe it is misleading to patients and has undermined doctors, or their abilities, in the past.
- The term 'Junior Doctor' does not accurately reflect the majority of respondents' abilities.
- The term 'Junior Doctor' is frequently misinterpreted to mean medical student.
- A significant proportion of doctors feel it is not a beneficial term and should be changed.
- Opinions differ by grade and there is a mismatch between consultant perceptions of this issue and those who are referred to as a 'junior doctor'.

A frequent open-box suggestion is that positive terminology that celebrates doctors' abilities should be used, and differentiation between how grades are addressed in front of patients should focus on representing specialist experience. No proviso should be used before 'doctor' to describe FY1s, to encourage a positive perception amongst patients and staff of their competencies. As such, 'doctors', 'specialists' and 'consultants' are appropriate words for patient-facing descriptions of other staff. Amongst staff, there seems to be a consensus that using individual grade creates no confusion. It is possible that in an attempt to find one terminology to suit both scenarios, the term 'junior doctor' has simultaneously undermined staff and confused patients.

Comments regarding the term 'Junior Doctor' included:

- "This is a nightmare term. I HATE that I use it myself...It has devalued doctors of ALL grades. Worst thing to happen to our profession".
- "The problem with the term "junior doctor" is that it focusses people's minds on what training the doctor is planning, rather than the work they are doing now. This stops them from being seen as part of the team. It makes the other staff (AHPs etc) see them as transient. Some patients feel they are there for their own benefit... There is also a huge problem in that many of the doctors working at this level (40% or so) are not in training and are not 'junior doctors'. Thanks for asking."
- "Junior doctor is a derogatory term that should be changed. The medical profession historically had excellent descriptive terms and i have no idea why they changed."
- "I would support the abandonment of 'junior doctor' but I would want it to be replaced with clear names of seniority like they have in the Army or Navy which would make things clear for the public and staff alike."
- "Before the press took hold of the term it was neutral, but I feel that now overworked and under-appreciated doctors feel very devalued as a result of this terminology."
- "A very undermining term not found in other professions. There are no junior nurses/ teachers/lawyers."

Further analysis is ongoing and publication of results is anticipated for September 2022. Please contact ramysaad@nhs.net for any questions or comments regarding this project.

Appendix 5: Terms considered for Doctors in a training post

Terms considered for the collective term only applying to doctors in approved training posts. This comprises all Doctors who have a National Training Number and a post at the level of Foundation, Core or Specialty training:

Postgraduate Doctors	PS Doctors
Postgrad Doctors	Postgraduate Qualified Doctors
Foundation-Core-Specialty Doctors	PQ Doctors
FoCoSp Doctors	Qualified Registered Licensed Doctors
Doctors in a training post	Registered Doctors
Doctors in training Programme	Graduate Doctors
Doctors in Approved Post	CCTneg Doctors
Doctors in Post approved for Training	ACCT Doctors (Aiming for Certificate of Completion of Training)
Post Approved for Training Doctors	BCCT Doctors (Before CCT)
Doctors in training	PC Doctors (Planning Certification)
DiT Doctors	Pre-CCT/GP Doctors
Dints	PGC Doctors
Donts	On-Going Training Doctors
DiTs Doctors	OGT Doctors
Doctors undergoing ARCPs	Doctors with NTN [National Training Number]
ARCP Doctors	NTN Doctors
Continuing Doctors	Numbered Training Doctors
Progressing Doctors	NT Doctors
Consultant or GP pathway Doctors	Doctors in PG post
CGP Doctors	Doctors in Approved Training Post
Pathway Doctors	ATP Doctors
Programme Doctors	AT Doctors
Competency Progression Doctors	TA Doctors
CP Doctors	Foundation Core & Specialty Doctors
Pre-Senior Doctors	Focus Doctors
SCF Doctors	FCS Doctors
FSC Doctors	
CSF Doctors	

Appendix 6: Terms considered to replace 'SHO'. 'Central doctors' eventually recommended.

This includes the years after Foundation Year 1: FY2, CT1, CT2, ST1 and ST2 for those in training posts and equivalent experience for those not in training. Most are in the first five years post-qualification.

