

BMA

When a doctor leaves:
Tackling the cost of attrition in
the UK's health services



British Medical Association
bma.org.uk

About this report

This report sets out the reasons why retaining doctors needs to be an urgent priority for UK governments, health services and employers. Drawing on new analysis, we set out the cost of medical attrition in the UK's health services and a series of urgent measures to better retain the workforce. The cost of attrition is high, but properly valuing doctors and their contribution provides an attainable solution to the problem.

Key findings

- **Too many doctors are pushed to leave the workforce early, from early career to before retirement age.** For every doctor that leaves, pressures worsen for those who stay, increasing the likelihood that they too will leave the profession.
- **Recruitment, without better efforts to retain existing staff, is an inefficient response to the workforce crisis and will come with a significant preventable price tag.** When a doctor leaves, employers will face the costs of recruiting and onboarding a new doctor. There will often be additional locum costs for cover whilst the position is vacant and costs from lost productivity whilst a new doctor settles into their role. When a leaving doctor is replaced with one who is trained in the UK, there is also a cost for education and health budgets on top of the training costs borne by doctors themselves.
- Between September 2022 and September 2023, between 15,000 and 23,000 doctors left the NHS prematurely in England alone. **We estimate that the minimum cost to NHS employers and the public purse of replacing those doctors lies between £1.6 and £2.4 billion.** Attrition looks set to rise, along with its associated cost.
- **While the cost of replacing an individual doctor varies, it can easily exceed £300,000.** Lost skills and experience, team dynamics, and continuity of care for patients alongside a potential reduction in service quality are difficult to cost but no less important.
- **The good news is that there is plenty that governments, UK health services and employers can do to hold on to staff** and curb preventable costs in the process, many of which would result in immediate benefits.

Acting on attrition

The cost of attrition is high, but properly valuing doctors and their contribution provides an attainable solution to the problem. The BMA recommends action in four key areas:

- 1. Pay and debt.** Reversing years of real-terms pay erosion is the first step in rebuilding good faith, showing doctors they are valued and retaining them. A failure to do so will mean that doctors will continue to leave for better paid jobs elsewhere. Furthermore, writing off student debt while doctors work within the NHS will provide added incentive to stay.
- 2. Working conditions.** Working conditions need to make doctors want to stay, not push them out of the door, but too frequently they are uncaring, uncomfortable and unsafe. Governments, health systems and employers must act to reduce workload pressures, improve work-life balance, expand access to basic facilities and services and stamp out harassment and abuse.
- 3. Diversity and inclusion.** The NHS is fortunate to have a workforce that has become more diverse over time. To keep this diverse workforce, action needs to be taken to end discrimination and support those with additional needs to contribute to their potential.
- 4. Development and support.** In the context of relentlessly pressured environments, staff are afforded less and less time for learning and development. To better retain staff, employers need to ensure that doctors are able to practise in roles that make the most of their skills and experience, with the support to develop and progress personally and professionally.

Introduction

The UK has a shortage of doctors. While these shortages are finally getting some much-needed attention on the national stage, the policy focus is almost exclusively on expanding recruitment and training extra doctors. Better recruitment is essential, but we also need to stop the flow of doctors leaving the health service prematurely.

Attrition is high and rising

Though the number of licensed doctors is growing, a rising number of doctors are also leaving the UK medical system. In 2022, [over 11,000 \(3.8%\)](#) doctors across the UK relinquished their license to practice, up from 9,800 in 2021. Since not all leaving doctors relinquish their license, the actual number of doctors leaving UK health systems may be even higher.

Some doctors leave to retire, or because they have reached the end of a fixed-term contract, but too many leave for other, preventable reasons. Of the doctors who chose to relinquish their licence to practice in 2022 (latest data), almost a quarter (24%) of those who provided a reason for leaving said they left due to retirement, while around one in three (33%) said they wanted to practice or live abroad.

Without action, in the time it takes to train a doctor – a minimum of ten years for a GP, for example – doctors will continue to leave the health service. And there are signs that more doctors are going to leave in the future. In 2023, [the GMC reported](#) that one in seven doctors in the UK have now taken 'hard steps' to leave, compared to one in fourteen in 2021. For every doctor that leaves, pressures worsen for those who stay – increasing the likelihood that they too will vote with their feet and leave.

Without retaining existing staff, plans to abate the workforce crisis through extra recruitment will be ineffective and inefficient with a high cost attached

While the overall number of doctors is growing, attrition is already severely affecting the rate at which staffing numbers increase and the ability of health services to meet increasing demands for care. For every two doctors that joined [the UK medical register in 2022](#), one doctor left: it's two steps forward and one step back.

Even if it were possible to recruit enough doctors to meet increasing demand in this context, this is an inefficient approach to tackling the workforce shortage problem. As we set out below, medical attrition comes with a significant, preventable price tag. The good news is that there is much that UK governments, health services and employers can do to hold on to staff and their experience, curb preventable costs and increase the rate at which the medical workforce expands.

1. The cost of attrition

Attrition in the NHS leads to considerable financial cost to the public purse, NHS employers and doctors themselves. When a doctor leaves it incurs several types of cost, including:

Administrative replacement costs: Employers will face costs as they have to hire a new doctor, which results in recruitment, separation, and onboarding costs – for example, the costs of staff time spent on shortlisting and interviewing, removing the leaving employee from internal systems and adding the new hire to these systems.

Cover costs: Employers will often be forced to rely on expensive locums to cover the position whilst it is vacant. Agency costs are notoriously high and soaring. NHS Scotland, for example, [spent £120 million](#) on medical and dental agency staff in 2022/23 – 17% more than the previous year. If an employer decides not to provide temporary cover for a vacant position, work will either be absorbed by existing staff – contributing to stress and burnout, which in turn invites attrition – or output will fall.

