



Your Training Counts

An investigation of Trainee wellbeing and their experiences of clinical learning environments in Ireland 2017



Comhairle na nDochtúirí Leighis
Medical Council

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About the Medical Council

The Medical Council is the regulatory body for doctors. It has a statutory role in protecting the public by promoting the highest professional standards amongst doctors practising in the Republic of Ireland.

The Council has a majority of non-medical members. The 25 member Council consists of 13 nonmedical members and 12 medical members. The Council receives no State funding and is funded primarily by doctors' registration fees.

The Medical Council maintains the Register of Medical Practitioners - the Register of all doctors who are legally permitted to carry out medical work in Ireland. The Council also sets the standards for medical education and training in Ireland. It oversees lifelong learning and skills development throughout doctors' professional careers through its professional competence requirements. It is charged with promoting good medical practice. The Medical Council is also where the public may make a complaint against a doctor.



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Finally, we would like to thank the 759 trainee specialists and interns across Ireland who took part in Your Training Counts in 2017; without their contribution Your Training Counts could not succeed and we are extremely grateful to everyone who took part.

FOREWORD

The Medical Council has a dual remit of protecting patients and supporting doctors. Through evidence-based, data-driven research we can provide a national picture of the medical workforce in Ireland, identify trends, highlight areas of concern and make suggestions on how to address issues.



While the Medical Council responds to concerns about doctors, it is also responsible for safeguarding the quality of doctors' education, training and lifelong learning in Ireland. In 2014, the *Your Training Counts* survey was created to support the continuing improvement of postgraduate medical training in Ireland. A key aspect of *Your Training Counts* since its inception has been to monitor trainee specialists' views on their own health and wellbeing, and each report published since 2014 has shown that Irish trainee specialists have consistently faced challenges during this period.

The results of *Your Training Counts* suggest that trainee specialist doctors and interns, in the main, feel safe in their workplace, have good general health and self-reported quality of life. Ireland's education and training of doctors is internationally recognised, and Irish trainees hope to work primarily in Ireland in their future career. However, retaining this pool of highly qualified Irish-trained doctors in practice is proving challenging.

Although we see improvements in numerous areas such as wellbeing and mental health, concerning trends which have been identified in recent years on issues such as bullying and long working hours continue.

This report, as with the recently published *Medical Workforce Intelligence Report*, contains significant and sometimes concerning insights, which need to be addressed collaboratively amongst policymakers, educators, planners and employers.

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Glossary:

Abbreviations & acronyms

ANOVA	Analysis of Variance
ARAF	Annual Retention Application Form
BMQ	Basic Medical Qualification
EWTD	European Working Time Directive
HSE	Health Service Executive
IMG	International Medical Graduate
IMGTI	International Medical Graduate Training Initiative
MPA	Medical Practitioners Act
NCHD	Non-Consultant Hospital Doctor
PGTB	Post Graduate Training Body
RCPI	Royal College of Physicians in Ireland
RCSI	Royal College of Surgeons in Ireland
RMP	Registered Medical Practitioner
SDHS	Short Depression and Happiness Scale
WHO	World Health Organisation
YTC	Your Training Counts

YOUR TRAINING COUNTS 2017 REPORT IN NUMBERS



76.9%

Majority of trainee specialists
reported enjoying good mental
wellbeing



33.5%

Reported working
60 hours or more
a week



40.9%

The percentage of
trainees who
reported instances of
bullying

Percentage of trainee
specialists reporting a good
or better quality of life

70%



Number of trainee specialists felt
physically safe in the hospital
environment

9/10



30.4%

Number of YTC respondents
involved in an adverse event in
the past 12 months

Alleged perpetrators of
perceived bullying behaviour

58%

Doctors



30%

Nurse/
Midwives

Percentage of trainee specialists
wishing to remain in Ireland



67.2%

41%



of those who were bullied
reported involvement in an
adverse event

Executive Summary

While the Medical Council responds to concerns about doctors, it is also responsible for safeguarding the quality of doctors' education, training and lifelong learning in Ireland. In 2014, the *Your Training Counts* (YTC) survey was created to support the continuing improvement of postgraduate medical training in Ireland. A key aspect of YTC since its inception has been to monitor trainee specialists' views on their own health and wellbeing, and each report published since 2014 has shown that Irish trainee specialists have consistently faced challenges with wellbeing issues during this period.

In order to examine the emergence of doctors' wellbeing as an issue of concern in Irish medicine, this report first uses wellbeing material published in the *Irish Medical Journal* as a prism to assess the evolution of wellbeing as a topic of debate among the medical community. Resources available to support trainees and their wellbeing was also compiled and set out.

Learning Environments

The quality of clinical learning environments were more highly rated by trainees in GP sites and Mental Health training sites than hospital training sites in 2017, consistent with previous findings. Learning from good practice in these sites is important to shape training developments and improvements in practice. Interns are scoring most poorly in their perceptions of their clinical learning environments. This must be addressed to improve training quality and service retention concerns as a priority for this young pool of doctors in their formative experience of clinical practice, for the future of the Irish health service.

Working time

Over one third (33.5%) of YTC 2017 respondents reported working 60 hours or more in a typical week. A good or better than good self-perceived quality of life was lowest among those who worked more than 59 hours per week, with over half (56.6%) of respondents reporting a quality of life that was good or better. Contrastingly, a higher percentage of those who worked less than 40 hours per week reported a quality of life

that was good or better (82.6%). More than half (56.6%) of those working more than 59 hours a week had been directly or indirectly involved in an adverse event in the previous twelve months. In contrast, respondents who worked 40-59 hours a week, were involved in proportionately less adverse events (24.1%).

Self-rated general health

Encouragingly, nine out of ten trainee specialists felt physically safe in the hospital environment, and this is a trend which has remained consistent since 2014. The percentage of trainee specialists reporting a quality of life that is good or better has risen by nearly 10% from 61.9% in 2014 to 70% in 2016 and 2017.

A higher percentage of males (32.3%) reported a quality of life that was less than good compared to their female counterparts (28.7%). Additionally, the closer an individual was to presenting with mental health quality that might benefit from additional supports and the lower their self-rated general health, the greater their chances of reporting a lower quality of life.

Age, gender, Short Depression and Happiness Scale (SDHS) score, self-rated general health and hours worked per week were significant predictors of self-rated quality of life. Older respondents were more likely to report a quality of life that was less than good, with 43.8% of those aged between 45 and 54 reporting health that was less than good. The closer a trainee specialist doctor was to presenting with mental health status that might benefit from additional supports, and the lower their self-perceived quality of life, the higher the chances were that they would report lower self-rated general health.

Mental Health

Overall, the majority of trainee specialists (76.9%) enjoyed good mental wellbeing. Just under half (47.8%) of respondents reported a score on the SDHS that indicated the presence of a mental health issue which may benefit from additional support were involved in an adverse event in the previous twelve months. It was observed that self-rated quality of life and self-rated general health were significant predictors of a score

on the SDHS which indicated the presence of a mental health issue that may benefit from additional support.

Bullying

Over forty percent of respondents to YTC 2017 reported that they had experienced bullying and harassment in their post. Since YTC began in 2014, reported bullying among trainee respondents has increased by over six percent. Of note, there has been a concurrent reduction in participation rates in the study during this time. This trend may indicate that the incidence of bullying is increasing, that awareness and/or perception of bullying behaviour in training is more acute, or that participants who agree to complete the survey are more likely to perceive bullying behaviour. These figures do, however, reflect lived experiences noted in published Medical Council [reports](#) into inspections of clinical training sites in the South/South West and Saolta Hospital Groups. These detail allegations of bullying being observed by interns that went unchallenged by other members of a multidisciplinary team, and further allegations of bullying against a consultant.

Doctors represented 58% of perceived perpetrators of bullying behaviour, while nurses and midwives represented just under one third of perceived bullying perpetrators (30%), as reported by respondents. Just under half (48.5%) of trainee respondents to YTC 2017 reported experiencing undermining behaviour from a consultant or GP. In addition, 19.3% reported that being undermined by a consultant or GP was something that occurred on a monthly or more regular basis. Over half (56.2%) of respondents reported witnessing a colleague being the victim of bullying or harassment. In 2017, just under 70% (68.9%) of respondents who reported being bullied and harassed did not divulge the incident(s) to an authority figure.

Over forty per cent of respondents (41%) who were bullied were also involved in an adverse event while 18.5% of those who were not bullied were involved in an adverse event. Doctors in GP Practice training reported significantly lower instances of bullying than in hospital settings. No trainee specialists in GP Practice reported frequent bullying, with three quarters not experiencing bullying at all and 14.9% reporting infrequent bullying.

Adverse Events

In 2017, just under one third (30.4%) of YTC respondents were involved in an adverse event in the previous twelve months, either directly or indirectly. Encouragingly, the percentage of respondents reporting being involved in adverse events in 2017 was 3% lower than the previous year, while the percentage of respondents who reported direct involvement in adverse events was also down by 3%.

Younger trainee specialists were significantly more likely to be involved in an adverse event than their older colleagues. A higher percentage of male respondents (34.4%) were involved in an adverse event than their female counterparts (27.3%).

Just under half (47.8%) of respondents who had an SDHS score suggesting mental health quality that might benefit from additional supports were involved in an adverse event. For those who did not meet this score threshold, 29.9% were involved in an adverse event. Trainee specialists who reported being bullied were more likely to be involved in adverse event than those who were not bullied. Those who worked longer hours were also more likely to have been involved in an adverse event than those who worked less hours.

Accessing supports

The results of YTC 2017 suggest that for trainee specialists, barriers exist in relation to accessing the support services available for staff in the health system. Less than half (43.5%) of those trainee specialists who were involved in an adverse event believed that confidential support services were available at their training site/hospital if they needed them. 40.6% of respondents agreed that their clinical line manager provided meaningful and sustained support after the occurrence of an adverse event. Similarly, just 40.5% of trainee specialists felt adequately supported by the training site/hospital and its structures after the event. For 59% of trainee specialists involved in an adverse event, family and friends were the main source of support afterwards.

Nearly a third (29.9%) of respondents involved in an adverse event found it difficult to practice immediately after the event. For 43.4% of respondents, memories of what happened during the adverse event troubled them for a long period of time following the event. One quarter (25.3%) of trainee specialists agreed that they had left or

contemplated leaving the speciality in which they were working after the adverse event, while 22.1% of trainee specialists contemplated leaving medicine altogether following the adverse event. This emphasises importance and need for effective, evidence-based supports for trainees in challenging circumstances.

Migration intentions

The number of doctors on the Trainee Specialist division of the register who expressed a desire to leave Ireland and practice medicine has steadily declined, falling from 21.3% in 2014 to 14% in 2017. In addition, those wishing to remain in Ireland has increased year on year, from 54% in 2014 to 67.2% in 2017. The proportion of trainee specialists who reported considering practicing medicine abroad because they found their work environment too stressful also declined substantially from 67.4% in 2016, to 29.7% in 2017. However, over half (57.8%) of trainee specialists flagged a lack of support from their employers as a motivating factor in their desire to practice medicine outside of Ireland.

Almost two thirds (65.9%) of trainee specialists considered practicing medicine abroad because they felt their working hours in Ireland were too long, and this was the main predictor of wishing to emigrate. Just under four in five (79.6%) of trainee specialists agreed that the prospect of a better work-life balance was central to their considering practicing medicine outside of Ireland.

