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How resident doctors' personal and professional development can benefit from a pause in training

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ABSTRACT

Introduction: Residency training is a demanding period marked by long hours, emotional strain, and ongoing assessments. Burnout and poor wellbeing among residents have become global concerns, affecting both patient care and workforce sustainability. Consequently, educators and researchers are seeking ways to foster sustainable learning, wellbeing, and professional growth in residency programmes.

Aims: To explore resident doctors' perspectives on the Out-of-Programme-Pause (OOP-P). Specifically, it asks what are resident doctors motivations for pursuing an OOP-P and what are their experiences in terms of personal benefits and benefits to the service?

Methods: The study adopted a qualitative research design situated with an interpretivist paradigm. Twenty-nine residents taking time out of programme in England were interviewed. Through a lens of self-determination theory, we created four ideal types to encompass how an out-of-programme model could meet the basic needs of residents and promote their autonomous motivation.

Results: Four resident ideal types were constructed based on the needs of respondents: residents sought (1) gain clinical exposure (2); solidify capabilities (3); manage burnout; and (4) consolidate specialty choice. For each ideal type, one or more basic needs were unmet at the point of deciding to take time out. Each ideal type used their time differently to regain autonomous motivation before returning to the programme. TPDs felt that residents taking time out of programme while continuing to work in patient-facing roles disrupted service less than the alternatives - moving to non-clinical posts, taking long-term sick leave or leaving medicine entirely. They were also optimistic about the long-term impact on resident retention.

Conclusion: A model permitting residents to step out of training while remaining in a patient-facing role can mitigate short-term detriment and, theoretically, offer long-term benefits to service provision. Recommendations are provided for each ideal type on how residents with diverse needs can be supported to prevent disaffection.

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Introduction

Medicine is widely regarded as a prestigious and rewarding career, yet the pathway to becoming a physician is marked by intense demands, high competition and high stakes. The journey through residency is particularly challenging, characterised by long working hours, continuous assessments, and emotional strain [1]. While these pressures can be framed as essential to professional development, there is growing global concern about the prevalence of burnout and poor wellbeing among resident doctors [2–5].

These concerns are exacerbated by increasing demands on healthcare systems, driven by ageing populations and the rising complexity of patient care. Although burnout affects physicians across all career stages, residency is consistently identified as

one of the most vulnerable and demanding phases of medical education [6].

International evidence highlights the scale of the issue. In the United States, a study involving approximately 7,000 physicians found that over half had experienced at least one symptom of burnout [5]. Similar findings have emerged elsewhere: Australian residents report high rates of fatigue and emotional exhaustion [4], while in the Netherlands, residents who exited training identified poor work-life balance and excessive workload as primary drivers [7]. In 2024, South Korea faced an unprecedented mass resignation of over 90% of its resident physicians, citing concerns about working conditions, limited autonomy, and the quality of education and healthcare delivery [8]. Similarly, structural challenges within

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Practice points

- Resident doctors face significant challenges including burnout, lack of autonomy, and rigid training structures that impact their wellbeing and professional development.
- The Out-of-Programme Pause (OOP-P) offers a unique opportunity for residents in England to step out of formal training while continuing patient-facing work, and developing capabilities, helping them meet personal and professional needs.
- Four distinct resident motivations for pursuing an OOP-P were identified: gaining clinical exposure, solidifying capabilities, managing burnout, and consolidating specialty choice.
- All residents lacked a sense of autonomy at the point of deciding to pause training, and each ideal type reflected different unmet psychological needs, highlighting the importance of flexible, individualised training pathways.
- OOP-P supports both individual and service-level benefits, offering a flexible, integrated model that enhances wellbeing, maintains clinical continuity, and may improve workforce retention.

residency programmes in Nigeria have been closely linked to dissatisfaction, burnout, and psychological distress [9].

The consequences of the pressures faced by resident doctors extend beyond individual wellbeing. There is evidence of links to compromised patient care and increased medical errors [2], as well as high rates of attrition from training programmes, subsequently threatening the sustainability of the medical workforce [10]. In response, medical educators and researchers are increasingly exploring how residency programmes might better support sustainable learning, wellbeing, and professional growth so that both doctors and healthcare services can thrive. This study investigates the motivations, experiences, and outcomes of resident doctors who take time out of training, with the aim of understanding how individual developmental needs can be balanced with the demands of healthcare service delivery.

Research context

The UK has felt many of these challenges acutely, with difficulties and frustrations among resident doctors demonstrated by long-term industrial actions (2016, 2023–2024), and growing numbers choosing to leave the NHS either temporarily or permanently [7]. Some

residents report feeling trapped on a training treadmill, provoking a sense of helplessness and lack of control over their education [11,12]. However, the predominant reason for withdrawal from training relates to health and wellbeing [13]. In 2025, the UK medical regulator, the General Medical Council, conducted its annual national training survey, receiving responses from 70% of the UK resident workforce ($n \approx 51,000$). It found that 61% of residents were at high or moderate risk of burnout, which exceeds pre-pandemic levels [14].