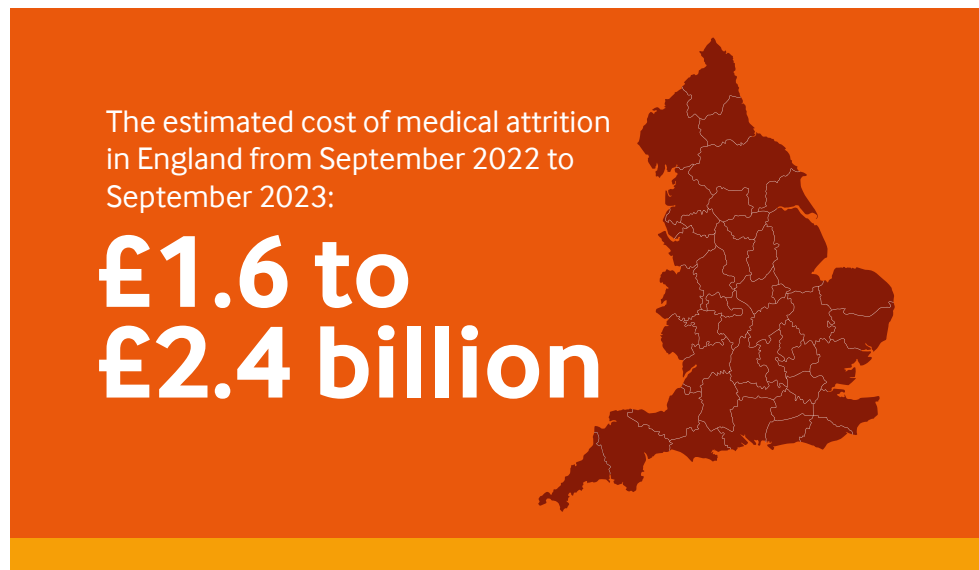
Productivity costs: When a new doctor is finally recruited, there will likely be initial costs resulting from lost productivity as they settle into their role. Although these productivity costs are not incurred directly, they represent a considerable cost to the healthcare system and its patients in the form of reduced healthcare output as well as additional pressure on medical teams.

Training costs: When a doctor leaves, there is one less doctor in the workforce. To maintain workforce numbers, an additional new doctor must be hired from abroad or trained within the UK. The majority of UK doctors (61% in 2022) are trained domestically, which requires public investment. Medical students and doctors pay a significant proportion of the cost of training themselves, in the form of tuition fees (up to £9,250 a year), maintenance loans (up to £13,022 a year) and mandatory post graduate exam fees, which vary by speciality but [often total in the thousands](#). There is also a public contribution which funds costs such as teaching grants for universities providing medical education and placement tariffs paid to healthcare providers for providing clinical placements.

Medical attrition costs are already large, and are likely to increase dramatically without action to better retain doctors

Using NHS workforce statistics, we estimate that between 15,000 and 23,000 doctors left the NHS in England before reaching the retirement age between September 2022 and September 2023.¹ Depending on the exact number of doctors leaving, we estimate that, at the very least, this loss has resulted in **£1.6 to 2.4 billion** in additional costs for NHS employers and the public purse.² Unfortunately, we were unable to obtain equivalent costs for devolved nations due to data availability.³ Further detail of how this estimate was calculated, alongside all of the estimates to follow, is set out in the appendix to this report.

If attrition is not urgently addressed, this annual cost could rise further in coming years. [According to the GMC](#), the proportion of doctors taking 'hard steps' to leave more than doubled between 2021 and 2022. If this rate of change continues and translates into twice the number of doctors leaving, the cost of replacing them in England alone could rise to up to £5 billion.



The actual cost of attrition may be much higher

The total cost of medical attrition for the past year in England may have even exceeded our estimate, which is based on conservative assumptions regarding the public cost of replacing all the doctors who left early.⁴ We assumed the minimum length of medical school training for every grade, but many doctors spend longer in medical training yielding higher training costs. Costs also vary depending on how long it takes to hire a replacement, and how long it takes for a new hire to achieve full productivity. We have assumed that the average leaving doctor will be replaced within 10 weeks, and that the newly hired doctor takes 25 days to reach full productivity. In reality, both may take much longer. Other costs – such as administration costs – are not included in our estimate.

The cost of an individual doctor leaving varies significantly and can be over £255,000

The actual cost of replacing an individual doctor varies significantly, and can be higher than the minimum costs set out above. To demonstrate the wide range of costs, we have set out and costed three possible scenarios: a senior obstetrician who resigns early, a salaried GP who resigns to move abroad, and a first-year Specialty Registrar in Psychiatry who leaves their training programme. Obstetrics and gynaecology, general practice, and psychiatry are all specialties with high levels of attrition. For each scenario, we calculate what it could reasonably cost to replace them if their length of training, locum cover costs, or productivity costs were higher than the bare minimum. These scenarios should not, however, be seen as showing a maximum cost of attrition, since other costs – such as administration costs – are still not included, and higher training, locum cover, or productivity costs are also possible.

Due to data availability, these scenarios are based on expected costs within the NHS in England.⁵

Within each case study, we have used full replacement training costs. For doctors who leave before retirement age but at a late stage in their career, arguably a significant portion of their training investment will have been realised. And replacement costs would still eventually be incurred if the doctor remained in post until retirement. However, from the point of view of short-term planning for the need for training and recruitment, this is an additional cost regardless of realised return or deferred cost.

EXAMPLE ONE: A consultant obstetrician resigns early

A full-time consultant obstetrician leaves the NHS earlier than planned, after 19 years of service as a consultant. It takes six months to fill the post on a permanent basis, and during this time it is filled by a locum doctor costing £140 per hour. Eventually, the Trust hires a newly qualified consultant, who was trained domestically. They take some time to settle into their new role and working environment, reaching the productivity level of their more senior predecessor after around 100 days.

Minimum replacement cost of

£365,000

based on:



MEDICAL TRAINING COSTS: £260,000.

Training up a new consultant to the same level would cost at least £260,000. This is in addition to the cost of tuition fees and student loans paid back by the doctor.



LOCUM COVER COSTS: £98,000.

Hiring a locum to cover the vacant position for 6 months would cost around £192,000. This is £98,000 more than the cost of retaining the leaving doctor.



