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'That's just how medicine is': A remote ethnographic study of Ireland's failure to meet the core work needs of its hospital doctors

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A B S T R A C T

This study focuses on hospital doctors' experiences of work during the pandemic. The context is the Irish health system, under considerable strain due to the pandemic and a legacy of austerity/under-funding. Although medicine is considered a prestigious job, hospital doctors often endure challenging working conditions and work-life imbalance. In this paper we consider how a narrative of 'medicine-*as*-vocation' is used to excuse challenging working conditions and to impede change. West and Coia (2019) proposed a set of core work needs required to support doctor wellbeing and minimise work-related stress, i.e. autonomy/control, belonging and competence and these are applied as a lens to examine the everyday work experiences of respondent hospital doctors. Data collection was conducted in 2021 using a remote ethnographic method – Mobile Instant Messaging Ethnography (MIME) - developed by the research team to enable data collection at a time of pandemic restrictions (Humphries, Byrne, et al, 2022). Twenty-eight hospital doctors were recruited for the study. Each respondent was interviewed twice and engaged in a 12-week conversation with the research team via WhatsApp. We report hospital doctors' experiences of heavy workloads, weak line management and the challenges of influencing change at work. Overall, the findings presented demonstrate the myriad ways that Ireland is failing to meet the core work needs of its hospital doctors and how 'medicine-*as*-vocation' is used to justify organisational neglect.

1. Introduction

On a current affairs programme aired in 2022 (RTE, 2022), an Irish doctor working in Australia outlined the challenging working conditions he had endured in an Irish hospital. After working for 19 days in a row, he began to struggle and felt low, upset, and extremely tired. He was concerned about his wellbeing and about the minor mistakes he had begun to make at work, due to exhaustion. He knew that he wasn't coping. He contacted the Human Resources (HR) Department in his hospital to seek support and/or a change to his roster. In response, HR explained that these working conditions were a standardcomponent of the job that he needed to accept because *'that's just how medicine is'* (RTE, 2022). In this instance, the organisation explained to the doctor that endurance and sacrifice are not optional , but rather are an integral part of their chosen profession; that the challenging working conditions endured are *expected* as part of their vocational commitment to medicine. This vignette illustrates how a 'medicine-as-vocation' (Humphries, McDermott et al., 2020) narrative is used by the organisation to justify and to excuse the challenging working conditions endured by Ireland's hospital doctors and to impede changes to the status quo. This is problematic, and typical of the challenges faced by our respondents

In this paper, we draw on qualitative data generated from 28 hospital doctors in Ireland in 2021 and consider how the idea of 'medicine-*as*-vocation' has informed the normalisation of challenging working conditions for hospital doctors and a neglect of their core work needs.

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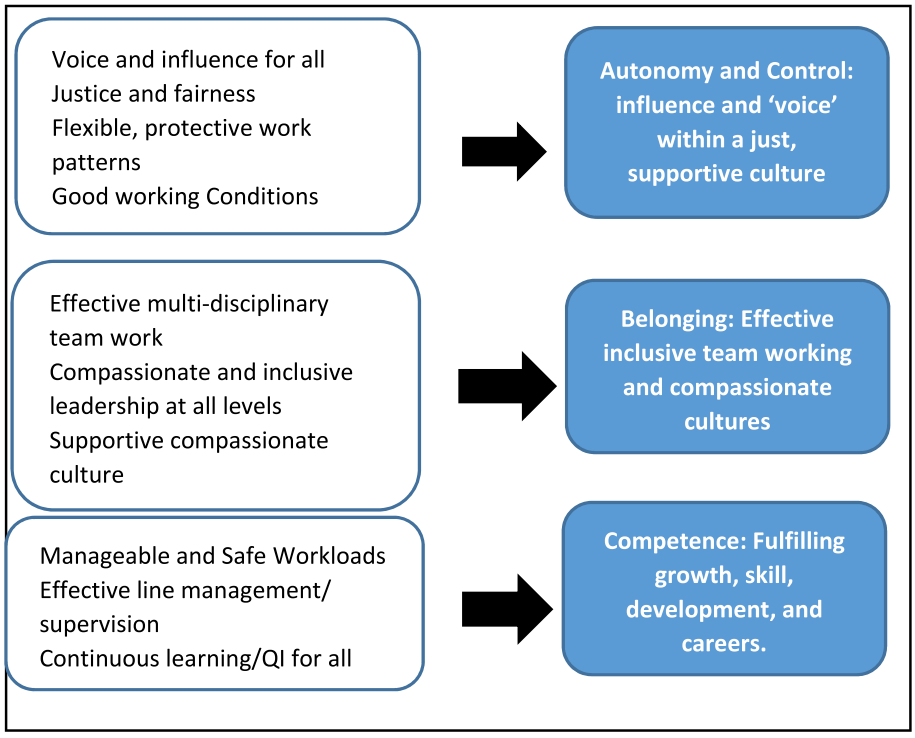

Fig. 1. ABC of core needs at work (West & Coia, 2019).

2. Irish health system and COVID-19

The COVID-19 pandemic (the pandemic) placed additional strain onto the Irish health system, an underperforming (OECD, 2019) and under-resourced health system. Although health spending per capita is close to the EU average, the Irish health system experiences capacity constraints in both primary and secondary care (OECD, 2019) and patients face lengthy waiting lists to access care in public hospitals. The number of hospital beds is below the EU average at 2.9 per 1000 population (EU average of 5.1/1000) (OECD, 2019), hospital occupancy rates *'are the highest in the EU and above recommended levels'* (OECD, 2019) and Ireland has fewer Intensive Care Unit (ICU) beds than the EU average (Walsh, Keegan, Brick, & Lyons, 2020).