The results of YTC suggest that doctors feel safe in their workplace, the general health of trainee specialists is good and their self-reported quality of life is similarly positive and improving year on year. Ireland's education and training of doctors is internationally recognised, and Irish trainees hope to work primarily in Ireland in their future career. However, in practice, retaining this pool of highly qualified Irish-trained doctors is proving challenging as the system they work in challenges. Trainee specialist doctors and interns in Ireland have a healthy desire for a balanced approach to living and working - supporting them to do this can only bolster the training experience, doctor wellbeing, retention and ultimately patient safety.

Introduction

Your Training Counts is the Medical Council's annual National Trainee Experience Survey. The purpose of the survey is fourfold. Firstly, the results of the survey are used to monitor trainee views on the quality of clinical learning environments. The survey is also used to monitor trainee specialists' opinions on other aspects of postgraduate medical education such as preparedness for transitions, retention and career plans, health and wellbeing, and trainee perceptions of safety at clinical sites. Thirdly, YTC informs the Medical Council in identifying opportunities for strengthening standards and guidance, allowing the Council to focus on its quality assessment responsibilities. Finally, the results of YTC are leveraged to inform dialogue and future collaboration between the individuals and organisations involved in medical education and training in Ireland, with a view to continually improving trainee experiences and outcomes.

Previous reports using data collected by the YTC survey have largely focused on trainee specialists' appraisals of the clinical learning environment. However, recently there has been growing acknowledgment within a regulatory sphere that doctors' wellbeing is a crucial element to ensuring good professional practice, effective doctor-patient relationships and the highest possible standard of medical care. For the Medical Council, the genesis of this wellbeing focus began in 2014, with the publication of the Council's Spotlight on Wellbeing report. This report found that a small minority of trainee specialists had poor quality of life, mental health and overall wellbeing. Furthermore, the report argued that there was a significant link between the experience of bullying, undermining and poorer health and wellbeing among trainee specialists. This report served to raise awareness around the fact that wellbeing was a prevalent issue for Irish trainee doctors by outlining the starkness of the specific wellbeing challenges being faced by Irish doctors.

Context of YTC 2017

The YTC 2017 report has been produced within the contextual backdrop of an ever-growing acknowledgement that the Irish healthcare system is severely challenged, with working conditions, retention and resourcing issues of concern. While addressing such problems are imperatives for policymakers, there has concurrently been increased policy focus on doctors' wellbeing, with widespread agreement that wellbeing is an important factor to addressing these challenges.

Additionally, there is acknowledgment that doctors' wellbeing remains ever-important to ensuring the highest possible standards of patient safety. Increasingly, the Medical Council are being made aware that wellbeing is a prominent concern for Irish trainee doctors. As the regulatory body responsible for overseeing medical training, the Medical Council is committed to responding to these calls for the need to institute improvements. Such wellbeing policy innovations and improvements are being supported by an evidence-base that is being deepened by research undertaken by the Medical Council and its partner organisations. Exploring variations in relation to trainee specialists' wellbeing experiences will help to direct the development of quality improvement strategies.

Doctors are often required to work long hours, make difficult decisions in the face of uncertainty and cope with death and distress, all while maintaining a professional and compassionate disposition (Medical Council, 2016). Given the implicit nature of these stressors in the working lives of trainee doctors, the maintenance of these individuals' wellbeing, through adequate resourcing, cannot be taken for granted and requires proactive attention by employers, government, regulators and policy-makers.

While wellbeing is clearly important to individual performance, within a systemic context, analysis has suggested that doctors' health and wellbeing is closely linked to standards in patient care and health system outcomes. In an investigation of solutions to wellbeing problems faced by trainee doctors, Rich, Viney, Needleman, Griffin and Woolf (2016) argued that developing both social and structural support mechanisms can support improving overall wellbeing. In order to advocate for such developments,

it is first necessary to examine the landscape of wellbeing issues among trainee specialists. This examination will provide a foundation for future improvement on existing policies and act as a catalyst for innovation concerning the wellbeing of Irish trainee doctors.

In 2014, the Medical Council turned its focus to doctors' wellbeing, releasing the 'Your Training Counts: Spotlight on health and wellbeing report'. Using the results of the inaugural YTC survey, the report emphasised the fact that wellbeing influences good professional practice. While the YTC surveys sent to trainee specialists from 2014 to 2016 asked a series of questions concerning their wellbeing, the published reports primarily focused on evaluations of the clinical learning environments. A wellbeing-focused investigation of YTC data has not been undertaken by the Medical Council since 2014. Equally, the association between wellbeing related variables and prevalent issues in Irish medicine such as adverse events and the retention of Irish trained doctors has heretofore not been articulated.

Doctors' wellbeing: historical context

In Ireland, wellbeing-related research has primarily focused on recent issues and innovations, with cross-sectional studies examining the component parts of the overall picture of doctors' wellbeing in Irish medicine. However, the emergence of wellbeing as a concern among Irish doctors and the evolution of discussions championing such issues has heretofore remained unexamined. Foster (2018) determined that exploring the development of the discourse surrounding the mental and emotional health of doctors in Britain has utilised historical inquiry in order to inoculate current discourse and decision-making against nostalgia. The value of such an investigation is clear, in that it contextualises current programmes and policy innovations appropriately.

As one of the longest-standing medical publications in Ireland, the *Irish Medical Journal* (IMJ) has provided a forum for debate among the Irish medical community since its establishment in 1867. Examining material published in the IMJ from the commencement of the Medical Council's operations in 1979 to the present day reveals whether wellbeing was considered important to Irish doctors during the formative years of the Council, and whether these perceptions evolved over time. Such analysis grounds contemporary wellbeing policies in their historical and structural contexts.

The material included in this analysis refers to articles published in the Irish Medical Journal from 1979 to 2017. Incorporated in this assessment are articles wherein the title contains one or more of a list of wellbeing related keywords. As this approach did not yield results for articles published before 1998, a further investigation was undertaken for articles published from 1979 to 1998 in which wellbeing related topics were discussed tangentially. While it is possible that some wellbeing related material published after 1998 has evaded detection, it is likely that wellbeing was not the thrust of such discussions, and as such, the search methodology employed here fulfils the objective of providing an overview of the trajectory of wellbeing-centric discussions among Irish doctors from 1979 to 2017.

The early years

During the late 1970s and 1980s, debate among doctors about workplace wellbeing was rare, and where the issue was raised, it was often done so in a tangential manner when discussing societal issues such as alcoholism, poor mental health, or perceived financial constraints being imposed on the profession. Health spending cuts introduced in 1987 led one doctor to comment that: *'morale among all hospital staff will be at zero-point, and the dignity and safety of the patient will be all but submerged'* (Fitzgerald, 1987, p. 354). Doctors' wellbeing began to be more prevalently discussed in the IMJ during the 1990s. These arguments focused on the stress experienced by many trainee doctors, and the consequent impact on their ability to learn, leading in many cases to *'indifferent attitudes to patients ... which may last a lifetime'* (Murphy, 1992 pp 147-50). By 1998, these concerns had accelerated, with Irish doctors acknowledging the existence of elevated drug abuse and suicide in the profession, with 'kerbside consultation', self-medication and the excess risk of depression and anxiety being discussed as *'occupational realities'* (Clarke et al, 1998, p. 176).

2004 to 2018

A significant increase in wellbeing discourse occurred in the IMJ during 2004, with numerous articles debating issues such as pregnant doctors' working conditions, the relationship between the European Working Time Directive and fatigue among surgeons, work-related stress among paediatric non-consultant hospital doctors, and the impact of wellbeing related topics on the career plans of Irish interns. Within these debates, issues including sub-optimal on-call conditions (O'Mahoney, 2012), long

hours (Roche-Nagle, 2004), extreme stress (Shaw, Brown & Dunn, 2012) and burnout (Nason, Liddy, Murphy & Doherty, 2013) were repeatedly flagged.

In 2005, the IMJ published an analysis of the bullying of junior doctors in the Irish health system (Cheema et al, 2005). This research found that thirty per cent of the doctors surveyed had experienced bullying, with cases of juniors being physically abused, pushed around, verbally abused, ignored and being given a dressing-down in front of other staff and patients by their consultants and senior staff on their team. While workplace bullying was framed by Cheema et al., (2005) as a major source of stress, breakdown and malfunction, it was also noted that the majority of trainee specialists were afraid to report bullying due to a perceived negative impact on their future careers.

While the pace of published wellbeing related material in the IMJ slowed after 2004-2005, topics affecting doctor's wellbeing remained a consistent presence in the following years. In 2007, an article about self-healthcare among doctors' stated that 'the implications for reduced health and wellbeing of a doctor can be serious for themselves and their patients' (Ní Úallacháin, 2007). The motivations behind Irish doctors' reluctance to seek medical care were listed as *'lack of time, fear of being seen as not able to cope ... embarrassment and lack of trust'* (Ní Úallacháin, 2007, p. 490).

By 2010, doctors were questioning whether there were cultural issues at play during instances of medical error and adverse events. Reviewing the ten year anniversary of 'To Err is Human' by Kohn, Corrigan and Donaldson (1999), Murphy argued that a *'no blame'* culture has not received universal acceptance and that *'the culture of blame is the greatest cause of litigation in medical error today'* (Murphy, 2009, p. 36).

In the following years, articles about fatigue, working hours, stress and the effect of these issues on retention were published in the IMJ. Many of these were written by the journal's editor JFA Murphy. In 2011, Murphy referenced the fact that sleep deprivation had been vexing medical practice for decades, without significant improvement. 'The problem is that all 168 hours throughout every week of every year have to be covered and there are a finite number of doctors to shoulder the burden' (Murphy, 2011). This issue was again raised in 2013 in connection with non-consultant hospital doctors, and the fact that the hours worked for those in acute specialities

remained *'stubbornly high'*. The effect of this, it was argued, was the blunting of *'professional, social and private lives'* (Murphy, 2013). The primary aggravating factor behind the fatigue levels being experienced by doctors' was long working hours. In 2011, Murphy argued that sleep deprivation was as detrimental to clinical performance as alcohol (Murphy, 2011). The same author reinforced this point in 2013, with Murphy pointing out that fatigue negatively impacted *'concentration levels, problem solving skills, numerical calculations and the quality of the patient-professional interaction'* (Murphy, 2013).

Discourse around increasing stress levels among doctors arose in 2011, with Murphy pointing out in an editorial that *'the provision of medical care has become more complex and correspondingly more stressful'*. In 2016, Murphy argued that patients were the ones at greatest risk from interacting with *'over-stressed and often exhausted doctors'*. In all of the above instances, wellbeing issues were raised within the context of the large number of Irish trainee specialists leaving Ireland to practice medicine abroad.