PRODUCTIVITY COSTS: £7,000.

Assuming the new hire takes 100 days to gain full productivity after settling in.

EXAMPLE TWO: A salaried GP who moves abroad

A full-time salaried GP decides to move abroad, leaving their post at a small rural GP practice after six years of working as a fully qualified GP. The practice struggles to recruit a new GP and is forced to rely on locum cover for 3 months. The locum cover costs around £735 per day. Eventually a newly qualified GP is hired, who was trained domestically. They take around 25 days to find their feet and reach full productivity.

Minimum replacement cost of

£295,000

based on:



MEDICAL TRAINING COSTS: £208,000.

Training up a new GP to the same level would cost at least £260,000. This is in addition to the cost of tuition fees and student loans paid back by the doctor.



LOCUM COVER COSTS: £86,000.

Hiring a locum to cover the vacant position for 7 months would cost around £148,000. This is £86,000 more than the cost of retaining the leaving doctor.



PRODUCTIVITY COSTS: £1,000.

Assuming the new hire takes 25 days to gain full productivity after settling in.

EXAMPLE THREE:

A first-year speciality registrar in psychiatry who leaves during training

A first-year speciality registrar in psychiatry decides to quit medicine halfway through their first year of speciality training. Since there were six more months left on their rotation, the hospital where they work needs to arrange locum cover for this period, with a locum paid £68 per hour. A new Speciality Trainee joins the Trust at the end of this six-month period, when a new placement rotation starts.

Minimum replacement cost of

£230,000

based on:



MEDICAL TRAINING COSTS: £183,000.

Training up a new speciality registrar in psychiatry would cost at least £183,000. This is in addition to the cost of tuition fees and student loans paid back by the doctor.



LOCUM COVER COSTS: £47,000.

Hiring a locum to cover the vacant position for 6 months would cost around £91,000. This is £47,000 more than the cost of retaining the leaving doctor.

No productivity costs are included for the Speciality Registrar since some productivity loss is to be expected within the context of training rotations, regardless of attrition.

There are a range of additional, non-financial costs of attrition

An experienced doctor is of huge value to the NHS. Although the above discussion focuses on the financial costs of attrition, there are a large range of additional, non-financial costs that occur when a doctor leaves the NHS.

When a doctor leaves, even if their position is immediately covered, health services lose their experience and expertise, to the detriment of their patients and colleagues. Those towards the later part of their career in particular have a wealth of skills and knowledge that is critical to ensure the delivery of high-quality, safe and efficient services for patients. The loss of these senior colleagues can also affect the ability to train the next generation of medical students and doctors.

Attrition costs cannot be avoided, except by acting to better retain doctors

If an employer doesn't recruit for a vacant position or instead employs another position – such as a medical associate professional – some work will either be absorbed by remaining colleagues inviting further attrition or output will fall. Whilst doctors may cost more individually, they cannot be replaced by other staff members. Only doctors hold medical degrees and are medically trained. The only way to reduce the cost of attrition is to take measures to better retain doctors.

2. Tackling avoidable attrition

There is much that can be done to stem the flow of doctors out of the health service and curb preventable costs in the process. Below, we set out four areas for UK governments, health systems and employers to prioritise when thinking about retention, based on the reasons why doctors say they leave the profession. Within each area are actionable policy recommendations that doctors have identified as crucial steps for overcoming the attrition challenge.

(a) Pay and debt

Feeling chronically undervalued and underpaid is forcing more and more doctors to weigh up whether to stay in the NHS.

Since 2008/09, doctors' pay in the UK has fallen against all measures of inflation. For example, Junior doctors' pay across the UK is now down by as much as 30.7% in real terms. And there has been a sustained trend of declining real-terms average income before tax for both GP contractors and salaried GPs. 10% of practices told the BMA in [our practice finance survey](#) that contractor income dropped by more than a fifth in 2022/23, for example.

It's therefore no surprise that pay is a factor for many doctors leaving the service, or thinking of doing so, including those who move to practice medicine internationally. The GMC report that pay is a reason for [66% of the doctors](#) who want to move to practise abroad, where better terms and conditions are regularly offered. [A 2024 survey](#) found that 13% of doctors currently practising medicine in the UK responding to the survey were very likely to move abroad to practise medicine in the next 12 months. Among UK doctors, 'increasing pay' was the top reason for this, cited by 79% of respondents. International healthcare systems with more competitive pay have even started [actively recruiting doctors](#) from the UK, including via bus stop adverts, billboards next to strike picket lines and the promise of settling in bonus incentives.

Part of the problem is the pay review process for doctors and dentists (DDRB) has been interfered with by governments across the UK and can no longer be considered independent. This includes the use of remit letters to place financial constraint upon recommendations from the outset. For too long, the DDRB has ignored historical losses that doctors have suffered and failed to consider international salaries in their decision making. Recent commitments to change the terms of the DDRB process, agreed as part of the consultant pay deal in England, could rectify this, but only if commitments are honoured in practice and government swiftly follow through on their recommendations in future.

On top of declining real terms pay, many doctors have to cope with unusually large amounts of student debt, due to the length of medical courses but also because of high workloads, meaning there is less time for additional paid work to help with living costs. Foundation Year doctors can have debt as high as £100,000 and beyond. In addition, doctors often have to front the cost of mandatory training and exams themselves, which can rack up to thousands of pounds a year.

As well as the risk of putting off a lot of people taking up a medical career, our members report that a combination of large student debts and high training costs can be an added push factor for doctors considering leaving the NHS for better pay and conditions elsewhere. This is likely to be contributing to attrition rates amongst those in training and in their first years of work. [Recent Nuffield Trust](#) analysis shows that around one in four NHS hospital and community service doctors in core training leave within the first two years. Last year, for every two GP training places filled, only one fully qualified full-time equivalent practitioner joined the GP workforce. The AIM survey of medical students [recently found](#) that a third of foundation year doctors are planning on emigrating to practice medicine after their training, with over 40% not intending to return.