The pandemic exposed weaknesses in the Irish health system, particularly in relation to shortages of doctors and nurses (OECD, 2021) and ongoing health workforce recruitment and retention challenges. When the pandemic struck in 2020, the Irish health system had not yet recovered from the impact of the 2008/9 economic crash (Burke, Thomas, Barry, & Keegan, 2014; Murphy, 2020). As Fleming et al. explain, health system performance in the Irish context is influenced not only by the most recent shock, i.e. the pandemic, but also by the legacy of previous shocks (Fleming, Caffrey et al., 2023) which have had a cumulative impact on health system performance, on the health workforce (Fleming, Thomas, Williams, Kennedy, & Burke, 2022) and on *'health worker resilience'* (Fleming, Caffrey et al., 2023). This is the context for this paper: a health system under considerable strain as a result of pandemic, the legacy of austerity (Fleming, Caffrey et al., 2023) and historic underfunding (Turner, 2018). All these factors combined have impacted (and continue to impact) on the medical workforce (Doherty, Colleran, Durcan, Irvine, & Barrett, 2022).

3. Medical working conditions in Ireland and internationally

This research paper draws on findings from a larger research project focussed on retention and on the everyday *'work-as-done'* (Braithwaite, Wears & Hollnagel, 2016) by Irish doctors (Humphries, McDermott et al., 2020). Other studies in the Irish context have outlined the high rates of burnout among Ireland's hospital doctors (Hayes, Prihodova, Walsh, Doyle, & Doherty, 2017; Hayes et al., 2017; McNicholas, Sharma, O'Connor & Barrett, 2020) and have highlighted the need to improve the work environment to improve retention (Higgisson, 2023).

Ireland is not unique in facing these challenges. Although medicine has traditionally been regarded as a *'high-status, high-skill occupation …* [that] *provided access to good quality jobs and relatively high salaries'* (Humphries et al., 2019) a medical career can also *'be arduous'* (Rich, Viney, Needleman, Griffin & Woolf, 2016) in terms of the working conditions endured. In recent years doctors have drawn attention to working conditions that would be deemed unacceptable in any other profession (Clarke, 2017), and have begun to voice their discontent in print (Clarke, 2017; Kay, 2017) and on the picket line, with UK hospital doctors striking for better pay and conditions (Davidson, 2023).

In some respects, hospital doctors appear *worse* off than employees in other sectors in terms of their ability to achieve reasonable working hours or to access standard workplace supports, such as access to meals and comfortable rest facilities while at work (Higgisson, 2023). There are professional, organisational, and wider societal factors at play here. From a societal perspective, Laverty et al. describe recent changes to medical work as a breach of the traditional social contract which promised doctors secure employment in a health service that would adequately resource them to do meaningful work (Laverty, Checkland & Spooner, 2023). Similarly, Rich et al. explain how hospital doctors feel *exploited* by their employers and by the government because of the ever-increasing demands placed on them at work (Rich et al., 2016). While Messac explains how medicine has transformed from being independent practitioners to being *'employees of sprawling, hierarchical organisations'* and suggests that medicine has been slow to adapt to this new reality, arguing that medicine *'can remain a vocation—labor that is infused with purpose and dedication—but it cannot be what it was'* (Messac, 2023). Koltonski (2018) explains that members of the caring professions are particularly vulnerable to the *'exploitation of their vocational commitment'* (Koltonski, 2018), for instance, when employers expect them to routinely work beyond their rostered hours and/or to work

unpaid overtime. This expectation is then built into staffing rotas and organisational norms, as illustrated in the opening vignette. In a UK context, doctors describe 'skeleton' staffing models which routinely rely on doctors working overtime in order to get the work done (Kay, 2017). This makes it difficult (if not impossible) for hospital doctors to achieve work-life balance (Humphries et al., 2020).

Wellbeing and work-life balance are of critical importance to today's hospital doctors. Smith has spoken about a generational rift within the medical profession that has seen recent generations of doctors prioritise wellbeing and work life balance above the *'total workaholism in the pursuit of medicine'* (Smith, 2010) that was previously standard (Humphries, Crowe, & Brugha, 2018). Today's hospital doctors want to work in organisations where their *'expertise is valued and their wellbeing is not compromised'* (Butcher, Saeed, Morrison, Donnelly & Shaw, 2022). In terms of organisational support, UK researchers highlight the inadequate wellbeing supports extended to hospital doctors from hospital management as well as a tendency to focus on quick fix wellbeing solutions rather than addressing underlying problems such as heavy workloads (Butcher et al., 2022).

In this paper we consider how the idea of 'medicine-*as*-vocation' (Humphries et al., 2020) has enabled the acceptance and normalisation of challenging working conditions for hospital doctors, informed by the ABC framework of core work needs (West & Coia, 2019).

4. Doctors core work needs

In a 2019 report on the UK medical workforce, West and Coia explained that medicine is a *'tough job'* but also one that is made *'far harder than it should be by neglecting the simple basics in caring for doctors' wellbeing'* (West & Coia, 2019). Their report illustrated how UK doctors felt undervalued at work, unsupported in their roles, overwhelmed by their workloads and experienced minimal control over their working lives (West & Coia, 2019). They recognised that this situation was unsustainable both for individual doctors and for the workforce and explained that developing working conditions that support doctors *'in their work is fundamental to the success of our health services'* (West & Coia, 2019). West and Coia proposed a set of core work needs required to support doctor wellbeing, and to minimise work-related stress for doctors. These are applied as a lens to examine the everyday work experiences of hospital doctors in Ireland. As per Fig. 1, the ABC of core work needs proposed are: autonomy/control, belonging and competence (West & Coia, 2019) and they are defined as follows:

- Autonomy/control is about the need to have control over work life, and to act consistently with work and life values. It includes the ability to have voice and influence at work and to have good working conditions (West & Coia, 2019).
- Belonging describes the need to be connected to, cared for, and caring of others in the workplace. This often involves working within a supportive work environment; *'doctors' needs for belonging are met when they work within supportive teams and organisations and feel valued, respected and supported'* (West & Coia, 2019). It is about effective team working and compassionate cultures at all levels.
- Competence is the ability to deliver high-quality care. Safe and manageable workloads are critical to achieving competence; *'doctors' need for competence is likely to be met first and foremost when their workloads are not chronically excessive'* (West, Baker et al., 2010). Also critical to competence is the presence of effective line management and supervision structures (West & Coia, 2019).