Training pathways in the UK typically involve four to six years of undergraduate education, two years of Foundation training involving rotations across different specialties, then either a run-through training programme (up to seven years depending on specialty) or a period of core training followed by higher specialty training (up to eight years). Afterwards, doctors may obtain consultant or General Practitioner (GP) specialist status. However, these timeframes are based on full-time working arrangements. Less-than-full-time working arrangements have steadily increased over the past five years, with nearly 25% of residents opting for this structure, and two-thirds of such residents citing a desire for a better work-life balance as their motivation [14]. Further flexibility is available to UK residents through a suite of 'Out-of-Programme' (OOP) options that allow residents to suspend their training for between one and three years to pursue one of the four opportunities summarised in Table 1.

OOP options have proved popular; approximately 10% of UK residents pursue an OOP at some stage [15]. Motives appear to be both personal and professional [16]. Residents report OOP-E's value in preparing for consultancy [17] and acquiring new skills pertinent to future practice [18]. OOP-R, the most commonly pursued option [16] appears to be regarded as valuable for career progression by offering opportunities for publication [19]. Despite evidence for resident satisfaction of OOP options, researchers also caution challenges. The most reported drawback appears to be the halt OOP places on the training progression, thus prolonging residents' completion of training and acquisition of consultant status [16,20]. Similarly, residents may return to training feeling behind, or lacking competence in clinical knowledge, with rusty or out-of-date skills [21], thus placing additional burden on trainers and senior colleagues to support this transition. However, a key limitation of those OOP options (Table 1) is that none requires residents to continue working in a UK, patient-facing role. Resident absence presents implications for service provision.

Researchers have encouraged recognition of OOP experiences that can be formally accredited within the training programme [18]. In response, in August

Table 1. UK-wide out-of-programme (OOP) options.

Out-of-programme option	Description
Out-of-programme for research (OOP-R)	A period of time agreed prospectively by the postgraduate dean to undertake research or an appropriate higher degree.
Out-of-programme for approved clinical training (OOP-T)	A prospective period of training which occurs outside of a resident's specialty training programme, counting towards a certificate of completion of training (CCT) award. This requires approval from the General Medical Council and may include UK and overseas posts.
Out-of-programme for clinical experience (OOP-E)	A postgraduate dean-approved post that is not contributing to an award of a CCT but augments a resident's clinical experience through varying exposure.
Out-of-programme for career breaks (OOP-C)	A postgraduate dean-approved planned career break not contributing to a CCT.

2019, Health Education England (HEE), the government body responsible for ensuring the medical workforce is prepared to support healthcare delivery in England, introduced a new OOP option, the Out-of-Programme Pause (OOP-P), which allows residents to step off their training programme for up to 12 months, to pursue a patient-facing role within the National Health Service (NHS). Although they are 'off' training, upon their return, any relevant skills or capabilities residents developed during their OOP may be counted toward their training progression. Thus, the OOP-P does not necessarily delay programme completion and residents can still demonstrate progress on their training pathway.

Although there has been some attention towards residents' views on the value of OOPs and how they transition back into training, there is little research into how residents make use of their time out of training, or what benefits may accrue to individuals and the service. Aguis et al. [16] emphasise that if extra-curricular activities are to be embedded into the structure of medical training, they must benefit not only the individual resident, but also services and patient care. This study addresses this gap and is the first to focus specifically on the Out-Of-Programme Pause option.

Aims

In the context of resident doctors in England who have taken time out of programme to pursue another patient-facing role, this paper explores resident doctors' perspectives on the Out-of-Programme-Pause. Specifically, it asks:

1. What are resident doctors' motivations for pursuing an OOP-P?
2. What are resident doctors' experiences of pursuing an OOP-P in the context of their sense of the benefits to both them and to service?

Theoretical framework

The conceptual frame informing this study was Gagne and Deci's self-determination theory (SDT) of

motivation. SDT offers a framework for understanding why individuals do what they do, and what leads healthy functioning and wellbeing to either flourish or degrade [22,23].

Self-determination represents a continuum of amotivation, extrinsic motivation, and intrinsic motivation. Amotivation describes the absence of any intention to act. Extrinsic motivation is governed by factors external to the individual, although these may be wholly peripheral; the person only acts because they feel required to do so, with some external factors recognised as being important, or even congruent to the individuals' beliefs and values. This latter scenario is referred to as internalisation of extrinsic motivation [22]. Intrinsic motivation exists when actions are driven purely by the individual's inherent interest and enjoyment.