Recommendations: Improving pay and reducing debt

- **Fix pay now and for the future.** Valuing doctors properly after years of real terms pay cuts is the first step in rebuilding good faith and retaining them. This starts by making credible offers to end and prevent pay disputes and honouring the recently announced changes to the Review Body for Doctors and Dentists Remuneration process to ensure its independence and fairness, considering both historical pay cuts and international medical salaries. Governments across the UK must swiftly act on recommendations moving forwards.
- **Write off student debt for those remaining within the NHS and cover the cost of mandatory examinations.** Student loan repayments due while a doctor is in NHS employment should be paid by the government, providing an incentive to stay. First attempts of any mandatory exams should also be covered, along with any mandatory portfolio costs.

(b) Working conditions

Working conditions must make doctors want to stay not push them out of the door, but conditions are increasingly uncaring, uncomfortable and unsafe.

Workload

Persistent staff shortages mean excessive workloads. Every year, [more doctors report](#) working beyond their rostered hours and many find it increasingly difficult to take breaks. In 2022, [42% of doctors responding to a GMC survey](#) reported feeling unable to cope with their workload, 25% were at high risk of burnout and 22% took a leave of absence due to stress.

The GMC's [largest study to date](#) on attrition in 2021 found that 27.7% of those who had decided to stop or take a break from practising medicine cited burnout or work-related stress as the primary reason for doing so. For GPs, this figure reached 42.8%. If retention improves, the recruitment of extra staff will help to ease workloads over the longer term. In the shorter term, however, excessive demand on the medical workforce must be better managed.

Recommendations: Reducing workload pressures in the shorter term

- **Manage demand by capping levels of patient contact.** General practice should be supported to move away from a system of uncapped demand in which clinicians are expected to maintain unsafe levels of patient contacts per day to a waiting list system based on clinical need. Job planning is crucial to identify which of the various demands on a doctor's time are prioritised for delivery within their working hours. The BMA's [safe working in general practice guide](#) has more detail
- **Reduce pressure from operational failings, including poor IT.** The BMA estimates that more than 13.5 million working hours are lost annually in England alone due to delays because of inadequate or malfunctioning IT systems and equipment. This is frustrating for staff and significantly adds to workloads. Alongside providing the level of capital investment necessary to upgrade defective or inadequate IT hardware, software and broadband, national governments should hold local health systems to account for addressing operational failings impacting workload. Providers need to open up avenues for staff to feedback poor operational practices, and swiftly act on them. The Government's new £3.4bn investment in NHS digitisation, starting in 2025/2026, will help, but only if enough of this is earmarked for getting the IT basics right. The BMA's [digital infrastructure](#) report has more information.

Work-life balance

In the context of increasing workloads and longer hours on the job, doctors want better work-life balance and there is a growing appetite in medicine to work more flexibly to achieve it. Too frequently, however, system leaders are viewing flexibility as an inconvenience instead of an opportunity to retain a happy and healthy workforce, even when refusal of less than full time working requirements contribute to some doctors' decision to leave.

Recommendations: improving work-life balance

- **Make flexible working options available for every doctor.** Governments and health services across the UK should commit to a review of flexible working arrangements, and act to ensure that flexibility, including remote working and less than full time working, are accessible across all specialities and roles. Employers need to provide information to staff about their entitlements and managers need to be trained adequately to support colleagues' flexible working requests effectively. Job planning should be undertaken to support staff to balance work, life and additional needs. Pragmatic and widespread use of sabbatical and career break options could help doctors to counteract exhaustion and burnout.
- **Design rotas to honour breaks, facilitate work-life balance and reasonable leave requests.** Employers should ensure that rota design and management allow doctors to stay safe, maintain work-life balance and avoid excessive fatigue. All employers should undertake forward planning for anticipated gaps. Managers must encourage and support doctors to log missed breaks and overtime to access pay or time off in lieu. Employers should honour annual leave and other requests for time off where possible, without last minute rota changes or cancelled leave. All doctors should be entitled to leave for significant life events. The BMA's [Good Rostering Guide](#) and [rota checker](#) provides more detail on what safe rota design means.

Access to basic facilities and services

Too often, doctors must cope in pressured and stressful environments without basic facilities or support services. Our members [regularly report](#) not having access to rest or break facilities, an inability to access hot meals, proper food, protected meal breaks and not enough toilets or changing rooms. Car parking charges and poor transport options to the UK's healthcare estate remain perennial problems, too. Few have access to adequate occupational health or mental health services, despite [signs of rising levels of mental ill health](#).

- **Get the basics right by ensuring staff have access to adequate facilities.**

At a minimum, NHS Trusts and boards must ensure that staff have (1) access to 24/7 hot food and drinks; (2) free on-call designated parking with safe routes to and from workplaces, paid-for taxis in cases of fatigue and subsidised public transport options; (3) safe and secure storage facilities; and (4) places to rest, shower, change and take breaks. These are quick wins that would immediately improve retention in secondary care settings. The UK's health services should conduct a welfare provision assessment to consider how to move towards consistently meeting these standards across the UK. The BMA's [Fatigue and Facilities Charter](#) outlines minimum requirements in more detail.

- **Improve access to high-quality occupational and mental health services,**

including psychological and psychiatric interventions for the management of severe and complex problems. Proper funding at a national government level will be needed to ensure services are universal, comprehensive and timely. All employers should adopt the BMA's [Mental Wellbeing charter](#), paying special attention to the impact that the rotational nature of junior doctors' work can have on wellbeing.

Bullying, harassment and blame

[In 2022](#), one in three doctors responding to the BMA's viewpoint survey reported experiencing verbal abuse and one in six had been threatened the prior month. [55% of doctors](#), meanwhile, reported feeling fearful they will be blamed for system pressures or failings. [Two fifths of doctors](#) say that bullying, harassment and undermining behaviour is often or sometimes a problem in the workplace. The impact of bullying, harassment and cultures of blame are often worse for professionals who share protected characteristics such as disability, from ethnic minority backgrounds and women. The impact of poor workplace cultures must be tackled by promoting inclusive working practices at all stages of doctors training and careers.