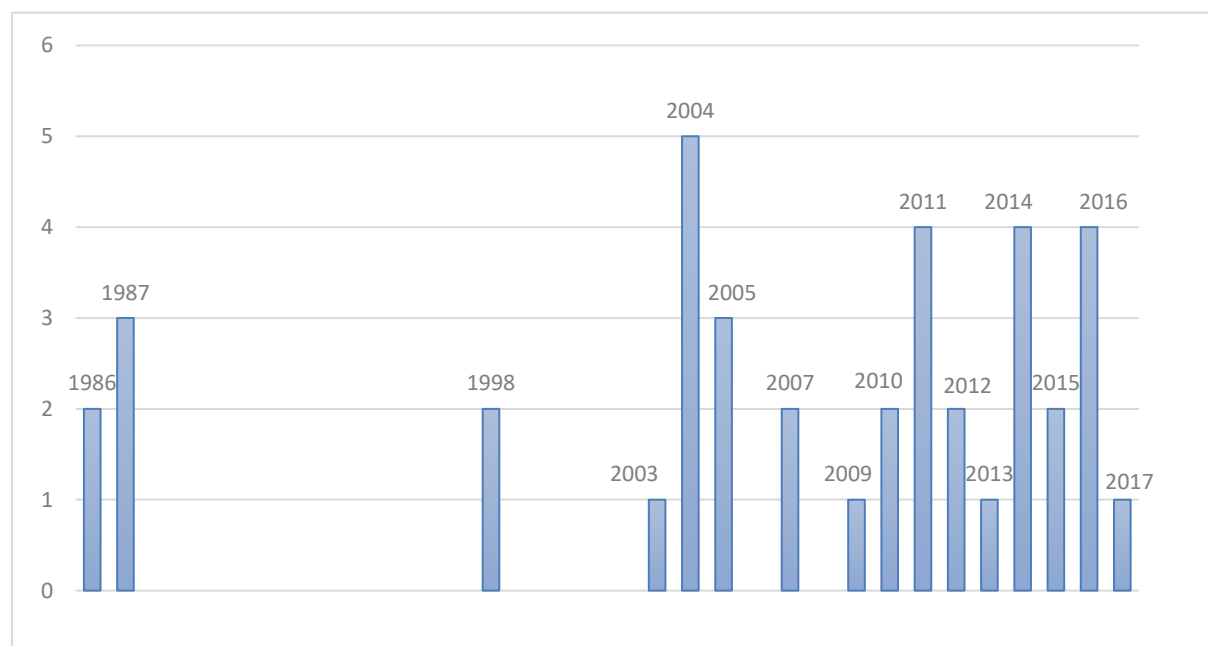
Conversations around retention became prevalent in the IMJ in 2011. In an editorial, Murphy exclaimed that initially, increased numbers of doctors leaving for periods of working abroad had left hospital administrators *'bewildered as to why doctors left and where did they go'* (Murphy, 2011). However, by this point there was more assuredness as to the root causes:

"There is a growing awareness that many junior doctors find the working conditions in Irish hospitals unattractive and onerous. Tiredness affects their training and their ability to study for postgraduate exams. The drop-out from SHO rotations is excessively high. These matters will need to be addressed if the 'NCHD drain' is to be contained."

By 2014, the *'spiral of medical exodus'* was being described in crises terms (Murphy, 2014). In 2015, Murphy stated that the most common reason for emigration and a reluctance to return were stressful working conditions and unclear or unsatisfactory career progression, with many doctors expressing deep frustration and anger *'at the working conditions in Irish hospitals that forced them to leave'* (Murphy, 2015). These sentiments were repeated in the following years, and were tied to a *'depth of feeling,*

frustration and sometimes anger’ among *‘over-stressed and often exhausted doctors’* (Murphy, 2016). In 2017, Murphy wrote an editorial concerning growing concern about the welfare of doctors in the face of increasing numbers of complaints being made. Medico-legal complaints for many doctors were described in terms of the *‘most traumatic experience of their professional life’* which, in many cases resulted in *‘anxiety, depression’* and *‘loss of self-esteem’*. In light of this, Murphy advocated for the introduction of a coherent system of counselling for such individuals (Murphy, 2017).

Figure 1. Wellbeing discussions in the IMJ, 1979 to 2017



Turning the spotlight towards wellbeing

The Medical Council is committed to contributing to discussions on doctors’ health and wellbeing, as both are critical to good professional practice and to ensuring strong and effective patient-doctor relationships. Following the publication of the first YTC report in 2014, the Medical Council compiled [Your Training Counts: Spotlight on Health and Wellbeing](#). The report detailed that 62% of Trainee specialists who used support services available reported a positive experience. Tellingly, 86% of Trainee specialists who reported a need for support, did not avail of support services. The study sought to open a discussion with the Medical Council’s partner organisations concerning the development of wellbeing supports for Irish trainee doctors’. Besides being an important issue for individual trainee specialists, this report emphasised that good

health and wellbeing among doctors was systemically important to fostering good professional practice through medical education and training, while also ensuring safe, effective and compassionate care for patients, and designing a strong and sustainable health system.

While the Medical Council is committed to undertaking research into doctors' wellbeing, it is equally committed to working with partner organisations to identify, investigate and challenge wellbeing issues, to create a more engaged, energised and resilient medical workforce. Since the launch of YTC in 2014, a number of partner organisations have undertaken research designed to investigate Irish doctors' wellbeing, with a view to driving change improvements.

Contemporary Irish wellbeing research

A number of regulatory bodies have worked to establish an evidence base on doctor's wellbeing in Ireland. In 2013, a Department of Health Working Group chaired by Prof Brian MacCraith was established to carry out a [strategic review of medical training and career structure in Ireland](#). In 2014, the Group submitted three reports and made twenty-five recommendations. A key facet of these reports is the importance of improving mentoring in postgraduate medical education and specialist training. Mentoring has been shown to improve doctors' wellbeing, with mentors and mentees reporting positive changes to their personal confidence and morale, and to having an enhanced sense of personal wellbeing.

While YTC reports from 2014 to 2017 prompted conversation regarding the wellbeing issues that exist among Irish trainee specialists, a number of specialist training bodies have also strived to conduct research providing greater insight into doctors' wellbeing in Ireland. In 2014, the Royal College of Physicians in Ireland (RCPI) conducted the [National Study of Wellbeing of Hospital Doctors in Ireland](#). This is a collaborative project governed by a multi-stakeholder steering group that includes representatives from the RCPI, RCSI, the College of Anaesthesiologists, the College of Psychiatry, the Irish Association of Emergency Medicine and Dublin City University. As well as examining the causes of stress in the workplace, this project collects data on doctors' lifestyle choices, interpersonal relationships and rates of mental health problems, including burnout, depression, anxiety and substance misuse.

Contemporaneously, the [Civility Project](#) is a joint project between RCPI and RCSI, funded by the HSE NDTP. The Civility Project is exploring incivility in hospital settings and its effects on individuals, in order to design potential interventions to improve civility. Incivility defined in this context as rude or unsociable speech or behaviour, which is highly undesirable in a hospital and creates a negative workplace. The project acknowledges that incivility can have serious consequences, and affect not only the wellbeing of staff but also patient safety. The project aims to gain a better understanding of incivility in a hospital setting through a mixed methods study and how the working environment can be improved for all hospital employees, with a view to developing a suitable programme of improvement to promote civility.

The [RCPI Hospital Doctor Retention and Motivation Project](#) also implicitly deals with wellbeing issues by exploring doctor emigration, retention and workplace morale. This project seeks to find out why highly-trained hospital doctors are emigrating, and how best to motivate them to either stay in Ireland or to return to practice medicine in Ireland.

[Wellbeing supports for Irish doctors](#)

While wellbeing research is crucial to building the evidence base necessary to drive strategic improvement, practical supports are also necessary in practice. The Medical Council operates with the knowledge that doctors with health-related problems have good outcomes with the correct interventions, balanced on occasion with the involvement of the relevant regulatory authority. The [Health Sub-Committee](#) which monitors and advises Council about the health of individual doctors who have relevant medical disabilities with this in mind. Our partner organisations including employers, postgraduate training bodies and indemnifiers, have also established a series of practical measures to provide support structures to improve doctors' wellbeing.

In 2015, the HSE launched the [Health Services National Implementation Plan 2015-2017](#). This strategy set out 126 actions for improvement across the health services, and was led by the HSE and the Department of Health. Outputs from this strategy included a Healthy Workplace Framework and a Staff Health and Wellbeing Fund. The HSE [Workplace Health and Wellbeing Unit](#) was established in 2016 to ensure the delivery of high quality staff support services, including Staff Health and Wellbeing,

Occupational Health, and a Staff Engagement and Employee Assistance programme. This Unit also provides an online resource tool detailing the available supports aimed at improving doctors' workplace, emotional and physical wellbeing. The HSE-led [Strategy for Doctors' Health and Wellbeing 2018-2021](#) also contains a series of recommended standards designed for medical students, Non-Consultant Hospital Doctors, Consultant/Senior Doctor Medical Personnel and GPs. Wellbeing is an implicit consideration in other HSE policy initiatives such as the [2018 Health Services Change Guide](#), which seeks to prioritise staff health and wellbeing and publicise the supports available.

Postgraduate training bodies have also established a number of wellbeing supports for their trainee specialists and members. The RCPI [Physician Wellbeing Programme](#) offers a range of courses and workshops – specially tailored for doctors – to help manage stress and workplace challenges, while reminding doctors about the importance of self-care. In 2017, the RCPI published a detailed [Bullying Policy](#), which sets out the College's commitment to promoting a work environment that upholds the dignity and respect of all staff and supports every individual's right to work in an environment which is free of any form of harassment, intimidation or bullying.

The Irish College of General Practitioners Doctors' [Health in Practice Programme](#) educates and supports GPs when they become ill, or when they have concerns about their own or a colleague's health. While promoting health and wellbeing preservation, this programme also provides confidential healthcare through the Healthcare Support Networks.

The RCSI runs a [Positive Health Programme](#), which emphasises students' professional obligation to actively manage their personal health during their academic and clinical training, and provides access to a confidential personal counselling service run by, [RCSI's Centre for Mastery: Personal Professional & Academic Success](#) (CoMPPAS). The RCSI has also adopted a strong stance on bullying and inappropriate behaviour. In January 2018, it published a revised version of its [Guidelines on Dealing with Inappropriate Behaviour](#), while also fully endorsing the Joint Committee on Surgical Training's policy statement on bullying and undermining.

From an indemnifier perspective, the [Medical Protection Society Counselling Service](#), provided independently by Optum Healthcare, has been introduced specifically to assist members who present with stress. This in-house telephone counselling provides 24/7 access to support. Face-to-face counselling sessions can also be arranged.

Independently, The [Practitioners' Health Matters Programme](#) is body unaffiliated with any regulator, established to provide appropriate care and support for health professionals in Ireland who may have mental health issues such as stress, anxiety or burnout, or who may have a substance misuse problem. Of note, in 2018, the programme reports that just under half (49.3%) of new presentations to the service were non-consultant hospital doctors (NCHDs). Practitioners' Health Matters has been endorsed by a Memorandum of Understanding from the relevant professional councils, including the Medical Council, and it is supported by representative organisations and training bodies.

With these resources in mind, Murphy (2009) notes that “many doctors speak about their sense of isolation and not knowing where to turn for support” (p. 36). This sentiment was echoed by Ní Úallacháin, (2007) who, in a sample of Trainee General Practitioners, observed that 65% felt unable to take time off when ill and 92% self-prescribed medication on at least one occasion. In addition, a further 49% reported that they neglected their own health (Ní Úallacháin, 2007). Ní Úallacháin concluded that there exists a need to improve awareness about self-healthcare from an early stage in a doctor's career, citing the implications for reduced health and wellbeing on, not only the trainee but, their patients.

Without the provision of sufficient support structures to promote the maintenance of a sense of personal wellbeing, patient safety could be negatively impacted. Bourne et al., (2015) made the twin observations that depression in practitioners can predict an increase in medical errors as well as a loss of empathy towards patients. In addition, Tawfik et al., (2018) observed that access of initiatives promoting physician wellbeing, led to a reduction in rates of medical errors as well as promoting safety in the work unit. Given these consequences, it is of imperative importance that practitioners are appropriately resourced. A non-exhaustive list of the wellbeing initiatives that are provided, as well as the organisation providing same are presented in Table 1.