Intrinsic motivation, coupled with the internalisation of extrinsic motivation is described by SDT as autonomous motivation; an individual is motivated by their inherent interest or because an activity is, or has become, compatible with their own beliefs and values. Conversely, controlled motivation describes behaviour that is driven purely by external contingencies or fear of consequences [19] (Figure 1). According to SDT, to achieve autonomous motivation, three basic psychological needs must be satisfied: a sense of competence, autonomy, and relatedness [19] (Figure 1). Competence is satisfied when one feels confident and effective in exercising and expressing their capacities in their environment [24,25]. Autonomy involves self-government of behaviour and decisions that are free from external control or influence, thus it is not involved in controlled motivation. These two needs are required to maintain intrinsic motivation. Relatedness describes an individuals' status within a social environment, relating a sense of belonging and connectedness to others and to one's community [25]. In the context of external factors, it is this sense of relatedness that is required for an individual to internalise and take on an attitude or behaviour internally, moving away from controlled motivation and the external regulation that is required of extrinsic motivation [22]. An environment that supports these three basic needs

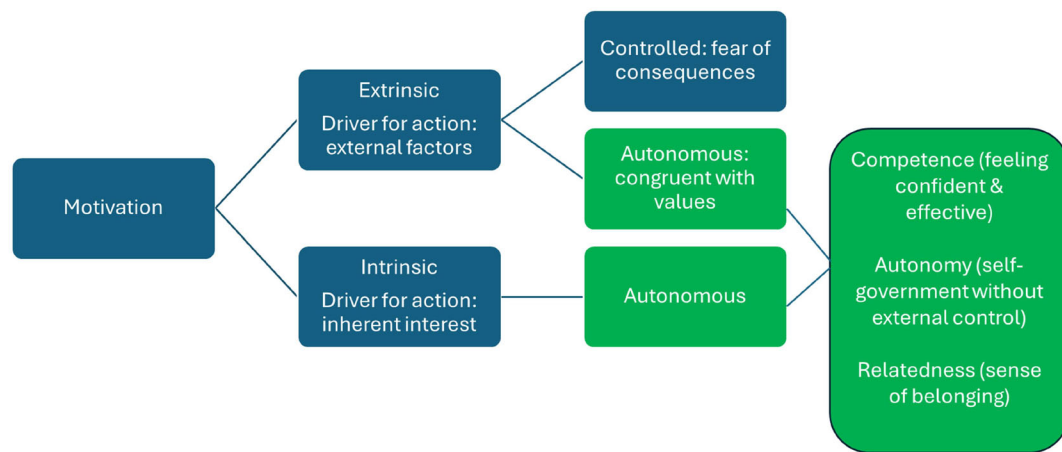


Figure 1. Key elements of self-determination theory.

enhances the individual's healthy functioning and development [26].

The application of SDT to healthcare settings is not new and has been used in the context of doctor-patient relationships, patients' basic psychological needs in managing their health, and how physicians manage their own occupational health and wellbeing.

While individuals choose a career in medicine, the arduous nature of training can subdue residents' sense of autonomous motivation, pressing a more controlled motivation on them. Residents report a lack of autonomy [27]; failing to gain desired training posts, working to rigid timelines and pathways, and experiencing external contingencies that overlook their intrinsic motivations, such as demands from service provision [12,28]. Where these basic needs are not satisfied, residents may seek alternative opportunities to address them, including exiting their training programme. This study applied SDT to explore the training programme and OOP-P environment in fostering residents' sense of competence, autonomy, and relatedness in order for residents to maintain intrinsic motivation and internalise extrinsic factors.

Methods

Study design

This study adopted a qualitative research design situated with an interpretivist paradigm. An interpretivist stance assumes that reality is socially constructed and that human experiences are best interpreted through participants' subjective meanings that are intertwined with their social, professional, and personal contexts [29]. This orientation aligns with the study's aim to explore how resident doctors make sense of their decision to take an OOP-P, and their perceptions of the benefits for themselves and for healthcare service delivery.

Participant recruitment

Residents who had undertaken and completed an OOP-P by March 2023 were eligible to participate. HEE acted as a gatekeeper, distributing an invitation and information sheet (prepared by the research team) to all eligible residents. The invitation included a link to an online survey that formed part of a larger research project. At the end of the survey, participants were invited to indicate their interest in a follow-up interview by providing their contact details.

Author SB subsequently contacted all residents who expressed interest to arrange a one-to-one interview. Participation was entirely voluntary, and informed consent was obtained prior to data collection.

Data collection

Data were gathered through semi-structured interviews, conducted either online or by telephone by one of the three authors. Interviews took place sequentially, at two possible time points: while residents were on the OOP-P (Time 1), and/or approximately three months after completing their Pause (Time 2). This longitudinal element enabled exploration of evolving perspectives over time.

Interviews were semi-structured to maintain a focus on participants' motivations for taking the OOP-P, their experiences during the pause, and reflections on their return to training. Question schedules are provided in Question schedules are provided in [Appendices 1–3](#). Interviews were audio-recorded with consent and transcribed verbatim.