Recommendations: Tackling bullying, harassment and blame

- **Take a zero-tolerance approach to harassment and abuse.** The UK Government should set clear expectations that bullying, harassment and violence are unacceptable through a national campaign and immediately stop scapegoating doctors for political failures, underfunding of health systems and shortages of staff. All employers should ensure they have developed up to date plans to safeguard staff against abuse and steps should be taken to provide or upgrade security measures in hospitals and GP practices where appropriate. Managers and senior leaders should provide staff with adequate support during and after an accident, and ensure that action follows reporting. The BMA's [preventing and reducing violence towards staff](#) sets out how employers can better protect staff.
- **End the silence on bullying and improve the resolution of problems.** Employers need to take steps to visibly combat bullying, offering multiple avenues for raising concerns and actively monitoring where there may be problems. Doctors must be better supported to speak up about bullying and action must be taken to improve the way such complaints are dealt with. The BMA's [bullying and harassment: how to address it and create a supportive and inclusive culture](#) details how this should be done, comprehensively and systematically.
- **Reform employer referral and fitness to practise processes so they are fair, timely, proportionate and reduce the personal impact on doctors.** Doctors from ethnic minorities are twice as likely to be referred to the GMC by their employers for fitness to practise concerns than white doctors, and the referral rate for doctors qualifying outside of the UK is three times higher than that for UK doctors. Doctors are also concerned that too many fitness to practise decisions fail to fully take account of doctors' working environments and have little regard to the personal impact of the referral process. [Over 30%](#) of doctors experiencing a fitness to practice referral report thinking about quitting the profession as a result.

(c) Valuing the growing diversity of the workforce by tackling discrimination and making inclusion a priority

The NHS is fortunate to have a workforce that has become more diverse over time. [Between 2017 and 2021](#), the number of Black or Black British doctors increased by 67%, while the number of female doctors increased by 20%. It is only by valuing these groups of doctors that we will keep them in the workforce and make the most out of their potential. But not enough is being done.

Discrimination

In recent years, the BMA has conducted surveys on sexism, racism, and discrimination based on disability, gender identity and sexual orientation. Discrimination is prevalent and, in many cases, doctors have left their jobs as a result of discriminatory behaviour.

Disabled doctors are [more likely to report](#) bullying (9.1% vs 4.9%) and burnout (38.8% vs 25.7%) as a reason for leaving, compared with those without a disability. [One in eight](#) lesbian, gay, bisexual and queer respondents, and one in three trans respondents, have considered leaving or have actually left their job due to discrimination. Over three quarters (76%) of respondents to our [Racism in Medicine survey](#) reported experiencing racism in their workplace on at least one occasion in the last two years. 23% of respondents reported that they considered leaving their job, 9% had left their job and 16% took sick leave or time off due to racial discrimination. Overseas qualified doctors experience racism more often than doctors trained in the UK.⁶

To keep this diverse workforce, things need to change.

Recommendations: Supporting retention by tackling discrimination

- **Set out clear commitments from senior leaders and managers to actively promote inclusion and challenge discrimination.** Employers should also act by example and review existing practices and policies to ensure they are inclusive of all staff, including those with protected characteristics. There should be clear messaging on *all* forms of abuse and violence as these may take the form of less 'obvious' microaggressions, insults, condescending language or other less 'overt' forms of discrimination which are often targeted at staff based on, for example, their racial identity, gender or sexual orientation. Messaging should be clear that this type of behaviour is not acceptable from *anyone* so that staff feel supported reporting these incidents from colleagues too.
- **Employers and managers should listen to staff who experience discrimination and have policies in place to support everyone who experiences and witnesses discrimination to report it.** Doctors must have access to a fair and transparent reporting structure, and employers should ensure that there is a designated person that people can discuss concerns with. Doctors must feel as able and welcome and supported to report an incidence of racial verbal harassment, for instance, as they would feel reporting a physical assault.
- **There should be organisation-wide accountability for addressing discrimination in medical workplaces,** including transparency about how issues are being tackled and inclusion within organisational strategies and targets. Evaluation of actions should be reported at board level. This must also include access to appropriate induction for International Medical Graduate doctors at a local level to ensure patient safety and that they have an equal start to their UK practice as set out in our [Delivering racial equality in medicine](#) report.

More detailed recommendations, covering different forms of discrimination in the medical workforce, can be found in [Sexual orientation and gender identity in the medical profession](#); [Disability in the medical profession](#); [Racism in medicine](#); and [Sexism in Medicine](#). Employers can sign up to the [BMA's Ending Sexism in Medicine Pledge](#) to demonstrate their commitment to end gender-based discrimination.

Inclusion

Several groups face barriers to making the full contribution of which they are capable. In too many situations the lack of support or reasonable adjustment leads to doctors exiting the workforce early.

Older doctors. Everybody's needs and circumstances change over the course of their working lives. Doctors who are at a more advanced stage of their career report that undertaking more onerous unsocial hours working patterns take a greater toll on their mental and physical health, for instance.

Both retired doctors and those approaching retirement continue to play a vital role both in boosting the workforce and contributing their careers' worth of valuable knowledge and experience. There are options, such as retiring and returning to the NHS on specific contracts, that employers can use to accommodate this. Too often, inflexibility and wide variability in the interpretation and functionality of these policies lead to reduced participation and therefore, causes doctors to choose to leave entirely instead.

Recommendations: valuing and including older doctors

- **Better support for older doctors to remain practising by ensuring duties reflect evolving needs.** Employers should ensure that appropriate adjustments can be made to ways of working as needs evolve, including removing night-time and on-call working if necessary.
- **Enable retired doctors to return to the workforce on a flexible basis.** Employers should review, clarify and actively promote retire and return policies, proactively seeking higher take-up.

Doctors with caring responsibilities. It can be difficult to secure affordable childcare and social care that fits with shift patterns, and workplaces can often be unaccommodating and lack support for those with caring responsibilities. The BMA's [Sexism in Medicine](#) survey found that doctors with caring responsibilities were more likely to state that they had been actively discouraged from applying for senior positions, as well as experience of bullying and harassment. Those with caring responsibilities can be made to feel guilty and viewed as less committed to their roles.