5. 'Medicine-*as*-vocation'

'A vocation is an approach to a particular life role that is oriented toward demonstrating or deriving a sense of purpose or meaningfulness and that holds other-oriented values and goals as primary sources of motivation' (Dik & Duffy, 2007). There is much debate about whether medicine is a vocation (Trimble, 2022) or a calling (Clarke, 2017) or whether it is *'just'* a job, one *'out of countless others that keep our world moving'* (Profeta, 2016). Trimble cites the fact that doctors (and other health workers) continued to show up for work throughout the COVID-19 pandemic, despite personal risk, as evidence of vocational commitment (Trimble, 2022). On a similar note, Gerada explains that medicine is an identity as well as a job - that being a doctor is *'more than just something I do, but something I am'* (Gerada, 2021).

The vocational aspect of medicine is something the authors have written about previously (Humphries et al., 2018, 2019, 2020) in seeking to understand why doctors as high skilled workers accept (and come to expect) such challenging working conditions. The authors suspect that the professional socialisation process, the process through which students and early career doctors are *'initiated into the status of physician'* (Becker, Geer, Hughes & Strauss, 1961) and the culture of medicine, offer some clues. This socialisation process (both formal and informal) encourages doctors to demonstrate their commitment to medicine by working long hours (Jovic, Wallace & Lemaire, 2006), not showing fatigue while working long hours (Kellogg, Breen, Ferzoco, Zinner & Ashley, 2006) and accepting challenging working conditions as normal and/or something to get used to (and not complain about) (Humphries et al., 2018). In short, the socialisation process appears to 'groom' doctors for a life of work life conflict (Silver & Williams, 2016) justified on the basis that medicine is a vocation which rewards doctors with meaningful work and a sense of purpose, rather than a job for which they might expect good working conditions.

It is telling that debates about whether medicine is (or is not) a vocation frequently arise when doctors demand improvements to their working conditions, e.g. by threatening or taking industrial action. Perhaps it is assumed that the ability to have work that is purposeful or meaningful (Dik & Duffy, 2007) is sufficient compensation for doctors and that to demand any more, is unreasonable. Morgan explains that doctors should not have to choose between 'medicine-*as*-vocation' (Humphries et al., 2020) and medicine with adequate working conditions and instead asks why medicine is so frequently *'powered by guilt, endless duty, and sacrifice rather than by safe working conditions, fair pay, and patient centred reorganisation?'* (Morgan, 2023).

Drawing on qualitative data generated from a remote ethnographic study in 2021, this paper explores how Ireland is failing to meet the core work needs of its hospital doctors and explains the risk this poses to individual doctors, the medical workforce, and the health system. In this paper, we consider how the idea of 'medicine-*as*-vocation' (Humphries et al., 2020) has informed the normalisation of challenging working conditions for hospital doctors and a neglect of their core work needs (West & Coia, 2019). As in the opening vignette, medicine is considered synonymous with challenging working conditions and this, in turn, is used to explain and excuse organisational neglect.

6. Method

This study was part of a wider research project on the retention and working conditions of hospital doctors in Ireland 2017–2023. Research ethics for this component of the study was obtained from the institutional ethics committee in May 2021; qualitative data collection was conducted from June to December 2021 by a team of three experienced qualitative researchers (NH, JC, J-PB). The decision to use remote ethnographic methods for this study stemmed from the fact that pandemic-related work-from-home orders and restrictions on hospital access (and on mobility) remained in place in Ireland throughout 2021, making an in-person hospital ethnography, impossible.

Inspired by qualitative researchers (Posthill, 2016, Vindrola-Padros et al., 2020) and remote ethnographers (Posthill, 2016) and building on the work of Kaufmann and Peil (Kaufmann & Peil, 2019), a method of remote ethnography - Mobile Instant Messaging Ethnography (MIME) - was developed. MIME was an agile method (Creese, Byrne, Olson, & Humphries, 2023) that used Zoom and WhatsApp to connect the researchers with

Table 1
Respondent Table HDRM MIME (N = 28).

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Gender	Male	8	28
	Female	20	
Caring Responsibilities	Yes	10	28
	No	18	
Current Grade	Consultant (senior hospital doctor)	13	28
	Non-Consultant Hospital Doctor (NCHD/junior hospital doctor)	14	
	Associate Specialist (staff grade)	1	
Location	Urban hospital	19	28
	Rural hospital	9	
Country of training	Ireland	28	28

hospital doctors. MIME entailed recruiting hospital doctors remotely via personal contacts and social media (Twitter), using commissioned illustrations to aide recruitment (Humphries, Byrne, Creese, & McKee, 2022). Once recruited, each hospital doctor (N = 28) was interviewed remotely (via Zoom/phone), engaged in a guided conversation with a member of the research team (NH, JC, J-PB) via WhatsApp over a 12-week period and then interviewed for a second time (via Zoom or by phone). Both interviews and WhatsApp conversations were guided by topic guides and data collection was conducted by the research team (NH, JC, J-PB). Further detail on the method has been detailed elsewhere (Creese et al., 2023; Humphries et al., 2019). Of the 28 respondents, 26 respondents completed two interviews and several weeks of WhatsApp interactions. Two respondents exited the study early but consented for their data to be included. Additional information about respondents is included in Table 1 below.

As a method, MIME generated a significant amount of qualitative data - three separate transcripts for each respondent – two interview and one WhatsApp transcript and two transcripts for respondents who exited the study early (82 transcripts in total). The research team (NH, JC, J-PB) reviewed each transcript, removing identifiable details and then providing respondents the opportunity to review and amend their own transcripts. Once this process of transcript approval was completed, transcripts were uploaded to MaxQDA for coding and analysis.