Table 1. Wellbeing supports available to Irish doctors in training

Organisation	Initiative	Target population	Resources	Training	Publications
<u>Health Service Executive</u>	<u>Workplace Health and Wellbeing Unit</u>	HSE employees	<u>Occupational health team</u>	Consultancy to Managers on staff wellbeing issues	<u>Safer, Better Care: Standards for Occupational Health Services 2017</u>
			<u>Employee Assistance and Counselling Service</u>	Critical Incident Stress Management (C.I.S.M.)	
				Individual & group staff support following a critical incident & other CISM supports	
				Pre-Incident Critical Incident Stress Management training for staff, managers and teams	
				General and Group Staff Support	
				Staff Wellbeing Workshops	
	Strategy for Doctors' Health and Wellbeing 2018-2021	Medical students; NCHDs; Consultants; GPs			<u>Strategy for Doctors' Health and Wellbeing 2018-2021</u>
	People's Needs Defining Change; Health Services Change Guide	Service Users, Families, Citizens, Communities and Staff			<u>People's Needs Defining Change; Health Services Change Guide</u>

Organisation	Initiative	Target population	Resources	Training	Publications
<u>Royal College of Physicians of Ireland</u>	<u>Physician Wellbeing Programme</u>	Doctors at all stages of their careers	<u>National Education Day for Doctors in Training</u> <u>Wellness Matters (HST):</u> <u>An Approach to Caring and Coping</u>	<u>Wellness Matters</u> <u>An approach to Caring and Coping</u> <u>Identifying and Managing the Distressed Trainee</u> <u>Resolving Interpersonal Conflicts</u>	<u>RCPI Bullying Policy (November, 2017)</u> <u>National Study of Wellbeing of Hospital Doctors In Ireland</u> <u>Looking after your health and wellbeing: A guide for doctors</u> <u>Quality care, public perception and quick-fix service management: a Delphi study on stressors of hospital doctors in Ireland</u> <u>'Caring for the Care-givers' Physician Well-being Position Paper Sep 2014</u> <u>Doctors don't Do-little: a national cross-sectional study of workplace well-being of hospital doctors in Ireland</u>
	Mentoring Programme	Basic Specialist Training Trainee specialists	Skilled feedback, assist in identifying learning opportunities		
	<u>Developing Resilience Programme</u>	Doctors at all stages of their careers			

Organisation	Initiative	Target population	Resources	Training	Publications
<u>Irish College of General Practitioners</u>	<u>Health in Practice Programme</u>	General Practitioners	<u>Healthcare directory; helpline/text line</u>	Winter Meeting theme 2018: "Cultivating a Happy, Healthy Workplace"	Publications can be accessed by members here
			<u>Practice management; Network of Establishing GPs; Information Technology; Quality Initiatives; Healthcare helpline</u>	Webinars including "The Power of Positive Change in the Practice" available on ICGP website	Examples include:
			<u>Doctors' Health in Practice Programme; healthcare directory</u>	Training and other CME events can be found here Examples include: Wellbeing and Resilience Retreat (2019) Inspiring Minds at GEMS (2018) Mindfulness Tools 5 Day Programme (2016) Mindfulness Based Stress Reduction Course (2015) A freer way of being - A mindfulness-based approach to promoting quality of life (2015)	Peer Support for Past and Potential Incidents in the Practice: ICGP AGM 2019 Making Every Consultation Count To request any articles of interest enrolled students are encouraged to contact library@icgp.ie

Organisation	Initiative	Target population	Resources	Training	Publications
<u>Royal College of Surgeons in Ireland</u>	<u>Positive Health Programme</u>	RCSI medical students	<u>Confidential counselling service</u>	<u>CoMPPAS Educate programme</u> <u>MSc/Postgraduate Diploma in Human Factors and Patient Safety</u> Human Factors and Patient Safety principles is a mandatory component of surgical training at junior and senior levels of training, over three full day sessions per year of training.	<u>Guidelines on Dealing with Inappropriate Behaviour (Revision 2)</u>
	<u>CoMPPAS</u> Guidelines on Dealing with Inappropriate Behaviour		<u>Centre for Mastery: Personal Professional and Academic Success</u>		
Organisation	Initiative	Target population	Resources	Training	Publications
<u>College of Anaesthesiologists of Ireland</u>	Training supports	Anaesthesiology trainee specialists	Designated Tutor within each Training Site; Directors of Training; Training Department; Exams Department; Committee of Anaesthesia Trainee specialists; Lead Anaesthetic Trainee Co-ordinator	Training details available at training@coa.ie Sessions at Annual Congress of Anaesthesiology and Intensive Care Medicine 2019 including: Caring for the carers: maintaining wellness and resilience Mindfulness	<u>Professionalism in Anaesthesia, Intensive Care and Pain Medicine</u> <u>CAT news (December 2018)</u> This includes findings of survey on training and wellbeing resources in the College)

Organisation	Initiative	Target population	Resources	Training	Publications
<u>Irish College of Ophthalmologists</u>	Human Factors Program (at RCSI)	Trainee specialist ophthalmologists	<u>Core Curriculum Specialist Training in Surgical Ophthalmology Curriculum</u> <u>Specialist Training in Medical Ophthalmology Curriculum</u>	<u>MSc/Postgraduate Diploma in Human Factors and Patient Safety</u> Human Factors and Patient Safety principles is a mandatory component of ophthalmology training at junior and senior levels of training, over three full day sessions per year of training.	N/A
Organisation	Initiative	Target population	Resources	Training	Publications
<u>College of Psychiatrists of Ireland</u>	<u>Sensible Living Optimizing Well Being Conference</u>	Psychiatrists	<u>Healthy Living – Tips for maintaining good mental health</u> <u>Why it's not always 'good to talk'...</u> <u>Policy on Bullying and Harassment</u>	<u>Hot Topics in Psychiatry Dublin (September 2019 – April 2020)</u> <u>Regional Academic Meeting "Mental Health & Well-Being amongst Medical Staff"</u>	<u>Paying the Price – The Physical, Mental and Psychological Impact of Caring</u>
Organisation	Initiative	Target population	Resources	Training	Publications
<u>Medical Protection Society</u>	Member supports	Doctors, Dentists and Health Professionals (300,000)	<u>Medical Protection Factsheets, Case reports</u> <u>Counselling Service</u>	<u>Workshops</u> <u>Online courses</u>	Medical Protection Publications (<u>Casebook</u> , <u>Practice Matters</u> , <u>New Doctor</u>);

Organisation	Initiative	Target population	Resources	Training	Publications
<u>Practitioner Health</u>	Practitioner Health Matters programme	Doctors, Dentists and Pharmacists	Access to a range of specialists in psychiatry, psychology, occupational health, career mentoring, life coaching, addiction counselling and financial advice Drug and alcohol testing	N/A	Annual Report 2018 Annual Report 2017 Media report from Irish Times
Organisation	Initiative	Target population	Resources	Training	Publications
<u>Medical Council</u>	Health Sub-Committee	Doctors with a medical disability	Online resources	N/A	Guide to the Health Committee Safe start guide Your Training Counts: Spotlight on health and wellbeing

Methodology

While contemporaneous research has explored the importance of the wellbeing of Irish trainee doctors to the health services, this report provides insight into the extent to which these issues are affecting the quality of care being offered to patients in Irish hospitals.

To ensure comparability and enable us to track changes in indicators, we replicated the previous methodology for YTC 2016 in the 2017 iteration of the survey. You can read more on our website about the original design and development of Your Training Counts in our consultation report and more about the first National Trainee Experience Survey in 2014.

The survey was hosted online (30th June 2017 to 30th November 2017) and interns and trainee specialists were sent reminders to participate across the survey window. A total of 759 doctors in training participated in 2017 (response rate = 24.5%). While this represents a low response rate, in line with that obtained in 2016, demographics of respondents and specialist trainees at retention 2017 broadly mirrored each other, as can be seen in tables 2 - 4 and figure 2 below.

Table 2. *Age of 2017 YTC participants and trainee specialists at retention 2017*

	Trainee specialists at retention 2017	Participants in YTC 2017
N	2373	751
Mean	31.71	31.21
Median	31.00	31.00
Std. Deviation	4.536	5.155
Minimum	24	23
Maximum	58	58

Figure 2. Age distribution of 2017 YTC participants and trainee specialists at retention 2017

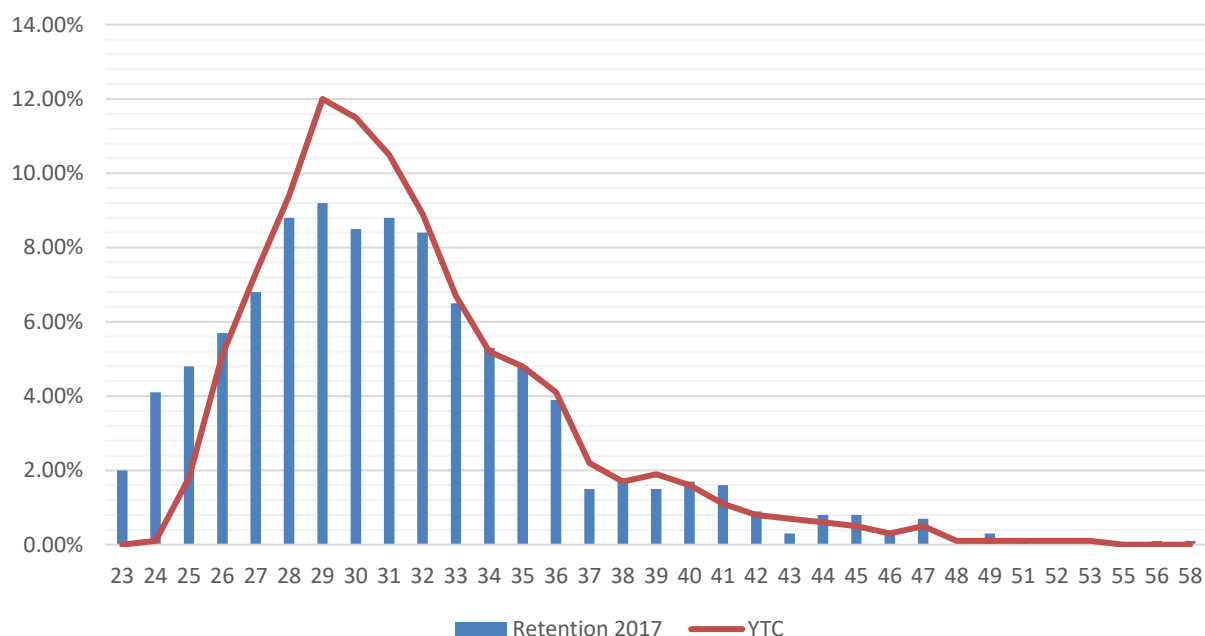


Table 3. Category of BMQ obtained by 2017 YTC participants and trainee specialists at retention 2017

BMQ category	At retention 2017	Percent	YTC 2017	Percent
Category 1. Graduates of Irish medical schools	1919	80.9%	609	81%
Category 2: Medical Practitioners who graduated in a medical school in the EU and are EU Nationals	200	8.4%	61	8.1%
Category 3. Graduated in a medical school in the EU (and they are not an EU National)	106	4.5%	30	4%
Category 4. International graduates from a medical school outside the EU and Ireland	148	6.2%	51	6.8%
Undeclared	0	0%	1	0.1%
Total	2373	100%	752	100%

Table 4. Gender of 2017 YTC participants and trainee specialists at retention 2017

BMQ category	Gender of trainee specialists at retention 2017	Percent	Gender of participants in YTC 2017	Percent
Female	1336	56.3%	437	58.0%
Male	1037	43.7%	316	42.0%
Total	2373	100%	753	100%

The Dutch Residency Educational Climate Test (D-RECT) (Boor, Van Der Vleuten, Teunissen, Scherpbier & Scheele, 2011), a valid and reliable tool for use in Ireland (Bennett, O' Flynn, O'Rourke & Hammond, 2014), was used to collect trainee experiences of clinical learning environments. D-RECT contains 50 questions which, when added together, provide a rating for clinical learning environments on a scale of 50 – 250 (with higher scores indicating higher quality learning environments). Following review, the Medical Council will be utilising an abridged, but valid and reliable, 35 item questionnaire (Silkens et al, 2016) in future iterations of Your Training Counts. For each attribute, trainee views are measured on a scale of 1-5 (with higher scores indicating better trainee experiences of that attribute of clinical learning environments). The results of the D-RECT measure are displayed in tables 2-5. The study invited trainee specialists to respond to 11 different questions about health and wellbeing: one item on self-rated general health and one item on quality of life, six items comprising the Short Depression-Happiness Scale to examine mental health and wellbeing, nine items on engagement with work using the Utrecht Work Engagement Scale, three items to examine utilisation of and experience with support services.