The result is that some doctors have to leave the profession due to their caring responsibilities. Career changes are mainly shouldered by women with significant impact on the gender pay gap. [Women are more likely than men](#) to cite parental leave (5% vs 0.5%), childcare (9.9% vs 3.4%) or other caring responsibilities (10% vs 6.3%) as their primary reason for leaving.

Recommendations: valuing and including doctors with caring responsibilities

- **Improve parental leave schemes to incentivise the sharing of childcare responsibilities**, including enhanced pay for shared parental leave for all doctors and take steps to facilitate a cultural shift in workplace attitudes towards working parents.
- **Ensure a supportive and safe environment for doctors returning to work.** Employers should make the return to work as seamless as possible, providing additional support and flexibility doctors may need after taking a period of parental or carers leave, including resources to enable employees to get 'up to speed', access to mentoring and coaching, and arrangements around flexible hours or staged returns where necessary. Employers must also provide a private, hygienic and safe area to express and store milk.
- **Improve access to childcare by working with childcare stakeholders** with a particular emphasis on enhanced hours of availability. Rostering should be self-led to fit working patterns around caring responsibilities and family commitment.

Women going through menopause. The failure to support women going through menopause, meanwhile, is forcing many to step down from senior positions or leave medicine earlier than intended. 90% of respondents to a [BMA survey of doctors](#) who are going through, or have gone through, menopause reported that symptoms impacted their working lives. A significant portion reported reducing their hours, leaving management roles or intending to leave medicine altogether, despite enjoying their careers, because of difficulties faced.

Recommendations: valuing and including doctors going through menopause

- **Employers should set up clear policy and processes to support staff going through the menopause.** Doctors experiencing symptoms should be allowed to work flexibly and receive support for the mental, as well as physical, effects of menopause. Adjustments should be made to the workplace, such as improving room ventilation and easy access to cool drinking water and toilet facilities. Employers should raise awareness about the menopause and provide training for line managers, ensuring that doctors can speak openly and access the support they need. Menopause-related discrimination must be tackled through an employer's wider work on addressing bullying and discrimination.

The BMA's report, [challenging the culture on menopause for working doctors](#), has more on the steps that should be taken.

Disabled and neuro-divergent doctors. Doctors with a disability have a less positive experience compared with non-disabled doctors, and the [GMC have found](#) that of the doctors who left in the past three years, disabled doctors make up a higher proportion than their relative size on the register (10.6% vs 5.9%).

Often, workplace challenges are easily addressed through reasonable adjustments, such as flexible working, changes to buildings or premises or specialist equipment, but disabled doctors can struggle to get the adjustments they are entitled to. [The BMA's disability in the medical profession survey](#) found that just over half (55%) of disabled doctors and medical students who require reasonable adjustments say they have obtained them. 69% of disabled doctors surveyed said that improving access to adjustments was a top priority for action.

Recommendations: Supporting retention by valuing and including disabled and neuro-divergent doctors

- **Ensure doctors are properly supported in the workforce with access to reasonable adjustments.** Create centralised budgets and simplified processes for funding reasonable adjustments, ensuring requests are managed in a timely and supportive manner. Support for doctors seeking these adjustments needs to be there to help them navigate the process of identifying and obtaining the right adjustments.

The BMA's report [Disability in the medical profession](#) has more.

(d) Development and support

In the context of relentlessly pressured environments, staff are afforded less and less time for learning and development. This is an issue for all doctors, but has particular impacts for International Medical Graduates (IMGs) and SAS doctors. IMGs report particular difficulties finding positions compatible with their qualifications, leaving them feeling 'stuck', as well as a lack of structure support to adjust to life and work in the NHS. SAS grade doctors, meanwhile, experience a lack of promotion prospects and development opportunities. Both groups [report](#) that these issues may impact the length of time they are likely to spend in the health service.

To better retain staff, employers need to ensure that doctors are able to practise in roles that make the most of their skills and experience, with the support to develop and progress personally and professionally.

Recommendations: Career development opportunities and support

- **Improve job planning and appraisal processes so staff can make changes to their roles.** There should also be an emphasis on making the process around job planning and appraisal as supportive as possible. Staff must be listened to if they want to make changes to their role, including devoting more time to education and training, research, leadership, and management. Balancing Direct Clinical Care activity with Supporting Professional Activity (SPA) time will be key to this. The BMA's [manifesto for an NHS with a supportive culture](#) has more detail.
- **Develop, support and promote SAS doctor career development opportunities.** NHS Trusts and boards should (1) develop internal campaigns to raise the profiles of SAS grades as senior medical roles; (2) appoint SAS doctor advocates to provide leadership opportunities at senior levels and improve representation, (3) appoint SAS doctor mentors, equipped with advice on development opportunities available for the SAS workforce; (4) expand the availability of specialist roles and (5) guide interested SAS doctors to make a Certificate of Eligibility for Specialist Registration (CESR) application to the GMC, providing those interested with the time and space to apply. Employers should refer to the [BMA's SAS charter](#).
- **Ensure IMG doctors get comprehensive inductions, mentoring and ongoing support.** All employers should implement an induction programme for all their new IMGs that focuses on (1) making new doctors feel welcome on arrival, (2) supporting them with personal and professional practical matters – from setting up a bank account to information about their trust and department; (3) placing them within a social/professional peer group and pairing them with a buddy; and (4) ensuring they have clinical supervision and a mentor. The BMA's guide to [welcoming and valuing international medical graduates](#) has more information about how this can be done well.

Conclusion

We cannot afford to lose more doctors. Unless there is immediate action to better retain staff, plans to abate the workforce crisis will fall short. Recruitment, without retention, will be inefficient and ineffective at addressing workforce shortages in the UK's health systems. It will also cost dearly. Attrition over the past year has already resulted in significant lost value. As we have shown, this is to the tune of at least £1.6 billion in additional costs. There are also significant non-financial costs that are difficult to quantify; from lost skills and experience often built up over years in the health service, to disruption to the continuity of care for patients. As the proportion of doctors taking hard steps to leave increases, this annual cost could rise further in coming years unless attrition is urgently addressed.