An abductive approach to coding was taken (Miles, Huberman & Saldana, 2013; Skjott Linneberg & Korsgaard, 2019). Initial deductive coding of the data was conducted in MaxQDA by a member of the research team (J-PB) who sorted the data into a broad 'ABC code' in line with the model proposed by West and Coia (West & Coia, 2019). A process of inductive coding (Glaser & Strauss, 1967) followed whereby the lead author (NH) moved back and forth between the ABC model in the literature (West & Coia, 2019) and the coded data to ascertain how the autonomy, belonging and competence were experienced by respondent hospital doctors. Analytical memos were used throughout the process *'to help materialize ongoing reflections'* (Skjott Linneberg & Korsgaard, 2019). Illustrative respondent quotes are presented verbatim along with a note as to whether the data was from the first or second interview, or from the WhatsApp transcript.

Although developed in response to the pandemic context, an advantage of the MIME method is that it enabled the research team to connect with hospital doctors of all grades, in all specialties and working in hospitals nationwide. This enabled the generation of in-the-moment qualitative input from hospital doctors about their experiences of work and reflections on its impact on their wellbeing, over the 12-week duration of the study. The disadvantage of the method is that, unlike an in-person hospital ethnography, the study did not generate data from a cluster of doctors at the *same* hospital site and did not generate observational data from individual hospitals, as would have been generated by an on-site hospital ethnography (Kietlińska, 2022). Another limitation of the method is the fact that recruitment yielded greater participation from female than male respondents and more respondents from urban rather than rural hospitals. The research team feels that recruitment challenges related to the pandemic context in which the fieldwork was conducted (Humphries et al., 2022).

7. Research findings

The findings presented have been aligned to the ABC of core needs at work (see Fig. 1) (West & Coia, 2019). Also included is a discussion of some of the ways that professional and organisational objectives may clash for hospital doctors who are simultaneously members of the medical profession and employees (of the hospital and the Irish Health Service Executive (HSE)).

8. Autonomy and control

An important aspect of autonomy/control is the ability to voice opinions and yield influence in the workplace. One aspect of this is the ability to initiate change or improvements at work. Both senior and junior hospital doctors in our study found the process of initiating change at a hospital level, difficult. They felt that they did not have the level of power or influence needed to improve their own ways of working or working hours. They struggled to establish new services or clinics for their patients, explaining that there are *'always competing voices shouting for limited resources'* (Respondent 6, Radiology/Interview 1).

They also explained how initiating change required them to navigate additional layers of red tape or bureaucracy, as this respondent explained: *'for every question you have, the answer is "we need to see a business case"'* (Respondent 14, Internal Medicine/Interview 1). To initiate change within their hospitals, respondents needed to complete their work (their 'day job') before taking on the *additional* task of advocating for and then implementing, improvement. In the context of a health system under strain, this is a Herculean task.

A related aspect of autonomy outlined by respondents was the lack of control they had over their own working patterns and working conditions.

> *'I don't feel in control during my work day or at the end of it … I never really go home and … say all my work is done'* (Respondent 19, Anaesthesiology/WhatsApp).

This is related to the number of days they were rostered to work and the length of their working week, but it also related to the structure of their working days and the intensity of the work, all of which made it difficult or impossible to take rest breaks within their working day (in compliance with the European Working Time Directive (EWTD)).

> *'When I was in* [Specialty 17] *I never knew when I would finish work. I never knew if I would get lunch. I never knew if I could go to the toilet'* (Respondent 25, Psychiatry/Interview 1).

> *'I'm constantly thinking when can I get to the toilet? When can I eat? When can I get some sleep?'* (Respondent 26, Surgery/WhatsApp).

Working in breach of the EWTD was considered a standard part of working (and training) as a hospital doctor in Ireland and something that doctors were unable to opt out of, regardless of their personal circumstances.

> I was *'told 'you're either full-on able to do all these illegal working hours, or we're not signing you off your internship or your training'* (Respondent 25, Psychiatry/Interview 1).

Respondents recognised that their work patterns were largely determined by staffing levels, which they perceived to be inadequate relative to the workload. Having too few doctors rostered to work meant that the workload was shared between fewer doctors and each doctor had more work than they could manage. This increased the work intensity for each doctor and made for evermore challenging working conditions, as these respondents explain:

'There aren't enough of us. That is the fundamental frustration' (Respondent 6, Radiology/Interview 1).

'Almost every issue I could bring up about hospital dysfunction boils down to inadequate staffing levels' (Respondent 26, Surgery/WhatsApp).

Another aspect of autonomy and the ability to speak up and voice concerns in the workplace was raised by junior hospital doctors. These respondents spoke about feeling pressurised *not* to speak up about problems they encountered within their hospitals, particularly as they related to their working conditions and working patterns, as these respondents explained;

Junior hospital doctors don't speak up *'because we don't want to be seen as 'difficult' and then end up getting an unfavourable review from a superior'* (Respondent 23, Obstetrics and Gynaecology/WhatsApp).

'Anyone who threatens to break rank and disrupt this hierarchy is quickly ostracised' (Respondent 17, Radiology/WhatsApp).

The pressure *not to* voice concerns appeared to be both professional and organisational and junior hospital doctors are vulnerable in both contexts. In organisational terms, junior hospital doctors are early career doctors on short-term, precarious employment contracts of 3–12 months in duration. In professional terms, junior hospital doctors are registered (or wish to be registered) on postgraduate training schemes. Respondents feared that raising a complaint would see them labelled a troublemaker, which would impede their medical career progression in terms of access to training and in terms of their ability to secure their next hospital post. This issue also speaks to 'belonging' (as well as to autonomy) and perhaps also to an absence of psychological safety (Edmondson, 2019) in the workplace for some junior hospital doctors. It is also an issue that has been raised by researchers previously (Crowe, Clarke & Brugha, 2017; Wu et al., 2021).