Analytic approach

As interviews progressed, it became evident that residents' accounts were highly individualised and context-dependent, reflecting the diversity of training pathways and the personal circumstances and

needs of residents. This complexity made it both challenging and inappropriate to categorise data by demographic or professional variables such as specialty, region, or training stage, and also meant that thematic analysis would not sufficiently capture the complexity of residents' narratives.

To address this, the research team adopted an ideal type analysis. In line with an interpretivist approach, ideal types are conceptual constructs that accentuate particular perspectives or patterns across participants' individual accounts of their experiences, identifying both commonalities and differences across participants [30,31]. The focus on entire individual accounts is what separates ideal types from thematic analysis, which identifies themes across the full dataset. While not all individuals within each ideal type hold identical experiences or perspectives, they are fundamentally linked through aspects of participants' narratives, separating them from other ideal types [30].

Each ideal type was generated through the synthesis of comparable narratives concerning residents' motivations for, and experiences of, stepping out of programme. These ideal types served as interpretive tools to understand variations in how residents experienced and made sense of the OOP-P.

Given the interpretive nature of the analysis and the interaction between participant narratives and researcher interpretation, reflexivity was embedded into the research process. Regular team discussions were used to surface and reflect on positionality and interpretations of interviews. Researchers maintained written records of their interpretations after each interview and their reasons for such. Such records facilitated the development of ideal types and permitted ongoing comparison across participant accounts, and researcher interpretations.

Direct verbatim quotations are included throughout the results to illustrate and contextualise the ideal types, providing insight into how interpretations were grounded in the data.

Results

At the time of study, 155 residents were engaged in an OOP-P and were eligible for participation. Fifty-one residents indicated a willingness to participate in an interview and were contacted. Twenty-nine residents responded and successfully arranged interviews. All 29 interviews were used in analysis which equated to just over 13 h of conversation data. Durations of interviews ranged from 13 to 80 min. Thirteen residents were interviewed at Time 1 and 16 at Time 2, four of the participants at Time 2 had also been interviewed at Time 1. Residents were between their first year of core training and eighth

Table 2. Resident ideal types related to self-determination theory of basic needs.

Resident ideal type	Competence	Relatedness	Autonomy
Gain clinical exposure	X	✓	X
Solidify capabilities	X	✓	X
Manage burnout	X	X	X
Consolidate specialty choice	✓	X	X

year of specialty training, although more than half were in stages 4–6 of specialty training.

Analyses led to the construction of four resident ideal types based on residents' needs and benefits realised (1): gain clinical exposure (2); solidify capabilities (3); manage burnout; and (4) consolidate specialty choice. For each ideal type, one or more basic needs prescribed by SDT were not being met at the point of deciding to take time out of training. Consistent across all types, was the absence of satisfied autonomy. This is summarised in Table 2.

Resident ideal type 1: Gain clinical exposure

Resident ideal type 1 is based on seven interviewees who are lacking the basic needs of competence and autonomy. Type 1 is progressing well on their training programme and enjoys a sense of relatedness in their specialty; however, they lack control over their clinical experiences and have identified specific areas of clinical exposure they cannot access in their current training post. Exposure is largely dependent on the hospital or unit in which the resident is based and the needs of patients in that location. Time out-of-programme provides resident ideal type 1s with greater autonomy and freedom of choice over the location of their post and the services to which they contribute, since national recruitment for UK training programmes does not guarantee residents their first choice of post.

Ideal type 1 is taking time of out-of-programme to pursue a post elsewhere that will offer this desired exposure, for example, in a larger or more specialised hospital (Box 1: A,B). The experience this resident ideal type gains during their out-of-programme is relevant to their training curriculum and so they are confident their enhanced capabilities will contribute to their formal training programme progression. As a result, resident type 1 feels that their broader experiences give them an advantage over their peers who may have stayed in the same hospital (Box 1: C). They are satisfied that their portfolio is strengthened and feel they have become a more competitive resident for future career prospects. Type 1 deems their time out-of-programme will give them a head start in the next phase of training, and they feel competent and effective in their capabilities (Box 1: C,D,E).

Box 1. Extracts evidencing resident ideal type 1.

[A] I took this Out-of-Programme in the exact same field, so it's still emergency medicine but it is in a slightly different set up. [...] Even though I felt I had a really good training experience, I felt that I lacked this area of major trauma and how to manage major trauma in children [Resident Time1]

[B] I found it quite difficult to get hands-on laparoscopic surgery during training. So, I thought I'd take Out-of-Programme and just focus on that. [...] It's different experience in a big unit where you have lots of opportunities to have more hands-on laparoscopic surgery and this is what I'm interested in. [Resident Time1]

[C] Yeah [I feel] very advantaged. The two sub-specs [sub-specialty staff] that were before me that are now consultants in the department, said that I'm way ahead where they were when they started their sub-spec. [Resident Time2]

[D] It is probably suited to those professions that particularly benefit from a broad range of experience [...] getting experience working in different places and maybe getting some research work done and all sorts of other experiences, very beneficial [...] I think for some specialties and some kind of people and personality types, it's incredibly beneficial and should be very actively encouraged. [Resident Time2]

[E] I had very clear goals... I already have my next step after my Pause sorted, it was reliant on the training from the Pause, but I don't know how you would do that if you didn't have that next step organized. [Resident Time2]

Resident type 1 demonstrated a clear focus and carefully planned their experience and exposure during their time out of the programme. They strategically selected a relevant post, which gave them greater autonomy and control over their training and development than would be usual in the UK's national recruitment programme with its lack of guarantee that first-choice posts will be assigned.