As we outline in this report, there is much that can be done to improve the working life of doctors and stem their flow out the health service, curbing preventative costs in the process. Retaining doctors needs to be an urgent priority for government, UK health services and employers.

References

- 1 Headcount estimate based on NHS workforce statistics and reasons for leaving data obtained directly from NHS. Doctors who left early are estimated by excluding from the total number of reported leavers those leaving for unavoidable reasons, such as reaching the retirement age. We present a range of for the number of leavers because some of the categories for leaving may not result in a permanent departure. For both the upper and lower bound, we exclude those who leave due to reaching retirement age, pregnancy, or the end of a fixed term. For the lower bound estimate of employees leaving, we also exclude those categories of leavers who could potentially return, for example 'Voluntary resignation'.
- 2 The estimate includes the full cost of training for any new joiners who are domestically trained, additional locum cover costs for all leaving doctors, and estimated productivity costs for doctors hired in their place. We have focussed on the costs it is easy and material to quantify – for example we exclude administrative costs of recruitment, as there is limited data available on these costs. Therefore, this cost represents an under-estimate. Full details of the costing are provided in the appendix.
- 3 Medical training costs in devolved nations are either not available or only reported at a system/board level (rather than at the individual level), meaning it is difficult to calculate separate attrition costs for individual doctors.
- 4 Doctors who left early are estimated by excluding from the total number of reported from leavers those leaving for unavoidable reasons, such as reaching the retirement age. More information about our method can be found in the appendix.
- 5 Medical training costs in devolved nations are either not available or only reported at a system/board level (rather than at the individual level), meaning it is difficult to calculate separate attrition costs for individual doctors.
- 6 84% of respondents who qualified overseas said they had experienced racist incidents in their workplace in the last two years, compared to 69% of respondents who trained in the UK.

Appendix

Total cost of attrition for 2022-23: method and assumptions

Summary

We estimated the minimum total cost of attrition for the NHS in England between September 2022 and September 2023. We took the following steps:

- (1) We first calculated a minimum cost of attrition for five grade categories: consultants, SAS doctors, Foundation Year Doctors, Core and Specialty Trainees, and GPs.^a We included (a) the full cost of medical training, (b) additional locum cover costs incurred whilst the leaver's post is vacant, and (c) productivity costs incurred whilst the new hire settles into their new role. More detail about how these three components were costed can be found below.
- (2) We then multiplied the estimated minimum cost of attrition for every grade category by the estimated number of FTE leavers in that category over the past year. This proportion was calculated based on reasons for leaving data by doctor grade directly obtained from NHS England. We produce a range for the number of leavers because some of the categories for leaving may not result in a permanent departure, and the NHS was not able to provide estimates for those permanently leaving. For both the upper and lower bound, we exclude those who leave due to reaching retirement age, pregnancy, or the end of a fixed term. For the lower bound estimate of employees leaving, we also exclude those categories of leavers who could potentially return, for example 'Voluntary resignation'. For this reason, our final estimate of cost also results in a range.
- (3) We then adjusted the estimate to account for leaving doctors who will have been replaced by doctors who trained abroad. For HCHS (Hospital and Community Health Service) doctors, we excluded medical training costs for a proportion of leavers equivalent to [the proportion of joiners](#) within the same period with a country of origin outside of the UK (used as a proxy for whether they trained abroad). For GPs we used the [proportion of domestically trained](#) licensed GPs in England for 2022.

Throughout, we have aimed to be conservative in our estimations (in many cases, as in some of the example case studies), costs may be higher.

More detail about the minimum cost of attrition for the five grade categories is included below.

The cost of medical training: assumptions

When calculating the cost of training a doctor in England, we have included three components: (1) tuition fees, (2) teaching grants, and (3) placement tariffs.

(1) Tuition fees

Tuition fees in 2023/23 are £9,250 a year, and medical students will at minimum spend 5 years in medical education. However, for the fifth year, medical students in England are eligible for the [NHS Bursary](#), which means their tuition fees are covered and they receive at minimum a £1000 grant.

This means only the first four years of tuition fees will be paid back to government.

^a 'Other and local HCHS grades', GP trainees, and GP locums were not included in this estimate.

(2) Teaching grants (now called high-cost subject funding, funded by Office for Students)

A teaching grant is a scaled allocation per student which Universities receive for teaching medical students, which is different for non-clinical and clinical years: the grants for [2023/24](#) are £11,290 for clinical years and £1,693.50 for non-clinical years.

We assumed there are 2 non-clinical years and 3 clinical years in a typical trajectory for medical education (i.e. before the Foundation programme).

(3) Placement tariffs

Placement tariffs are payments to healthcare providers for providing placements to medical trainees.

According to the [latest tariffs](#), healthcare providers receive £32,552 for a FTE **medical undergraduate**, and £12,637 for an FTE **medical postgraduate**. These tariffs do **not** cover basic salary costs for doctors on placements, which we are not including in the cost of attrition.

We have assumed the minimum training duration for every grade. This means three years of medical undergraduate training for all grade categories, plus:

- 9 years of postgraduate placements for consultants
- 6 years of postgraduate placements for SAS doctors (Associate Specialists, Specialty Doctors, Staff Grade Doctors, Hospital Practitioners, and Clinical Assistants)
- An average of 3 years of postgraduate training for Core and Specialty Trainees
- An average of 1 year of postgraduate training for Foundation Year doctors
- 5 years of postgraduate training for GPs

The cost of locum cover: assumptions

Our estimated minimum cost of attrition by grade includes a **net additional** cost for locum staff, in excess of what would have been spent had the leaving doctor remained in post. This cost is based on the estimated number of hours that locum cover will be required, and the estimated additional cost of hiring locum cover.