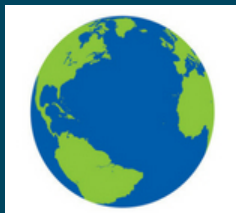
Analyses were performed using statistical software (SPSS version: IBM SPSS for Windows, V.25.0). Descriptive analyses were performed initially and these were supplemented by multiple regression analyses and ANOVAs (see Appendix). More information about the methodology we used to assess these data can be provided upon request.



YOUR TRAINING COUNTS 2017: RESULTS

**AN INVESTIGATION OF TRAINEE
WELLBEING AND THEIR EXPERIENCES OF
CLINICAL LEARNING ENVIRONMENTS IN
IRELAND 2017**

Respondent profile



BMQ Ireland: 81.1%
BMQ outside Ireland: 18.9%



Female: 58%
Male: 42%



Average age:
31.2 Years



Interns: 14.4%

Trainee Specialists: 71.2%

**Transferred to
General or
Specialist
Division: 14.6%**

Health good or better: 83.6%

Quality of life good or better: 70%



Health less than good: 16.4%



Quality of life less than good: 30%

D-RECT Scores

Respondent trainee specialists' scores attributed to their perceived quality of their clinical learning environments across subscales, stage of training and training body/network are described below in tables 2-5.

Table 5. Total D-RECT Scores by subscales

Subscales	N	Unreported	Minimum	Maximum	Std. Deviation	Mean
<i>Supervision</i>	747	12	1.00	5.00	0.87	3.76
<i>Coaching and assessment</i>	714	45	1.00	5.00	0.94	3.23
<i>Feedback</i>	725	34	1.00	5.00	1.14	2.79
<i>Teamwork</i>	739	20	1.50	4.75	0.48	3.49
<i>Peer Collaboration</i>	698	61	1.00	5.00	0.68	4.02
<i>Professional Relations</i>	705	54	1.00	5.00	0.95	3.29
<i>Work being adapted to trainee specialists' competence</i>	658	101	1.00	5.00	0.87	3.55
<i>Consultant Role</i>	728	31	1.00	5.00	0.77	3.85
<i>Formal Education</i>	748	11	1.00	5.00	0.87	3.67
<i>Role of Educational Supervisor</i>	646	113	1.17	5.00	0.88	3.36
<i>Role of patient handover</i>	633	126	1.00	5.00	0.89	3.41
<i>D-RECT total score: overall quality of clinical learning environment</i>	471	288	63	246	33.67	174.74

Table 6. Total D-RECT Scores by stage of training*

Training programme	N	Minimum	Maximum	Std. Deviation	Mean
<i>Intern Training Programme</i>	59	112	232	26.86	162.07
<i>Basic Specialist Training Programme</i>	153	93	246	36.23	170.82
<i>Higher Specialist Training Programme</i>	142	102	245	31.34	181.35
<i>Run-through (basic and higher) Specialist Training Programme</i>	45	112	245	30.91	177.22
<i>G.P. Training Programme</i>	66	63	246	35.68	179.61

**Registrar and “other” excluded due to low respondent levels

Table 7. Total D-RECT Scores Intern Training Network*

Intern Network	N	Minimum	Maximum	Std. Deviation	Mean D-RECT scores
<i>Dublin/ Mid-Leinster (University College Dublin)</i>	11	114	187	23.42	149.55
<i>Dublin/ Northeast (Royal College of Surgeons in Ireland)</i>	12	100	198	26.85	156.75
<i>South (University College Cork)</i>	18	117	225	25.32	165.28
<i>West/ Northwest (National University of Ireland, Galway)</i>	15	112	214	26.01	160.20
<i>Total</i>	58	113.83	207.83	28.7	159.11

*Intern Training Networks in Dublin/ Southeast (Trinity College Dublin) and Mid-West (University of Limerick) were excluded due to low respondent rates.

Table 8. Total D-RECT scores by Postgraduate Training body*

Training body	N	Minimum	Maximum	Std. Deviation	Mean
<i>Royal College of Surgeons in Ireland</i>	75	93	243	34.90	178.79
<i>The College of Anaesthesiologists of Ireland</i>	46	111	234	29.35	171.78
<i>The College of Psychiatry of Ireland</i>	42	101	246	33.51	200.10
<i>RCPI Faculty of Paediatrics</i>	34	102	231	30.1	170.06
<i>RCPI Institute of Obstetricians and Gynaecologists</i>	24	105	212	28.26	173.17
<i>The Irish College of General Practitioners</i>	66	63	246	35.92	178.91
<i>RCPI Irish Committee on Higher Medical Training</i>	67	105	235	31.77	171.19
<i>Other</i>	30	115	234	31.93	166.53

*RCPI Faculties of Occupational Medicine, Pathology and Public Health Medicine along with RCSI Faculty of Radiologists and The Irish College of Ophthalmologists excluded due to low respondent rates.

With an average D-RECT score across trainee specialists and interns of 174.74, it is particularly concerning that those in the first stage of training, interns, are scoring most poorly in their perceptions of their clinical learning environments (average= 159.11). This must be addressed to improve training quality and service retention concerns as a priority for this young pool of doctors and the future of the Irish health service.

A statistically significant difference was observed between Hospital groups and GP training sites as determined by one-way analysis of variance (ANOVA). Ireland East Hospital Group, RCSI Hospital Group and Saolta all reported D-RECT scores that were lower than those reported in GP sites in a manner that was statistically significant. Through an additional ANOVA, it was observed that Model 3 Hospitals and Model 4

Hospitals recorded D-RECT scores that were lower than those recorded in GP Practices as training sites, in a manner that was statistically significant. In addition, Mental Health Services recorded greater D-RECT Scores than Model 3 Hospitals and Model 4 Hospitals in a manner that was statistically significant (See Table 7, the Appendix).

It is encouraging that GP sites and Mental Health training sites scored more highly as quality clinical learning environments. Learning from good practice in these sites, potentially from the planned trainer survey, may provide further insights into this.

Working Time

- Over one third of respondents (33.5%) reported working more than sixty hours in a typical week. While this is lower than 2014, it means a significant number of trainees are working hours which far exceed the EWTD.
- A higher percentage 43.4% of those working in excess of 59 hours per week were involved in an adverse event than their counterparts who worked less than this (24.1%).

Working time

The provisions of the European Time Working Directive (EWTD, 2003/88/EC) in respect of doctors in training were transposed into Irish law by the way of Statutory Instrument in July 2004 (S.I. No. 494 of 2004). The Directive encompasses a number of measures to protect workers' welfare and safety. These include a maximum 48 hour working week. Over one third (33.5%) of YTC 2017 respondents reported working 60 hours or more in a typical week.

A key aggravating factor in occupational burnout is fatigue. Shanafelt et al., (2010) argued that while clear explanatory factors for medical errors 'remain to be uncovered' (p. 998), over 70% of surgeons in their study attributed an error to a personal level factor, such as fatigue, stress and burnout, rather than a system issue. This study concluded that efforts to reduce medical error needed to incorporate strategies aimed at reducing physician's degree of emotional distress and burnout. Jagsi et al., (2005) argued that one of the most common reasons for mistakes, as perceived by doctors themselves, was excessive work hours, and that subsequently, acute and chronic fatigue are relevant targets for quality improvement.

Figure 3. Hours worked per week

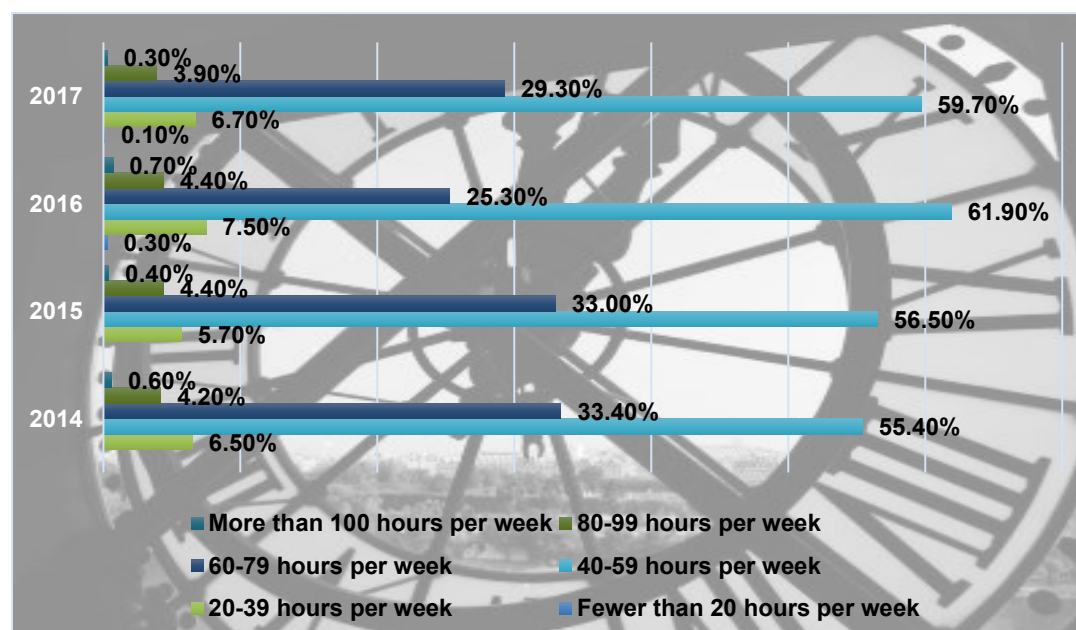
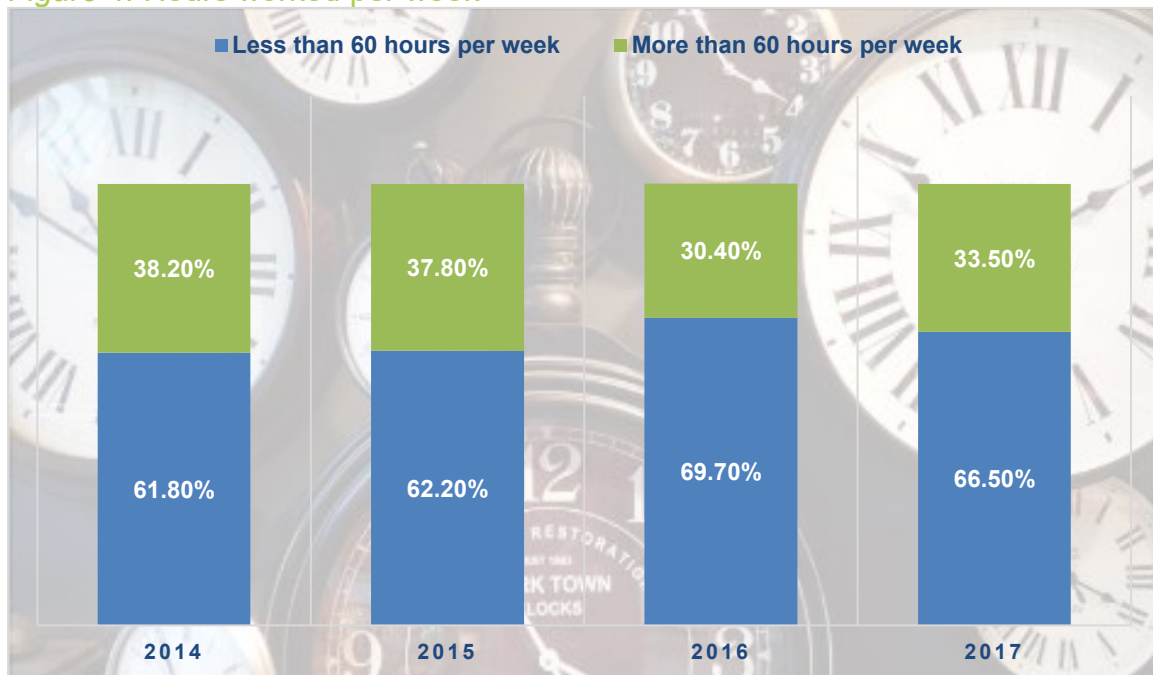