9. Belonging

Although respondents spoke of a strong level of peer-support in hospital medicine, this often related to informal relationships with colleagues at the same grade or within the same specialty. There was a positive sense of belonging at peer level and this was important for morale and wellbeing; *'immediate colleagues, yeah, we're really good … That's the only thing that gets you through'* (Respondent 2, Radiology/Interview 1). Other respondents outlined positive experiences of belonging within specific teams or specialties and explained their importance:

'within [names specialty] *I would have felt really supported by seniors all the time'* (Respondent 18, Surgery/Interview 1).

'the bosses are all really sound and approachable. And it's good … It's busy work, and demanding work, but it's a really nice atmosphere to work in' (Respondent 23.Obstetrics and Gynaecology/Interview 1).

However, other respondents spoke of silos, disengagement, and a sense of disillusion (in place of belonging) within their hospital workplaces, as this respondent explains:

'I think senior staff are disengaged … From junior staff, very much so. And from the day-to-day running. It's like everyone works in silos' (Respondent 1, Obstetrics and Gynaecology /Interview 1).

Respondents spoke about the challenges associated with maintaining a sense of belonging while working within a health system under considerable strain. Respondents related this to staffing levels and to workloads (see autonomy above and competence below).

'Everyone is very nice and everyone is very supportive, but morale is low. It's extremely short staffed and … there's constant frustration … because you're meant to be doing things, but you simply can't' (Respondent 26, Surgery/Interview 1).

Once again, respondents connected belonging and positive work environments more generally, with workload and staffing levels. When hospital doctors struggled to keep up with their workload in a challenging work environment, it becomes more and more difficult (if not impossible), to maintain a sense of inclusion or belonging.

In relation to belonging at a hospital level, findings were challenging. At the most basic level, many hospitals allocated no space to junior hospital doctors within their hospital. As a result, respondents found themselves at work without access to a computer, a place to rest or take a break, or even somewhere to safely store their belongings while they worked.

'There's loads of wards where there's one computer and it's the ward clerk's computer … or there's a break room on the ward but it's the nursing break room and you're not allowed in. Or there's a changing room, but it's the nursing changing room' (Respondent 22, Internal Medicine /Interview 2)

'There's no ward where you feel like you belong' (Respondent 26, Surgery/Interview 2).

This feeling of not-belonging appeared to be embedded into the physical layout of the hospital but extended beyond that with respondent hospital doctors feeling unvalued as hospital employees. This was particularly the case for junior hospital doctors: *'I don't get the sense that the hospital values my contribution or that of my colleagues'* (Respondent 7, Emergency Medicine/WhatsApp). At a national level, respondents felt a minimal sense of belonging to the Health Services Executive (their employer) or to the wider health system. They felt *'very, very expendable'* (Respondent 18, Surgery/Interview 1), feeling that they were *'just numbers within the HSE'* (Respondent 9, Paediatrics/WhatsApp).

This sense of not-belonging was not helped by antagonistic relationships between hospital HR/administration staff and junior hospital doctors, often relating to errors in the processing of salary, overtime, and pension payments. Respondents felt that these struggles impeded the possibility of belonging, as Respondent 19 explains; *' … if you were a valued employee you wouldn't have to fight for the correct pension or the right increment. It would just be done'* (Respondent 19, Anaesthesiology/WhatsApp).

10. Competence

As we can see from Fig. 1, manageable and safe workloads are critical to enabling competence, as are effective supervision and line management (West & Coia, 2019). Respondents frequently felt that they were attempting to manage workloads that felt neither manageable nor safe. Again, this was connected to staffing levels.

'Departments that … are supposed to have five or six consultants and have two. And if you're sent … there, there's no way you can provide any level of competent service' (Respondent 22, Internal Medicine/Interview 1).

'There's never enough time to get anything done because of the sheer volume of patients and lack of staff' (Respondent 7, Emergency Medicine/WhatsApp).

Respondents spoke about the gap between the level of care they wanted, or were *expected,* to provide and the level of care they were *able* to provide within the time and resources available to them. This mismatch between expectation and reality in relation to workload, was a source of significant stress and distress for respondent hospital doctors (both junior and senior).

'They expect us to provide a level of care which simply isn't possible' (Respondent 26, Surgery/Interview 1).

'It's impossible not to absorb all the misery of unmet need and not bring it home' (Respondent 16, Emergency Medicine/WhatsApp).

Respondents reflected on the personal cost of working with heavy workloads on an ongoing basis, with burnout considered an ever-present

risk; *'my colleague has suffered from burnout. I have felt very close to that recently'* (Respondent 2, Radiology/WhatsApp).

Along with heavy workloads, some respondents, particularly junior hospital doctors, felt poorly supported at work. This connects with the 'effective line management/supervision' aspect of competence outlined in Fig. 1. Weak supervision and management structures added significantly to their stress levels as this respondent explained:

> *'I am carrying too much responsibility at the moment … had a good consultant last year so it was different, I felt I could ring them … But at the moment I am way out of my depth'* (Respondent 25, Psychiatry/Interview 1).

While respondents were aware of where they should receive support from at work, e.g., from their consultant, from their HR department, that support was not always forthcoming.

> *'I had my first RIP* [mortality] *internal review about two weeks ago … there was no consultant with me in that internal review'* (Respondent 25, Psychiatry/Interview 1).

> *'HR I don't think do anything for our wellbeing'* (Respondent 5, Paediatrics/WhatsApp).

> *'They* [consultants] *mostly aren't really teaching … we were very much left to it on the wards. It's unsafe and deeply stressful for NCHD[#]s'* (Respondent 11, Internal Medicine/WhatsApp)

In some instances, respondent feedback indicated that they felt there was no-one advocating or protecting junior hospital doctor wellbeing at an organisational or hospital level. But also, in some instances, there was a sense that those who should be supporting junior hospital doctors, were actually making things *more* difficult for them.

> *'There was a call for staffing after I did two 24h shifts in a weekend with HR emailing me to see if I was available to cover call'* (Respondent 18, Surgery/WhatsApp).