We assumed that a post will be vacant and covered by agency staff for a minimum of 10 weeks, which is the [reported](#) average time between an NHS job advert being placed to a candidate receiving a confirmation of a start date.^b This is likely to be a significant underestimate. For example, if a job advert is only placed after the post has been vacated, staff cover would be required for a longer period of time. It is also not unusual for medical posts to be vacant for months on end.

We adjusted the amount of time locum cover is required to reflect the fact that locums only cover clinical time. We assumed that the proportion of time spent on clinical care was as follows for respective grades: 75% for consultants (as per the 2003 contract), 80% for SAS doctors ([as per the BMA's recommendation](#)), 88% for Core and Specialty Trainees ([as per the 2016 contract](#)), and 90% for GPs (based on previous conversations with the BMA's GP committee).

For HCHS doctor grades, we have assumed that the locum cost is 155% of the pay of the post being covered, in line with the [agency pay cap](#) – though we are aware that these caps are often breached. We assumed that the leaving doctor was paid

^b Note that the average used is for all NHS vacancies, not just medical vacancies – there was no available data the average time to fill medical vacancies specifically.

[the mean annual basic FTE](#) (Full-Time Equivalent) pay for their grade. For combined staff groups (SAS doctors, Foundation Programme Doctors, and Core and Specialty trainees), we calculated weighted average basic pay, weighing basic pay for included grades by the mean monthly sample size based on role count. This is an underestimate, as doctors usually earn additional money through overwork which is not covered by basic pay.

For GPs, we have assumed the average locum day rate for 2023 as reported by [Pulse Intelligence](#). For GP locums, we have included an employer pension contribution of 20.68% of the pensionable income (which is [90% of their total fee](#)), and have calculated the **additional** spend on pension contributions for locum staff. For HCHS doctors, we have **not** included additional spend on pension contributions as these are already included within the 155% locum pay cap for HCHS doctors.

No locum cover costs were included for Foundation Year doctors, since working as a locum is not possible during the first year, and exceptional during the second year.

Productivity costs: assumptions

Following [a 2022 study](#), we assume a new hire will be around 20% less productive during the first 25 days as they settle into their new role and environment. We calculated productivity costs as 20% of the daily pay of the new doctor, times 25.

We assumed that daily pay for newly hired HCHS doctors matches the [mean annual basic FTE pay for their grade](#). For GPs, we obtained a weighted average basic FTE salary for salaried GPs and Partners by obtaining the [estimated average pay](#) for all GPs in England between 2008/09 and 2021/22, converting pay for these consecutive years into real terms (2023/24 prices) using the [December 2023 GDP deflator](#), and producing a linear forecast for 2023/24 based on the historical trend in real-terms pay. We then converted this figure into a full-time equivalent by calculating the [headcount/FTE ratio for partners and salaried GPs](#) in England and multiplying the projected real terms pay for GPs in 2023/24 by this ratio.

The estimated minimum attrition cost for Foundation Year doctors and for Core and Specialty Trainees does not include any productivity costs, since reduced productivity whilst settling in is to be expected within the context of placement rotations.

Additional costs not covered

There are a range of additional costs that could be included in the overall calculation, but it was decided not to include them as there was insufficient data to produce a reliable estimate of these costs:

- Productivity costs incurred when colleagues spend time shortlisting and interviewing during recruitment, or conducting exit interviews.
- Additional productivity costs incurred where existing staff have to help out locum staff, since locum doctors may be less familiar with the work environment and patients than the leaving doctor. This is also likely to result in productivity costs for the locum doctor.
- Productivity costs of additional staff time lost due to stress and burnout in workplaces with high turnover, which is known to increase pressure on remaining staff.
- Any means-tested cost of living support and relocation costs provided during training;
- Additional training costs after medical school covered by the employer.

Examples: method and assumptions

For every example, we adjusted the variables used to obtain the minimum cost of attrition for the relevant grade category (see above) to obtain a full cost of replacement. All examples are for domestically trained doctors. Assumptions pertaining to each individual example are listed below, where they differ from the assumptions used in the minimum attrition cost for the relevant grade category (see above).

Note that we did not account for any 'savings' made when a higher-paid doctor is replaced by a lower-paid one, as doing so would discount the accompanying loss of experience and seniority.

What is more, within each case study we have used full training replacement costs. For doctors who leave before retirement age but at a late stage in their career, arguably a significant portion of their training investment will have been realised. And replacement costs would still eventually be incurred if the doctor remained in post until retirement age. However, from the point of view of short-term planning for training and recruitment, this is an additional cost regardless of realised return or deferred cost.

Consultant obstetrician

We assumed the leaving consultant, having served 19 years as a fully qualified consultant, has an annual wage of £126,281, which is the maximum pay band for the [2003 consultant contract](#). We assumed the newly hired consultant was newly qualified and received an annual wage of £ 93,666, which is the minimum pay band for the [2003 consultant contract](#).

We assumed that the post is vacant for 6 months, which is in line with the average time it takes to fill a consultant vacancy reported by some Trusts, and which our member reference group felt was a realistic assumption.

We assumed that the new hire takes around 100 days to settle into their new role, with an average productivity loss of 20% for every day.

Salaried GP

We assumed the leaving GP has an annual wage of £104,086, which is the maximum pay for salaried GPs [recommended by the BMA](#). We assumed the newly hired GP was newly qualified and received an annual wage of £ 68,974, which is the minimum pay for salaried GPs [recommended by the BMA](#).

We assumed that the post is vacant for 6 months, which our member reference group felt was a realistic assumption.

We assumed the covering locum was paid £850 per day, which is within [reported](#) range of average GP locum daily rates for 2023.

We assumed that the new hire takes around 25 days to settle into their new role, with an average productivity loss of 20% for every day.

Specialty Registrar

We assumed the leaving Specialty Registrar has an annual wage of £50,225, which is [the mean basic pay for Specialty Registrars at September 2023](#).

We assumed that the post is vacant for 6 months, assuming there were 6 months left on their rotation.

We assumed the covering locum was paid £544 per day, which is the [reported average pay](#) for a Psychiatry Registrar in 2023 who works 8 hours per day.

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