Resident ideal type 2: Solidify capabilities

Resident ideal type 2, based on 11 interviews, also lacks competence and autonomy. Unlike type 1, who lacked competence due to insufficient relevant clinical exposure, type 2 has had such exposure but now seeks to deepen their experience and solidify their skills. Resident type 2 is approaching a key milestone—such as completing training or applying for consultancy roles—but lacks confidence in demonstrating readiness for this new responsibility. Taking on a role similar to their training post will help them consolidate their experiences and patient numbers.

The structure of the training pathway imposes time pressures. For resident type 2s, stepping out of the pre-determined training timeline means they can enhance their existing skills and build their confidence required for their next career stages. The OOP-P thereby fulfils both the need for autonomy and competence. In terms of autonomy, it allows them to decide when to advance to the next stage of their career based on their development needs rather than predetermined by a rigid training pathway (Box 2: A,B).

In terms of competence, the time granted by OOP-P is regarded by resident ideal type 2 as critical for developing the confidence and expertise necessary for the next stage of their career; prioritising a deliberate and refined preparation over rushing to complete training (Box 2: C,D). Remaining in their current hospital may also be appealing as it preserves a sense of stability and relatedness and avoids

the unnecessary upheaval of moving elsewhere and transitioning into a new workplace with unfamiliar colleagues. They felt this not only benefits them, but their understanding of the workplace also enables them to provide better patient care (Box 2: E).

Resident ideal type 3: Manage burnout

Resident ideal type 3 is constructed around 10 resident interviews and is lacking fulfilment in all three basic needs: competence, autonomy, and relatedness. This ideal type is already feeling burnt out or approaching it and feels unable to negotiate both the stressors in their home life and the high-pressured training and assessment environment, thus their sense of autonomy and control over their professional and personal life is deficient. Type 3 feels ineffective in their work environment, therefore lacking a sense of competence, and may even be beginning to question whether becoming a consultant is the right aspiration for them, therefore lacking relatedness.

Ideal type 3 recognises they are in an unsustainable position, with insufficient time to rest or focus on personal wellbeing. They are considering, at least to some extent, exiting their training programme. Type 3 recognised time out-of-programme as an opportunity to take control; to focus on their wellbeing and relieve some of the unmanageable pressure they are experiencing (Box 3: A).

In terms of identifying an appropriate post, ideal type 3's key priority is finding a suitable work-life balance, away from the arduous environment of on-call duties, demanding rotas and ongoing assessments, whilst maintaining clinical skills. By pursuing a post that offers both these things, type 3 regains a sense of autonomy and control of both their professional and personal life (Box 3: B).

Resident ideal type 3 is somewhat apprehensive about returning to training after their time away, acknowledging that many of the same work-stressors will remain. Such apprehension is indicative

Box 2. Extracts evidencing resident ideal type 2.

[A] I certainly felt as a senior resident, nearing the end and having my reservations about being good enough. I felt I wanted to slow things down, I just wanted to put the brakes on. [Resident Time2]

[B] Rather than being told where to go, told what to do, I can approach an employer, develop an arrangement with them that's beneficial for both of us and take back some control of my training [...] and that's very different to what we have at the moment. So, a huge selling point for it. [Resident Time2]

[C] Confidence has always been a bit of an issue for me, but with sufficient time doing it, my confidence increases. And so, if I hadn't had that year, I honestly don't know what I would have done. [...] I would have got to the end of ST3 feeling completely at sea and just thinking 'I'm at a level that I don't feel that I can be, I need another year', and it's given me that year [Resident Time2]

[D] I've never been someone who's in a rush to get to the end and I think actually all of this stuff has got me to a position that I'm now definitely ready and feel like getting a consultant job now is the right time. [...] Had I carried on as was I don't think that would have been the position. [Resident Time2]

[E] I'm doing this placement at the same hospital that I was working with so it's not like there's lots of changes for me. My supervisors, we're very close and it makes you feel like you're part of a team. Especially as you're coming to work in the same place every day... So, this is a bit more stability as well, and I think it makes the care better. [Resident Time1]

Box 3. Extracts evidencing resident ideal type 3.