> Consultants *'actively contribute … to our workload. They do not monitor to ensure we are not overworked or stretched beyond our clinical limitations'* (Respondent 24, Psychiatry/WhatsApp).

> In my first week as an intern *'the consultant brought all the NCHDs into the room and said … "sick leave, we don't really believe in that around here"'* (Respondent 23, Obstetrics and Gynaecology/WhatsApp).

Another dimension of the findings relating to line management and supervision (and therefore relevant to competence (West & Coia, 2019)) was the lack of employment related supports available to consultants, once appointed. This could be considered another aspect of the *'exploitation of … vocational commitment'* (Koltonski, 2018) whereby consultants receive less support than others in similar leadership or management roles within the wider health system or HSE.

To become a hospital consultant, candidates must obtain a CSCST (Certificate of Satisfactory Completion of Specialist Training) to demonstrate completion of their postgraduate specialist training. From a professional or clinical perspective, being appointed as a consultant is the endpoint of several years of medical training (at undergraduate and postgraduate levels). Yet from an *organisational* perspective, the newly appointed consultant is taking up their first permanent position within the health system/hospital. It might be anticipated that these newly appointed leaders would be offered significant organisational support on appointment, including leadership training and support in developing their people management skills. One respondent outlined how *'consultants are very badly prepared to be leaders and to be managers'* (Respondent 1, Obstetrics and Gynaecology/Interview 1) in advance of appointment and went on to explain how this paucity of work-related support or supervision continued beyond their appointment as a consultant.

> *'I think it's a huge problem in the HSE, nobody is managing the consultants. Nobody is managing, like, "Are you achieving your goals? What are your goals? Are you happy at work?" I was miserable, absolutely miserable at work, and felt completely under-fulfilled. And couldn't really work out why'* (Respondent 1, Obstetrics and Gynaecology/Interview 1).

This lack of support or supervision for consultants is unusual in any organisational context and is problematic. If consultants themselves are unsupported in their roles, they may struggle to provide support to their junior colleagues. This speaks to 'competence' in that skill development and continuous learning should continue beyond their appointment as consultants and should enable them to support others in the workplace.

11. Medicine-*as*-vocation

We argue that 'medicine-*as*-vocation' (Humphries et al., 2020) is used to justify organisational neglect in terms of the Irish health system's failure to provide the core work needs of its hospital doctors. To illustrate this point, we draw on the experiences of Respondent 2, who explains how this plays out on the ground within the health service. They explain that hospital medicine in Ireland feels *'like the service runs on goodwill and our guilt that we might let our colleagues or patients down'* (Respondent 2, Radiology/WhatsApp). In this instance, the commitment that hospital doctors have to their patients, to their colleagues and to their work means that they regularly go 'above and beyond' to ensure that their work gets done and that good patient outcomes are achieved, for example: *'I go in on days off to help someone sort a patient. I go in when I'm not on call. Maybe it's my own fault, but I actually enjoy the 'doing' part of my job'* (Respondent 2, Radiology/WhatsApp). What this respondent describes is a vocational level of commitment to their job, an employee so committed to their work that they go into work on their personal time to ensure that work is completed in an efficient and safe manner and that patients get the best possible treatment. However, Respondent 2 (and other respondents) also express frustration that this vocational level of commitment they bring to their work is not necessarily matched by the organisation (i.e. the hospital or Health Service Executive (HSE), as they explain: *'I like being busy, I like being part of the team, sorting out patients, helping teams … but we are not resourced or* funded. *It is adhoc and based on goodwill, our good nature, always wanting to do the right thing for the* [patients]' (Respondent 2, Radiology/WhatsApp). In a sense, medicine-*as*-vocation (Humphries et al., 2020) is in-built into the delivery of healthcare in the assumption that vocational commitment that hospital doctors have to their jobs (and to their patients) will make up for any shortfalls in terms of health system resourcing and staffing levels.

12. Discussion

Comparing the everyday 'work-*as*-done' (Braithwaite, Wears & Hollnagel, 2016) by respondent hospital doctors with the ABC of core work needs (West & Coia, 2019) reveals significant organisational deficits within the Irish health system, to which we now turn our attention. As evidenced in our findings the vocational sense of purpose and meaningfulness(Dik & Duffy, 2007) provide a context in which our respondents attempted to personally compensate for health system deficits via their vocational commitment.

12.1. Line management – missing in action

West and Coia explain that *'in a pressured modern workplace, lack of* support *of and no access to a line manager has a negative impact on the work experience of doctors in relation to their core work needs'* (West & Coia, 2019). Our findings reveal an absence of visible line management or line management structures for hospital doctors within Irish hospital settings. The research findings raise questions not only around the *effectiveness* of existing line management structures (West & Coia, 2019) as

[#] NCHDs are non-consultant hospital doctors or junior hospital doctors in the Irish context.

they relate to hospital doctors, but even around their *existence*. This has significant implications for the perceived organisational support felt by hospital doctors towards their employer, i.e. the extent to which they feel that *'the organization values their contribution and cares about their well-being'* (Rhoades, Eisenberger & Armeli, 2001).

There are many ways in which this impacts on the hospital work environment, most critically in relation to workloads. It is unclear whose responsibility it is to ensure that doctors (both junior and senior hospital doctors) have safe and manageable workloads. Without a clear line manager, there is no-one whose role it is to ensure that workloads are manageable and that medical staffing levels are sufficient to meet demand. Our findings suggest that vocational commitment fills this gap, albeit at a personal cost to individual doctors.

From an organisational perspective, the absence of a line management structure impedes the gathering of 'organisational intelligence' (Dixon-Woods et al., 2014) and contributes to the sense that senior management do not understand the challenges faced by frontline hospital doctors. The National Institute for Health and Care Excellence (NICE) emphasise how the line manager facilitates communication between the employee and the organisation and plays a key role in protecting and promoting employee health and wellbeing (National Institute for Health and Care Excellence (NICE), 2015). McDermott et al highlight how line managers help employees to understand what is prioritised or valued within the organisation (McDermott, Conway, Rousseau, & Flood, 2013). Without a line manager to act as an intermediary between senior management and junior hospital doctors, those on the frontline feel that there is no one to listen to them, no one to advocate for them and therefore very little likelihood that their concerns will be addressed. This represents a significant organisational risk.