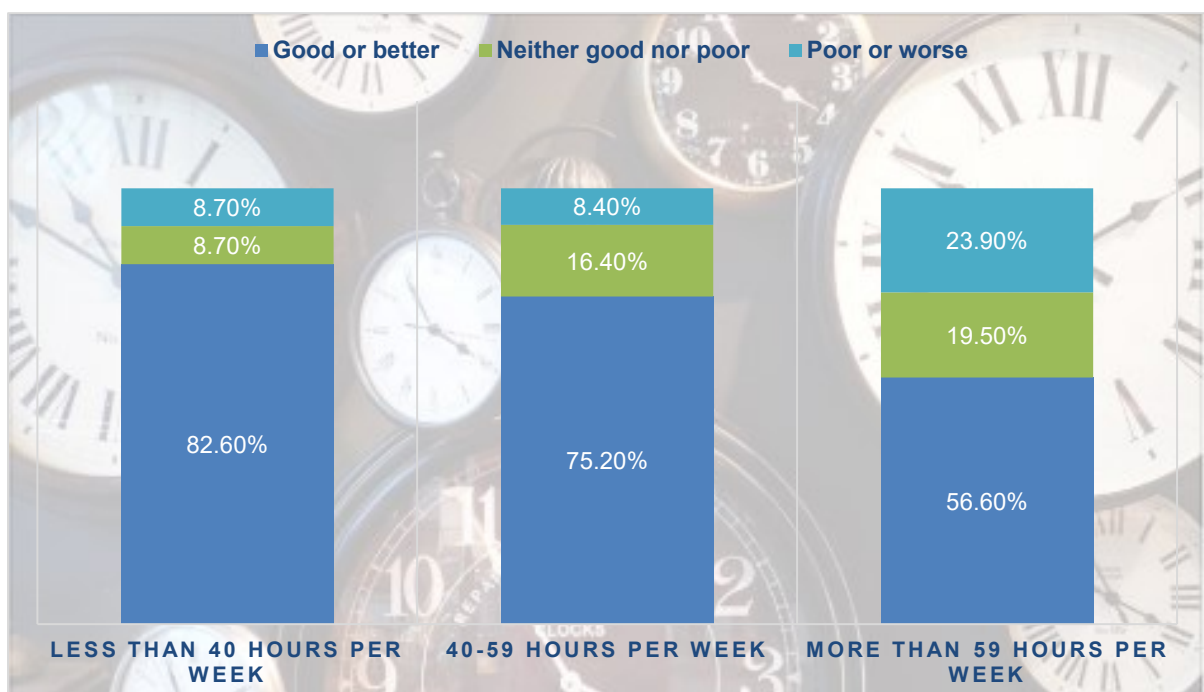
Figure 4. Hours worked per week



A good or better than good self-perceived quality of life was lowest among those who worked more than 59 hours per week, with over half (56.6%) of respondents reporting a quality of life that was good or better.

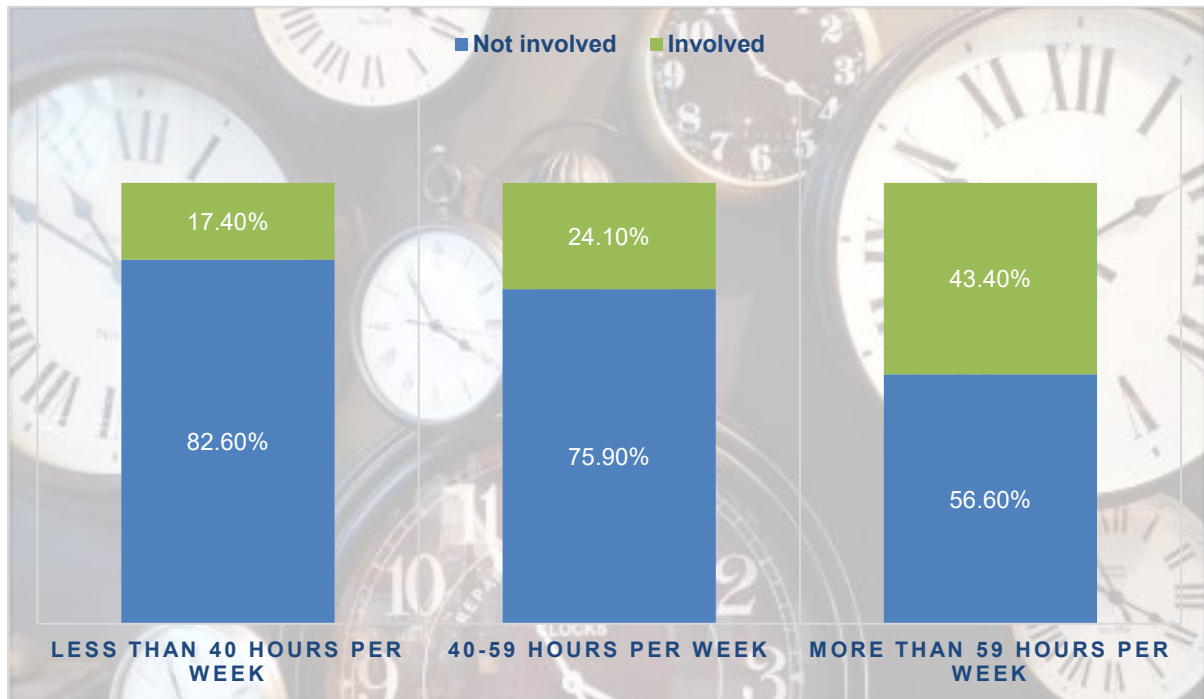
Contrastingly, a higher percentage of those who worked less than 40 hours per week reported a quality of life that was good or better (82.6%).

Figure 5. Hours/Quality of life



Nearly half (43.4%) of those working more than 59 hours a week had been directly or indirectly involved in an adverse event in the previous twelve months. In contrast, respondents who worked 40-59 hours a week, were involved in proportionately less adverse events (24.1%).

Figure 6. Hours/adverse event



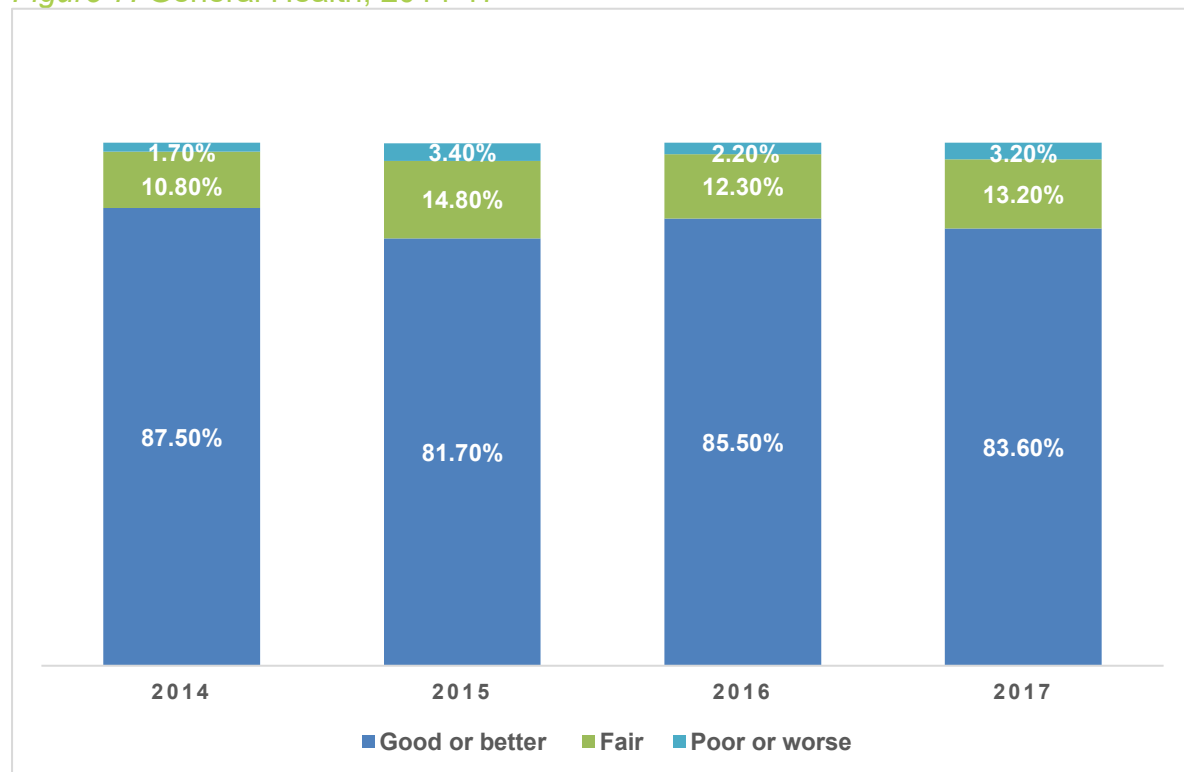
Self-rated Health

- Encouragingly, nine out of ten trainee specialists felt physically safe in the hospital environment, and this is a trend which has remained consistent since 2014.
 - 83.6% of trainee specialists enjoy good or better self-rated health
 - The percentage of trainee specialists reporting a quality of life that is good or better has risen by nearly 10% from 61.9% in 2014 to 70% in 2016 and 2017.
 - Respondents' SDHS score and their self-rated quality of life were significant predictors of self-rated general health.
 - Age, gender, SDHS score, self-rated health and hours worked per week were significant predictors of self-rated quality of life.
-