[A] The last five years, I've had a complete and utter crisis on my home-front... I was really struggling. And work got to the point of just turning up and trying to get through the shift, and then there were millions of assessments. You're supposed to do all this stuff in your own time and studying for the exam, it just wasn't happening. I couldn't do it. [Resident Time1]

[B] I still did a clinical fellow job, so I didn't lose my skills. It just gave me a break from training because I had a lot of personal issues going on and that just took the pressure off trying to meet ARCP [Annual Review of Competency Progression] needs and all that as well. So, it was just a really good... still doing the job I loved, but not having to worry about training and just be able to focus on myself. [Resident Time2]

[C] I think just a break of doing something different is really good for your mental health and wellbeing ... so for me, the benefit of having a bit of a better work-life balance has been the main thing. [...] I'm going to come into training a little bit more refreshed and ready to go, and a bit happier with my work-life balance. So actually, I'm hopefully going to be a more efficient resident out of it [Resident Time1]

[D] What it's done is allowed me to be more confident in saying, 'no, I'm not doing the extra hours, I'm not doing the locums, I'm not doing the extra shifts', actually calling out 'I was supposed to go home at nine o'clock and it's whatever time is now'. [...] The six months before coming to the Out-of-Programme was so unpleasant in paediatrics, I didn't even realise the impact it was having, on not only myself, but my partner. [...] So for me, it gave me the opportunity to say, burning out for the sake of hospital medicine is not what I'm interested in at all. [...] I'm no good to anyone if I'm burnt out and making mistakes at work because I'm not looking after myself. [Resident Time2]

that their sense of relatedness may still be vulnerable; however, the breathing space during their time out-of-programme has left them feeling refreshed and better equipped to continue progressing with their training (Box 3: C). There is also a sense that this rejuvenation will not be short lived. The additional breathing space provided opportunity for reflection and resident ideal type 3 now feels confident in techniques they can practise to maintain a better work ethic and work-life balance, thus offering a sense of competence. They feel this will allow them to wholly commit to their work, whilst being able to switch off at the end of the workday and not sacrifice their personal life (Box 3: D).

Resident ideal type 4: Consolidate specialty choice

Resident ideal type 4 was built from nine resident interviews, typically of individuals on uncoupled training pathways (pathways where resident doctors must complete core training before applying for a specialty programme) who hope to satisfy needs of autonomy and relatedness. Although type 4 feels competent in their abilities and is progressing well

on their programme (satisfied sense of competence), they are yet to decide on the next stage of training and which specialty programme most aligns to their intrinsic motivations. They see stepping out-of-programme as an opportunity to take control of what exposure and experience they have and control over their decision-making timeline, as well as ascertaining what pathway would provide the greatest sense of relatedness.

Type 4 has a clear idea of their alternative career options, for example sub-specialising or gaining dual-specialty status, so they want an OOP-P post that can provide some exposure to these options. They maintain that upon returning to programme, they will be better placed to make an informed decision about their career trajectory (Box 4: A,B).

On returning to programme, they are satisfied that the capabilities they developed during their time out-of-programme will contribute to their progression with their sub-specialty progression or dual-specialty status, and thus provide a head start in the next phase of their training. This wider exposure and informed decision making also provides a sense of connectedness and relatedness to that specialty (Box 4: C). Alternatively, if they decide to not sub- or dual-specialise, they are contented that the

Box 4. Extracts evidencing resident ideal type 4

[A] I was doing paediatric emergency sub-specialty training but was toying with the idea of doing post-paeds intensive care training. So was trying to look at ways to do some more time in paed intensive care whilst as a resident to help me make that decision. [Resident Time2]

[B] When we're training in ED [emergency department] we do three to six months of ICU as part of our core training. [...] You can qualify both as an Emergency Doctor and as an Intensive Care Doctor. [...] This [the Pause] was to get a longer period of time to see whether or not this is something I would actually want to apply for and want to do long-term. [Resident Time2]

[C] Essentially what they are doing is counting my time Out-of-Programme towards my ICU training. [...] So, in August I'm going straight into stage two, so it's not wasted time for me at all. [Resident Time2]

[D] Having taken a step back it's definitely paediatrics that I want to do. That's for sure. I want to go back into the training, but I want to be a paediatric mental health doctor. So, it's given me both of the answers that I wanted. [Resident Time2]

experience has solidified their position, providing certainty and confidence in their career trajectory moving forward (Box 4: D).

Discussion

This study extends existing research on resident doctors' dissatisfaction, burnout, and the demand for more flexible training pathways. Although the focus was on residents in England, the challenges identified (training pressures, limited professional autonomy, and difficulty maintaining work-life balance), are evident across healthcare systems internationally [4,5,8,9,32]. Framing these findings within SDT highlights how unmet psychological needs for competence, relatedness, and autonomy shift residents from autonomous to controlled forms of motivation. Residents often experience limited autonomy over their career trajectory and encounter external pressures to progress through training and assessment, driving many to seek out-of-programme options.

By exploring residents' motivations for taking time out of training and examining how this time is planned and utilised, this study develops a nuanced typology of residents, specifically, four "ideal types" characterised by distinct needs, experiences, and outcomes. The diversity of these needs and objectives, coupled with evidence of both professional and personal growth, suggests that the model has potential transferability across countries and contexts.