Another component of the line manager role and one mentioned in relation to the core work needs of autonomy, belonging and competence (West & Coia, 2019), is leadership. In their research with critical care nurses in the UK and Ireland, McMurray et al. outlined the need for leadership support of frontline staff as they struggled through the *'personal-professional upheaval'* of the pandemic (McMurray, Credland, Griffin, Hamilton & O. Harness, 2023). The research highlighted the sense of abandonment felt by nurses as a result of out-of-touch hospital leaders and managers who *'neither understood nor* supported *nurses on the ground'* (McMurray et al., 2023), findings which resonate with our own. Given that emotional pain and toxicity are a *'normal by-product of organizational life'* (Frost, 2007), particularly in healthcare settings and during times of crisis, it would seem important to have a designated person within the hospital whose role it is to assist doctors to process the everyday organisational pain (Frost, 2007, McMurray et al., 2023) of pandemic working. There may also be some confusion about where these responsibilities lie and NICE explain the importance of ensuring that *'line managers are aware that* supporting *employee health and wellbeing is a central part of their role …* [by] *including it in … job descriptions and emphasising it during recruitment'* (National Institute for Health and Care Excellence, 2015), they also emphasise the importance of having a named senior manager who prioritises employee health and wellbeing (National Institute for Health and Care Excellence, 2015). Our findings would suggest that there was no such support available to our respondents as they worked through the pandemic. Here a clear organisational risk stems from vocational reliance: where individuals struggle to align their work lives with their desire for work life balance and wellbeing, intention to leave (the organisation, the system) can rise (Humphries et al., 2019).

Edmondson explains that *'the people on the front line … are privy to the most important strategic data the company has available'* (Edmondson, 2019). From an organisational perspective, the lack of effective line management structures or alternative voice mechanisms (Creese, Byrne, Matthews et al., 2021) means that hospital management and policy makers are operating in the dark, without access to necessary *'organisational intelligence'* (Dixon--Woods et al. 2014). Wilkinson et al. explain that in a healthcare setting, voice is important to patient care as well as to employee wellbeing and that barriers to employee voice lead *'to poor outcomes for patients and employees alike'* (Wilkinson, Avgar, Barry & Mowbray, 2020). Another consideration is the distinction between the formal and informal organisation and its impact on voice and silence behaviour (Wu et al., 2021). In a hospital setting, Wu et al. have highlighted how the informal organisation can work to subdue voice, even if formal mechanisms for voice exist within the organisation (Wu et al., 2021). Our findings indicate the presence few (if any) formal organisational mechanisms to encourage or support employee voice. When combined with a professional culture that prioritises individualism, hard work and sacrifice, combined with a poor reputation for self-care (Hayes et al., 2017; Hayes et al., 2019) and a widespread sense of apathy that voiced feedback would be acted on (Creese et al., 2021) the likelihood of concerns being raised, seem slim.

Finally, the absence of a line management function makes it difficult to see how other components of competence - effective supervision, clear goals and performance management (West & Coia, 2019), - might be achieved. Findings presented here highlight this as an issue for senior as well as for junior hospital doctors, with senior hospital doctors lacking access to the professional development supports and training that would be commonplace in other employment settings. NICE highlight the importance of providing senior leaders and managers with training in (among other things) effective leadership; the importance of health and wellbeing at work and how to recognise if an employee needs additional support (National Institute for Health and Care Excellence, 2015) and explain that organisations should support managers to regularly review *'their own progress in promoting workplace health and wellbeing and acknowledge any gaps in their competencies'* (National Institute for Health and Care Excellence, 2015). It would appear that senior hospital doctors do not receive this standard level of organisational support from their employers (hospital or HSE). Training of line managers should be mindful of the benefits and boundaries of professional vocation and ensure that consultants as line managers are not complicit in socialising early career doctors into seeing personal sacrifice and inadequate support as a necessary and normal part of medical work.

12.2. *Disconnect between healthcare management and the frontline*

There is a sense of disconnect between respondent hospital doctors and the various levels of healthcare management (Humphries et al., 2022). From hospital management to senior decision makers and policy makers in the Department of Health and HSE, there is a feeling that those tasked with managing the health system do not understand the everyday work undertaken and sacrifice made by those delivering healthcare; that there is a disconnect between the *'work-as-done'* on the frontline and '*work-as-imagined'* by healthcare managers and policy makers (Braithwaite, Wears & Hollnagel, 2016). From the perspective of hospital doctors, this disconnect between management and the frontline means that they struggle to achieve autonomy (good working conditions), control (voice and influence), belonging (inclusion) or competence (manageable workloads, effective line management) (West & Coia, 2019) in the workplace. Crucially, as suggested here, professional vocation continues to drive individual efforts to provide care for patients despite shortcomings in the health system.

A key example of this is respondents' perception that their hospitals do not employ enough doctors relative to the workload. If a senior hospital doctor wishes to recruit an additional doctor to support their service, they must complete a lengthy administrative process which takes 12–18 months to deliver the additional doctor. This impacts on hospital doctors and their core work needs in a myriad of ways; specifically in terms of the extent to which they feel that they have influence (West & Coia, 2019) in the workplace. Although senior hospital doctors have sufficient voice to make a case for additional staff (by submitting a business case), during the lengthy wait for additional staff, existing staff continue to manage unsustainable workloads (West & Coia, 2019), which in turn impedes their competence. The slow speed of change

impedes belonging (West & Coia, 2019) and offers 'proof' to other hospital doctors that healthcare management (at hospital and national levels) are disconnected from the frontline and either unaware of or disinterested in, their workload levels or the urgency of their need for additional staff (i.e. that voicing concerns does not necessarily result in improvement). This leaves frontline staff struggling with unmanageable workloads and ensures that the achievement of core work needs (West & Coia, 2019), remains aspirational.