Self-rated general health

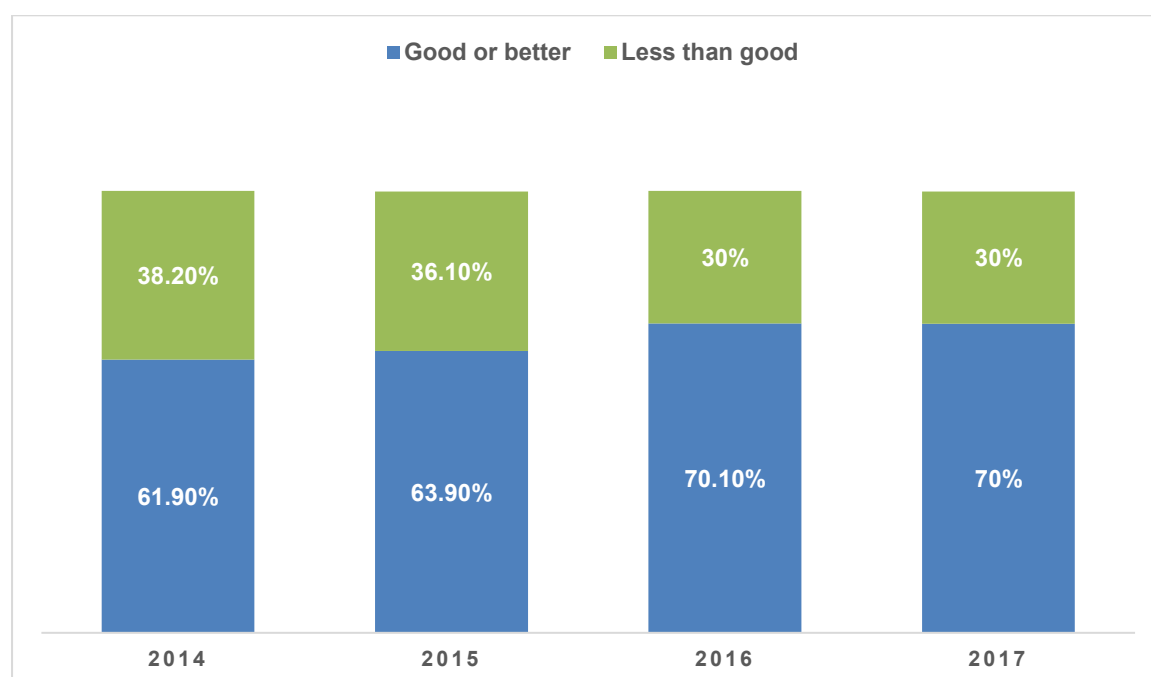
Since 2014, the number of trainee specialists reporting their health as good or better has fluctuated. The 2017 results (83.6% of trainee specialists enjoying good or better self-rated health) sit between a high of 87.5% in 2014, to a low of 81.7% in 2015.

Figure 7. General Health, 2014-17



Trainee specialists' perceived quality of life has risen during the same period. The percentage of trainee specialists reporting a quality of life that is good or better has risen by nearly 10% from 61.9% in 2014 to 70% in 2016 and 2017.

Figure 8. Quality of life, 2014-17



A higher percentage of males (32.3%) reported a quality of life that was less than good compared to their female counterparts (28.7%). Additionally, the closer an individual was to presenting with mental health status that might benefit from additional supports and the lower their self-rated general health, the greater their chances of reporting a lower quality of life.

Age, gender, SDHS score, self-rated general health and hours worked per week were significant predictors of self-rated quality of life. Older respondents were more likely to report a quality of life that was less than good, with 43.8% of those aged between 45 and 54 reporting health that was less than good.

A multiple regression analysis was conducted to observe whether respondents' age, gender, category, division, BMQ, SDHS score, self-rated quality of life, adverse event involvement, experience of bullying behaviour and hours worked per week were significant predictors of self-rated general health (see Table 2, in the Appendix).

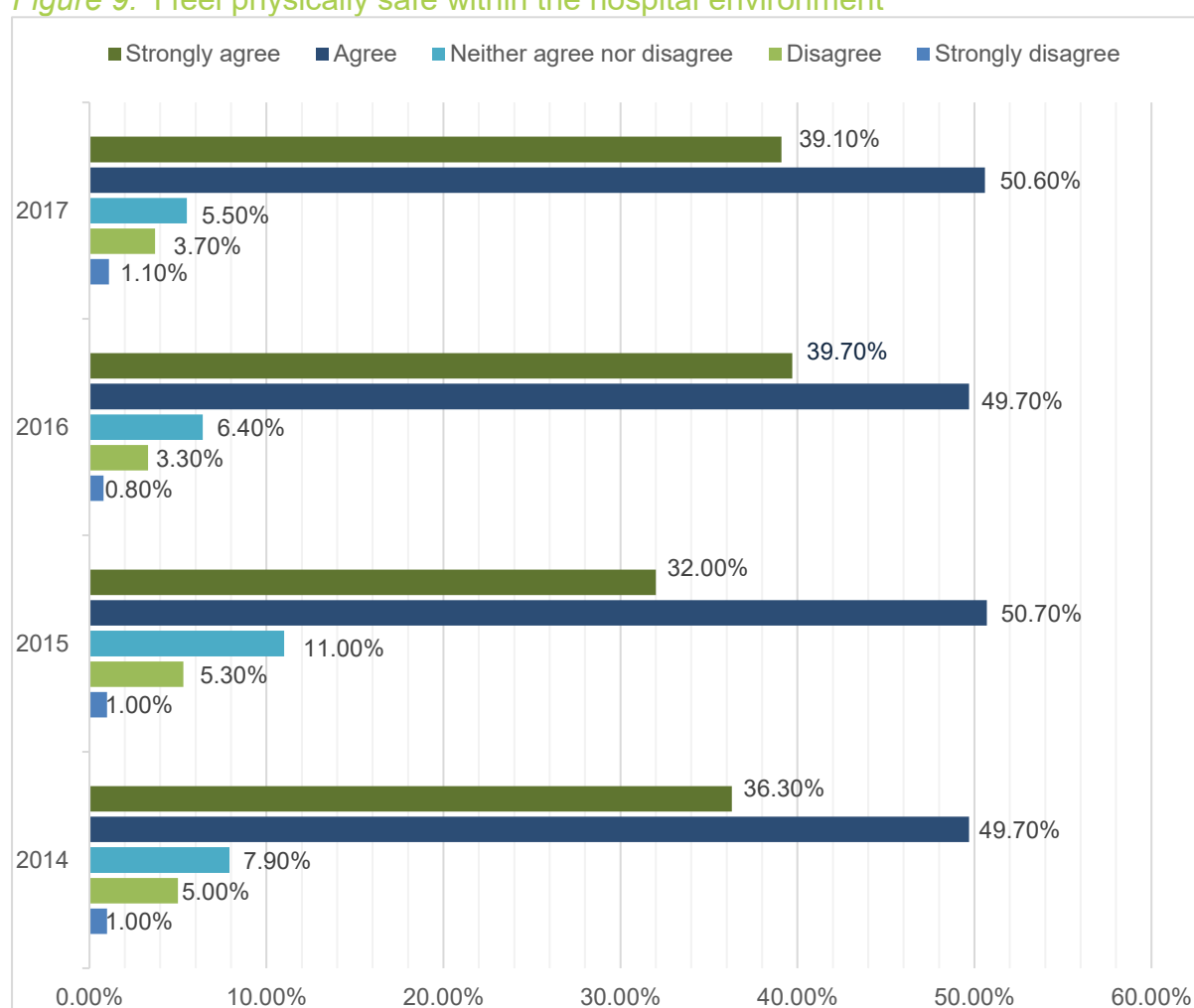
The results of this analysis were that a respondent's SDHS score and their self-rated quality of life were significant predictors of self-rated general health. This means that the closer an individual was to presenting with mental health status that might benefit

from additional supports, and the lower their self-perceived quality of life, the higher the chances were that they would report lower self-rated general health.

A further multiple regression analysis was conducted to observe whether respondents' age, gender, category, division, BMQ, SDHS score, self-rated general health, adverse event involvement, experience of bullying behaviour and hours worked per week were significant predictors of self-rated quality of life (see Table 3, in the Appendix). Age, gender, SDHS score, self-rated health and hours worked per week were significant predictors of self-rated quality of life.

Encouragingly, nine out of ten trainee specialists felt physically safe in the hospital environment, and this is a trend which has remained consistent since 2014.

Figure 9. 'I feel physically safe within the hospital environment'



Bullying

- The percentage of trainees who reported experiencing bullying has risen steadily since YTC began in 2014 (2014: 33.6%, 2017: 40.9%).
- Over two thirds (68.9%) of those who experienced bullying behaviour did not report the incident(s) to an authority figure.
- Over half (56.2%) of respondents had witnessed a colleague being the victim of bullying or harassment, while 2% of trainees reported witnessing such incidents on a daily basis.
- The percentage of trainees who reported witnessing others being bullied is also higher than when YTC began in 2014. (2014: 51.5%, 2017: 56.2%).
- Over half (52.4%) of respondents had experienced behaviour from a consultant that undermined their professional confidence or self-esteem.
- Younger respondents were more likely to report being bullied than their older counterparts. 67.4% of those under 25 reported experiencing bullying, while only 43.8% of 45-54 year olds reported experiencing the same.
- Self-rated general health was lower among those who had experienced bullying.
- Forty percent of respondents who were frequently bullied reported a quality of life that was less than good, with just under a quarter of these individuals (22.1%) reporting a quality of life that was poor or worse. Unsurprisingly, those who reported that they were never bullied had reported a significantly higher quality of life (79.9% good or better).
- Over forty per cent of respondents who were bullied were also involved in an adverse event, while for those who were not bullied, 18.5% were involved in an adverse event.

Bullying

Bullying may be defined as: 'persistent, offensive, abusive, intimidating, malicious or insulting behaviour, abuse of power or unfair penal sanctions, which makes the recipient feel upset, threatened, humiliated or vulnerable, which undermines their self-confidence and which may cause them to suffer stress' (Lyons, 1995). While the existence of bullying in health systems has long been known, its prevalence among trainee doctors in Ireland was first investigated in 2005, in a study undertaken by Cheema et al., (2005). This research found that 30% of the doctors surveyed had experienced bullying, with cases of juniors being physically abused, pushed around, verbally abused, ignored and being given a dressing down in front of other staff and patients by their consultants and senior staff on the team. While workplace bullying was framed as a major source of stress, breakdown and malfunction, it was also noted that most trainee specialists were afraid of reporting bullying due to a perceived negative impact on their future careers.

In a recent systematic review of workplace bullying internationally among junior doctors (Samsudin, Isahak & Rampal, 2018), a wide range (30–95%) of bullying prevalence was noted, based on 18 articles, reporting on a total of 9,597 junior doctors. There were significant differences in bullying rates according to gender, age, height, ethnicity and subspecialty, and significant associations between bullying and mental strain, job dissatisfaction, burnout, and increased accidents at work were observed.