A central finding is the critical role of autonomy in sustaining residents' engagement and wellbeing. While autonomy is well studied in relation to clinical decision-making and procedural independence, these contexts typically emphasise patient safety and supervision, where excessive autonomy can lead to greater error rates [33], but the right level can develop residents' confidence [34]. The present study makes an important distinction: autonomy in personal and professional development decisions. Residents' individual needs and aspirations often diverge from those of their peers, making rigid adherence to pre-determined training structures inappropriate in some cases. The variations observed across the ideal types in where autonomy is

perceived to be lacking underscore the individuality of these needs.

Having autonomy to strategically enhance clinical competence (Type 1), prepare for consultancy roles (Type 2), or explore specialty options (Type 4) illustrates how the OOP-P can promote alignment between residents' training, developmental needs, and long-term career goals. The capacity to count relevant competencies gained during the pause toward training progression mitigates a key drawback of traditional OOP models: delayed completion of training. This feature positions the OOP-P as a more integrated, service-compatible form of flexibility within medical education.

The findings also indicate that the OOP-P can act as a protective factor against burnout. Type 3 residents demonstrate how stepping out of training but remaining in clinical practice can offer a vital reprieve. Existing research in both medical education and organisational psychology highlights the cognitive and emotional benefits of taking a break or pause, whether brief or extended [35]. The present study suggests that these benefits can be achieved without residents disengaging from patient care, thereby maintaining service contribution while supporting wellbeing.

The analysis of ideal types provides a strong argument for embedding flexibility and mechanisms that accommodate individual needs within training pathways. Such approaches may not only enhance individual wellbeing but also improve workforce retention and competence. Because the OOP-P involves only patient-facing posts, it holds a key advantage over non-clinical OOP models: it limits service disruption and maintains clinical continuity, reducing the burden on supervisory staff when residents return to formal training.

Despite these benefits, the reality is that the formal training programme remains unchanged. While some residents, particularly type 3 (manage burnout) reported feeling refreshed and better equipped to handle the pressures of training, OOP-P offers only temporary remediation. Indeed, a limitation of this study is the absence of longitudinal follow-up to assess whether gains in autonomous motivation are maintained over time.

A further limitation is the modest participation rate (29 of 155 eligible residents) and focus on resident perspectives alone. While appropriate for interpretivist research, the sample may not capture the full diversity of experiences, and resident views could be complemented by those of supervisors and training leads. This limited engagement likely reflects the intense workload pressures faced by residents, particularly during the COVID-19 pandemic, when participation in research was understandably deprioritised. Nonetheless, the study elicited a rich variety of experiences and motivations, providing meaningful insights into the OOP-P's implementation and impact.

Conclusion

Results of this study demonstrate that residents are driven to pursue an OOP-P by a range of personal and professional needs including the desire for greater clinical exposure, consolidation of skills, recovery from burnout, and clarification of career direction. These motivations reflect unmet psychological needs for autonomy, competence, and relatedness, as framed by self-determination theory.

The OOP-P model offers a valuable mechanism for addressing these needs while maintaining residents' engagement in patient-facing roles. Residents reported that stepping out of formal training allowed them to regain control over their development, enhance their clinical capabilities, and improve their wellbeing, without deskilling or facing unwarranted delays to their completion of training. Residents' perspectives also suggest OOP-P could also benefit staff retention and service provision continuity.

These findings support the case for embedding greater flexibility and autonomy within medical training pathways. The OOP-P provides a promising framework for achieving this balance, enabling residents to pause their training without pausing their contribution. To maximise its impact, we recommend expanding access to the OOP-P and ensuring that competencies gained during the pause are formally recognised.

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Ethics declaration

Ethical approval was obtained from the School of Medicine at Cardiff University. Respondents were provided with information on the study and indicated agreement to participate by completion of a consent form.

No raw data are available. The authors gained ethics approval on the premise that no data would be shared outside the core research team.

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Authors AB and JB were responsible for the acquisition of the funding for this work. All three authors, SB, JB and AB were involved in data collection. Author SB led the initial coding and analyses of the data as well as the creation of the ideal types, codes and ideal types were discussed and reviewed with authors AB and JB. SB compiled the first draft of the manuscript. JB and AB reviewed and developed the first draft.

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Appendix A. Time 1 interview

Background information

Can you begin by giving a brief overview of your formal training role?

When did you pursue your OOP-P and what is the intended duration of your placement?

Pursuing OOP-P

What motivated you to pursue OOP-P?

Did you consider any of the other OOP options?

What was your experience of arranging your OOP-P?

How did you find the application process?

Did you have support from your employer?

OOP-P placement

Can you briefly describe your OOP-P placement in terms of your day-to-day role?

What key attributes were you looking for when identifying a suitable placement?

Were you able to satisfy these?

How would you describe your general experience so far?