A sense of disconnect between policy and practice is also evident in the ways in which policy is not reflected in the staffing levels or staffing configurations at hospital level. For instance, although consultant delivered care (HSE NDTP, 2020; National Task Force on Medical Staffing, 2003) has been the stated aim of Irish medical workforce policy since the publication of the Hanly report in 2003 (National Task Force on Medical Staffing, 2003), two decades later, the medical workforce is still not configured in this way. Ireland still has twice as many junior than senior hospital doctors (HSE NDTP, 2021) and has too few consultants/specialists relative to population (Ireland has fewer medical specialists relative to population than countries such as the UK, Australia, New Zealand or Canada (HSE NDTP, 2020)). Once again this highlights a disconnect between the medical workforce as it is *imagined* at a policy level and how it is organised and functions in reality. It also highlights a disconnect between medical workforce policy goals and their implementation on the frontline of the health service. Lastly, it is underpinned by continued, if implicit, reliance on the vocational commitment of the existing workforce to bridge the gap between the *'work-as-imagined'* and the *'work-as-done'*(Braithwaite, Wears & Hollnagel, 2016).

12.3. 'Medicine-as-vocation' as an excuse for organisational neglect

The idea that doctors take direction primarily *'from their profession not their organisation'* (Bate, 2000) is not new and has been noted by several researchers, including Mintzberg (Mintzberg, 2012). However, these debates have tended to focus on the power of the medical profession relative to hospital administration. In his ethnographic study of the culture of an NHS hospital undergoing a large-scale change process, Bate described the antagonistic relationship between hospital management and senior doctors as *'a relationship so embittered and hostile that the hospital had virtually ceased to operate as an organisation'* (Bate, 2000) and described how many of those working in the hospital *'had effectively given up on their organization, abandoning any hope of a shared future'* (Bate, 2000).

This paper draws attention to another aspect of the poor relationship between administration and the medical profession. As illustrated in the opening vignette, 'medicine-*as*-vocation' (Humphries et al., 2020) is used (in this case by the Department of Human Resources (HR)) to explain (in this case to a junior hospital doctor) why things cannot change. This could be considered as another aspect of the *'administrative gap'* (Mintzberg, 2012) between management and clinicians, but it is also one that is used to ensure that the achievement of core work needs for hospital doctors, remains aspirational.

As heavy workloads and short staffing have become normalised for hospital doctors within the Irish health system, both organisationally and professionally, doctors (particularly junior hospital doctors) have come under pressure *not* to speak up about their working conditions. This is not unique to Ireland and is something that was seen in the USA during the pandemic when health workers *'were reprimanded by their own hospital administrators for speaking critically about working conditions'* (Messac, 2023). In this way, issues of autonomy (voice) interact with and reinforce issues relating to control (working patterns) to leave junior hospital doctors extremely vulnerable, both from an organisational perspective (within their hospitals) and from a professional perspective, thereby impeding their sense of belonging and competence (West & Coia, 2019). A recent paper by Buchbinder and Jenkins spoke about the need to *'think big about the factors making the health workforce sick, and to consider even those factors that extend beyond one's unit or hospital, to the broader profession and healthcare system'* (Buchbinder & Jenkins, 2022). These are the questions that need to be answered in the Irish context, along with the critical issue of who (or what organisation) is responsible for improving the working conditions of Ireland's hospital doctors, for ensuring that their core work needs (West & Coia, 2019) are met, and that their vocational commitment is not exploited.

13. Conclusion

The findings presented in this paper demonstrate the myriad ways in which Ireland is failing to meet the core work needs (West & Coia, 2019) of its hospital doctors. Somehow, somewhere along the line, it became accepted that working without having their core work needs met (West & Coia, 2019) was *'just how medicine is'* (RTE, 2022) in Ireland. This status quo is unsustainable firstly because of how damaging these working conditions are to Ireland's hospital doctors and secondly because challenging working conditions continue to drive largescale doctor emigration (Humphries, 2023). Although medicine may be a vocation, hospital doctors are also employees and are entitled to work in healthy workplaces (Healthy Ireland, 2019) that protect and promote their health and wellbeing (National Institute for Health and Care Excellence, 2015).

As Ireland begins to emerge and recover from the pandemic, it is time to re-focus attention on frontline doctors in order to begin to strengthen the medical workforce and the health system more generally. Doctors *'know what good care looks like. We just need the opportunity to practice it'* (O'Conor, 2018). The role of the health system (and of Irish society) must be to enable hospital doctors to achieve their core needs at work (West & Coia, 2019) in order to enable them to provide a good standard of care to their patients without sacrificing their own wellbeing and work life balance in the process.

Post-script: Since data collection in 2021, policy attention has focused on the medical workforce to a greater extent than previously. To avert the threat of strike action from junior hospital doctors in 2022, talks between unions and employers were initiated and it is envisaged that this will be the basis for a new junior hospital doctor contract. A National Taskforce on the NCHD workforce was also established in 2022 to consider how the working conditions of junior hospital doctors might be improved (the lead author sits on this taskforce), it is due to report in early 2024. A new contract for hospital consultants was completed and launched in 2023. In October 2023, a recruitment freeze was imposed on the Irish health service, to include junior hospital doctors.

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CRediT authorship contribution statement

Niamh Humphries: Conceptualization, Formal analysis, Funding acquisition, Methodology, Project administration, Writing – original draft, Writing – review & editing. **Jennifer Creese:** Investigation, Methodology, Writing – review & editing. **Aoife M. McDermott:** Conceptualization, Funding acquisition, Writing – review & editing. **Gabrielle Colleran:** Resources, Writing – review & editing. **Cian McDermott:** Resources, Writing – review & editing. **John-Paul Byrne:** Formal analysis, Investigation, Methodology, Writing – review & editing.

Declaration of competing interest

NH is currently a member of a National Taskforce on the NCHD workforce.

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