By status attained:	By role in rota/firm:	By attribute:
Qualified Registered (QR)	Commissioned	Base
Registered Qualified (RQ)	Core Team Based (CTB)	Basic
2-5 Postgraduate (TFP)	Core Tier (CT)	Burden
Postgrad 2 to 5 (PG2-5)	Core tier team (CTT)	Capital
Qualified Doctor Status (QDS)	Cross- Specialty (CS)	Competent
Qualified	Central Phase	Conscientious
Qualified and Registered (QAR)	Central Tier	Crucial
Doctor with Registration (DWD)	Key Rank (KR)	Dynamic
Registered	Preliminary Tier	Effective
Resident	Cross Specialty Years (CSY)	Elemental
CET (Certified Emergency Trained)	Team-based	Firm
SHO	Broad-based	Focus
Fully Registered Medical Practitioner (FRMP)	Holistic based	Fundamental
Fully Registered Doctor	Core firm (CF)	Generalist
Within 5 years (W5Y)	Central	Holistic
Post-Registration to year 5 (PRT5)	Centre Rank (CR)	Immediate
Post-registration	Interdisciplinary (ITD)	Indispensable
Graduate	Generic	Intrinsic
Middle phase	Multi disciplinary	Key
Doctor within 5 years of Qualification	Emergency safe	Main
Postgrad to 5	Core Care (CC)	Order
Postgraduate year 2+	Team Tier	Pivotal
GMC registered	Core Experience Doctors CED	Prime
Registered Qualified Licensed (RQL)	Registered Experience Doctors RED	Prime
Registered Qualified Licensed (RQL)	Core Experience Base (CEB)	Professional
Qualified Registered Licensed (QRL)	Bleepable	Proved
Licensed Registered Qualified (LRQ)	Core Body	Recognized
PostGraduate Years 2-5 (PGY2-5)	Cover	Reliable
Accredited	Dynamic central team	Safe
Post-FY1	FY2CT1CT2ST1ST2 (F2S)	Universal
5 year cohort (5YC)	Middle stage	Versatile
Beyond Registration (BR)	Midpoint	Virtuoso
Broad 5 year (B5Y)	Multi-faceted	Vital
Doctors in Core Experience DiCE	Primary	
Doctors in first 5 years DIFY	Responding	
Fully registered Cohort FRC	Tier 1B	
Holistic Within First Five Years	Firm Support	
Qualified Within 5 Years (QWF /QF)	Key Firm Doctors (KF)	
Up to 5 years U5Y or UY	Registered Versatile (RV)	
	Category	
	Vital Care (VC)	

Appendix 7: Final recommendations on replacement of terms

Recommended terms to replace "Junior Doctor(s)"		
Recommended term	Term being replaced	Meaning of new term:
Doctors	Junior Doctor(s) (as used in work)	Doctors at all grades working for patient care. This includes doctors in training posts and doctors not in training posts.
"Doctors in Postgraduate training" or "PostGrad doctors" or "Postgraduate doctors"	Junior Doctor(s) (as used educationally)	Doctors with an approved training post.
Doctor in [Anaesthetic/etc] training	Trainee(s)	Doctor(s) with an approved training post, specifying the detail of the specialty

Terms recommended for broad grades in work when describing rota tiers for work purposes.	Meaning of new term:
Foundation Year 1 doctors or "FY1"	Doctor in their first year after qualifying as currently
Central Doctors	<ul style="list-style-type: none"> • This is a new term, to exactly replace 'SHO'. • This includes doctors in training posts and doctors not in training posts. • It usually refers to those in Post-graduate years 2-5 • Some have more experience than others. • They often rotate through or cover many specialties on a generic basis. • It encompasses FY2/CT1/ST1/CT2/ST2 and others in Trust-appointed posts. • Where there is a multi-disciplinary rota, it should be clear if the role on this rota is filled by another professional, eg 'specialist nurse on the Central Doctor rota tier'
Registrar	<p>Doctor with more senior skills in a specialty. This includes doctors in training posts and doctors not in training posts. This term was used in the past.</p> <p>Includes "ST3+", includes ST3/ST4/ST5/ST6/ST7/ST8. It includes locally employed doctors working at the Registrar level.</p>
Consultant / Associate Specialist	Doctors in senior posts as currently

SAS doctors are trained doctors in a Specialty Doctor, Staff Grade or Associate Specialist post. Their post title (eg Specialty Doctor) is better than Registrar. Many are involved in Registrar rotas or Consultant rotas. There is a separate strategy addressing issues for SAS doctors.

What should we call 'Junior Doctors'?

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