What support are you receiving whilst on your OOP-P? And from whom? (e.g. in doing the job, gaining capabilities, exam preparation)

Do you feel this support is sufficient?

Have you been able to (or expect to) develop any new capabilities?

So far, what has been the biggest benefit of pursuing OOP-P?

So far, what has been the biggest challenge of pursuing OOP-P?

Return to training

How are you feeling about returning to your formal training post?

How do you feel your pursuit of OOP-P will impact your next ARCP?

Recommendation

Do you have any suggestions of how your OOP-P placement could have been improved?

Would you recommend an OOP-P to others?

Who in particular do you feel the OOP-P is suited to?

Is there a particular stage of training you think best suits taking an OOP-P?

Do you think it is not advisable to take an OOPP at certain times in the training or in certain specialties?

Do you have any advice to those considering pursuing the OOP-P?

Any other comments?

Appendix B. Time 2 interview (those participated in Time 1)

Background information

To begin, when did you complete your OOP-P and return to formal training?

Can you give a brief overview of the training role you have returned to?

OOP-P placement

What did you hope to gain through your OOP-P?

Did your OOP-P meet your expectations? Why/why not?

What support did you receive whilst on your OOP-P?

And from whom? (e.g. in doing the job, gaining capabilities, exam preparation)

Do you feel the support you received was sufficient?

Transition back into training

How did you find the transition from OOP-P back into your formal training programme?

Was it as you expected?

Did you experience any challenges – professional or personal?

What support did you receive? (prompt: from ES, TPD)

Have you made use of the gap analysis tool since returning to training?

How helpful have you found this? Suggestions for improvements?

Impact of OOP-P

Having completed the Pause, do you feel it met your expectations? Why/why not?

What do you perceive to have been the greatest benefit of pursuing the OOP-P?

Do you feel the OOP-P has had any impact on

- a. your confidence?
- b. your competence?
- c. your wellbeing?

Do you feel you were able to gain any new capabilities whilst on your OOP-P?

[for those who have gained capabilities]:

Have you been able to implement/use any of these capabilities in your practice since returning to training?

Are you confident that the capabilities you gained on the OOPP will be recognised?

Do you feel there have been any disadvantages from pursuing the OOP-P?

Relative to your peers in training (who haven't taken an OOPP) do you feel there were any advantages or disadvantages from pursuing the OOP-P?

Have you had an ARCP review since returning to your formal training/How are you feeling about your next ARCP having completed an OOP-P?

Has pursuing the OOP-P had any impact on your CCT date?

Recommendation

On reflection, do you have any suggestions of how the OOP-P opportunity could be improved?

Would you recommend an OOP-P to others?

What advice would you offer them?

Any other comments?

Appendix C. Time 2 interview (those who did not participate at Time 1)

Background information

Can you begin by giving a brief overview of the formal training role you took a Pause from?

When did you pursue your OOP-P and what is the intended duration of your placement?

When did you return to formal training?

Can you give a brief overview of the training role you have returned to?

Pursuing OOP-P

What motivated you to pursue OOP-P?

Did you consider any of the other OOP options?

What key attributes were you looking for when identifying a suitable placement?

Were you able to satisfy these?

What was your experience of arranging your OOP-P?

How did you find the application process?

Did you have support from your employer?

OOP-P placement

Can you briefly describe your OOP-P placement in terms of the day-to-day role?

What key attributes were you looking for when identifying a suitable placement?

How would you describe your general experience?

What support are you receiving whilst on your OOP-P? And from whom? (e.g. in doing the job, gaining capabilities, exam preparation)

Do you feel this support was sufficient?

Transition back into training

How did you find the transition from OOP-P back into your formal training programme?

Was it as you expected?

Did you experience any challenges – professional or personal?

What support did you receive? (prompt: from ES, TPD)

Have you made use of the gap analysis tool since returning to training?

How helpful have you found this? Suggestions for improvements?

Impact of OOP-P

Having completed the Pause, do you feel it met your expectations? Why/why not?

What do you perceive to have been the greatest benefit of pursuing the OOP-P?

Do you feel the OOP-P has had any impact on

- your confidence?
- your competence?
- your wellbeing?

Do you feel you were able to gain any new capabilities whilst on your OOP-P?

[for those who have gained capabilities]:

Have you been able to implement/use any of these capabilities in your practice since returning to training?

Are you confident that the capabilities you gained on the OOPP will be recognised?

Do you feel there have been any disadvantages from pursuing the OOP-P?

Relative to your peers in training (who haven't taken an OOPP) do you feel there were any advantages or disadvantages from pursuing the OOP-P?

Have you had an ARCP review since returning to your formal training/How are you feeling about your next ARCP having completed an OOP-P?

Has pursuing the OOP-P had any impact on your CCT date?

Recommendation

On reflection, do you have any suggestions of how the OOP-P opportunity could be improved?

Would you recommend an OOP-P to others?

What advice would you offer them?

Any other comments?