The following questions regarding bullying were asked of trainee specialists in this survey:

- *How often, if at all, have you been the victim of bullying and harassment in this post?*
- *If you were bullied in post, what happened next?*
- *How often, if at all, have you witnessed someone else being the victim of bullying and harassment in this post?*

- *In this post, how often if at all, have you experienced behaviour from a consultant/GP that undermined your professional confidence and/or self-esteem?*

Figure 10. Frequency of bullying, 2017

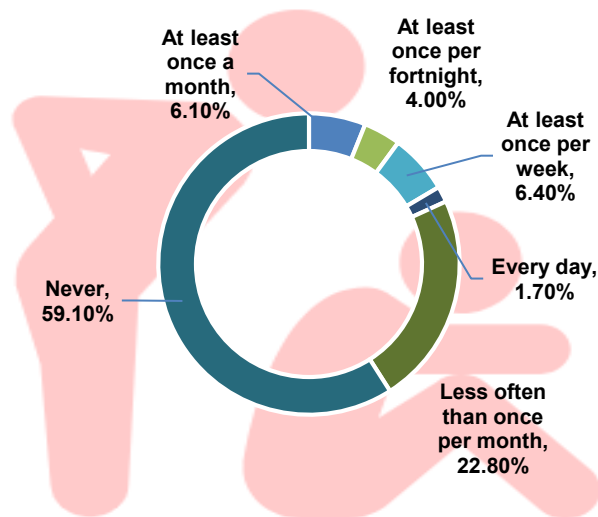
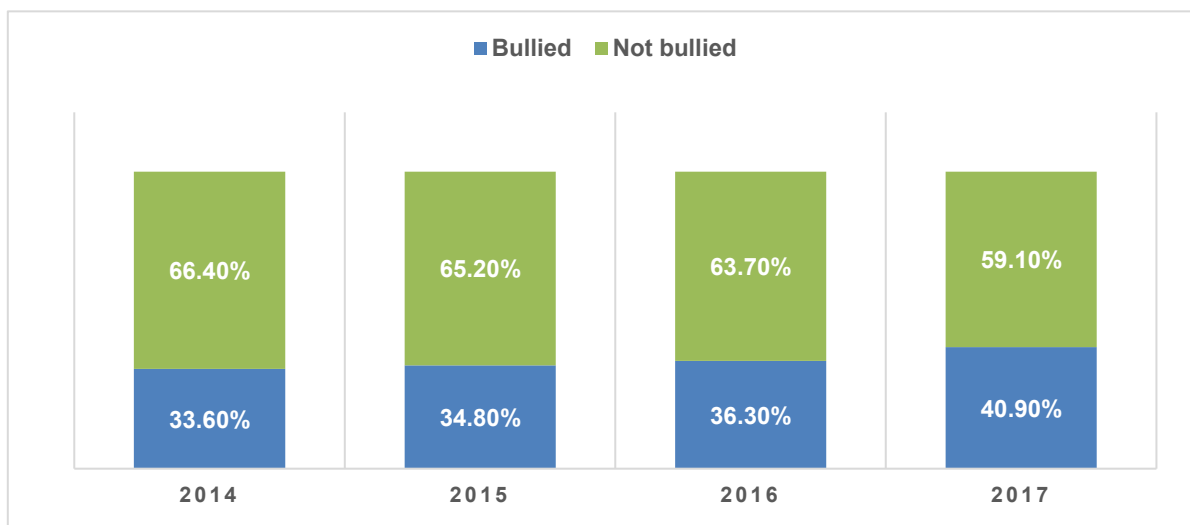


Figure 11. Prevalence of bullying, 2014-17



Over forty percent of respondents to YTC 2017 reported that they had experienced bullying and harassment in their post. Bullying and harassment were not specifically defined as terms, but were open to the interpretation shaped by personal experience of each trainee who responded.

Since YTC began in 2014, reported bullying among trainee respondents has increased by over six percent. Of note, there has been a reduction in participation rates in the study in this time also. This trend may indicate that the incidence of bullying is

increasing, that awareness and/or perception of bullying behaviour is training increasing or that participants who agree to complete the survey are more likely to experience or perceived bullying behaviour. These figures do, however, reflect experiences noted in published Medical Council [reports](#) into inspections of clinical training sites in the South/South West and Saolta hospital groups, which detailed allegations of bullying being observed by interns that went unchallenged by other members of a multidisciplinary team, and further allegations of bullying against a consultant. Actions recommended by accreditation teams included promotion of Dignity at Work, Occupational Health and counselling services and Open Disclosure and Protected Disclosure Policies amongst Interns and Multi-Disciplinary Teams, while it was also recommended that interns should be made aware of how to raise issues about colleagues' conduct and should be encouraged to do so ([South/South-West report 2018](#)). These reports also highlighted the ongoing nature of issues such as allegations of lack of respect shown to trainee specialists and lack of protected training time. Allegations were made on one site of signs displayed, explicitly stating 'No NCHDs'. The accreditation team in that instance recommended that any such signs were to be removed immediately ([Saolta Medical Council report 2018](#)). Strategies to address the issue of professionalism and, in particular, bullying and undermining behaviour, and respect for colleagues was recommended by another assessor team. These results speak to the continued need for wellbeing-focused strategies. There is a need for a reappraisal of current measures to curb bullying in the clinical learning environment.

In 2017, just under 70% (68.9%) of respondents who reported being bullied and harassed did not divulge the incident(s) to an authority figure. This low level of reporting has been a consistent feature since the question began to be asked in 2015. These figures align with previous research which has shown that Irish trainee specialists often display a reluctance to report bullying due to the perceived negative impact on their career progression (Cheema et al, 2005).

Figure 12. Management of bullying incidents

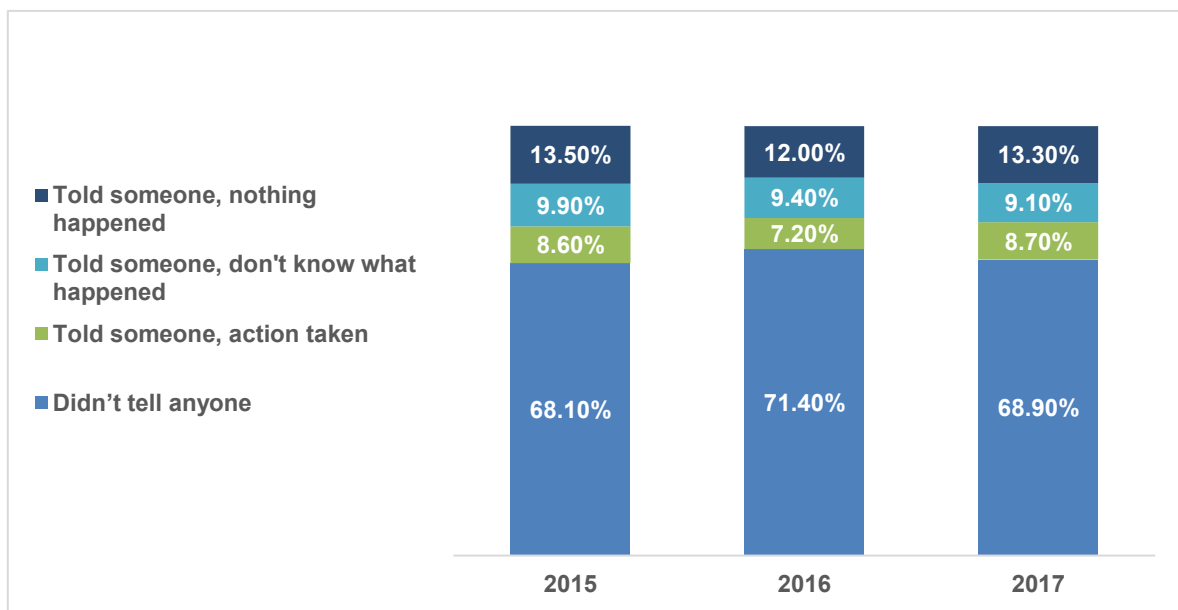


Figure 13. Action taken regarding bullying 2017

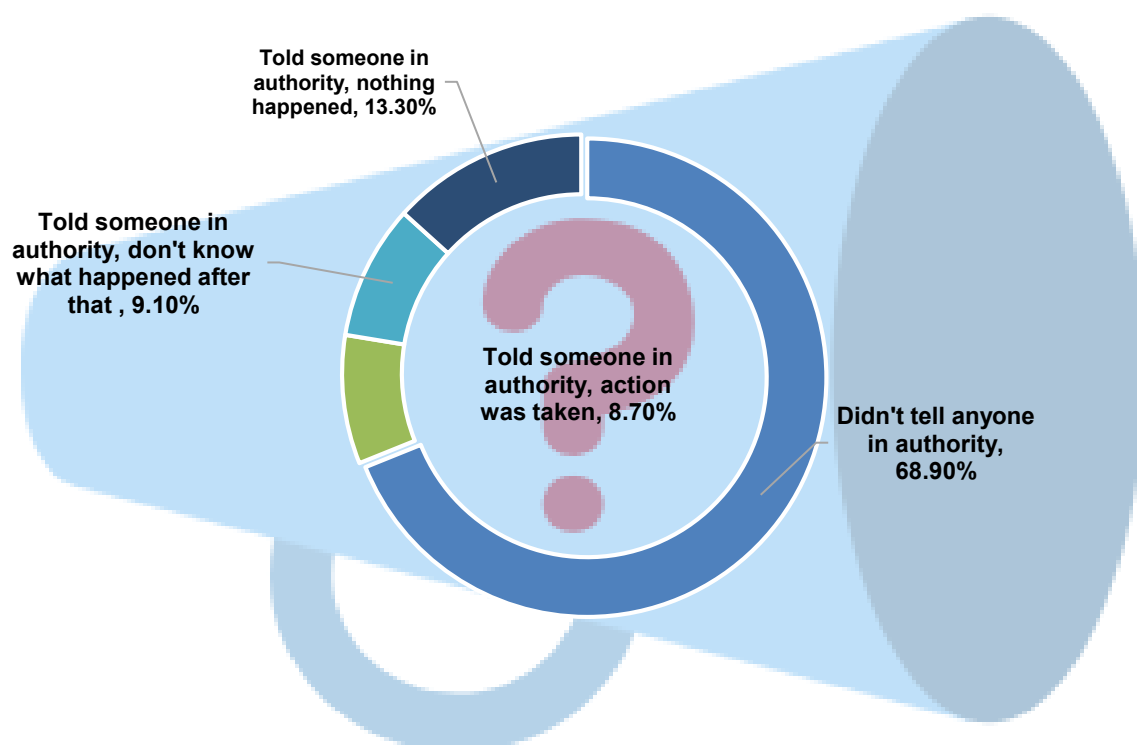


Figure 14. Witnessing others being bullied and/or harassed, 2017

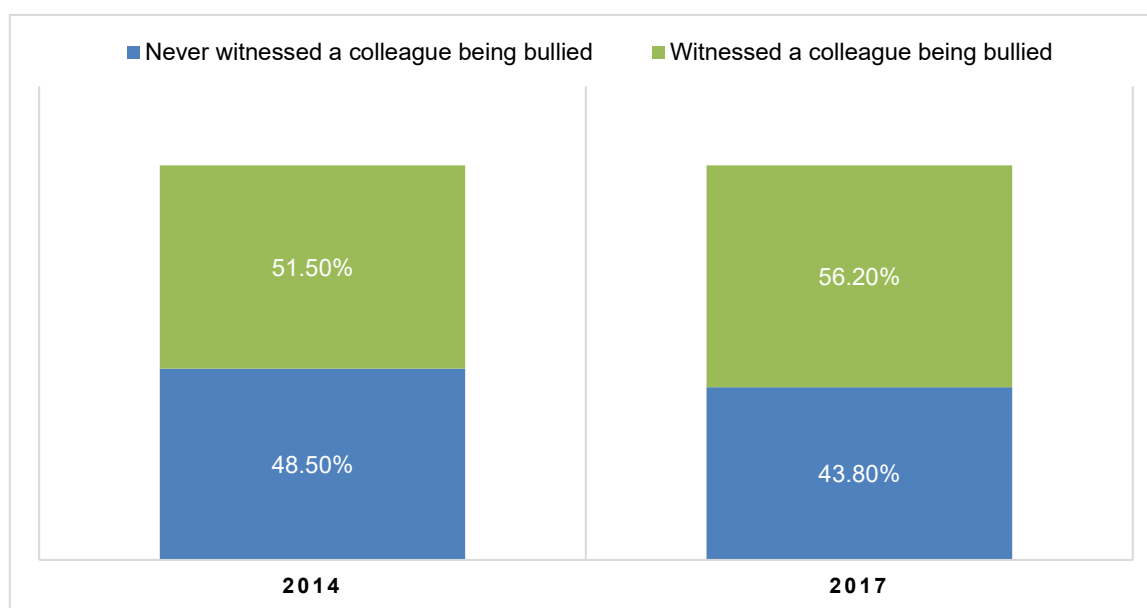
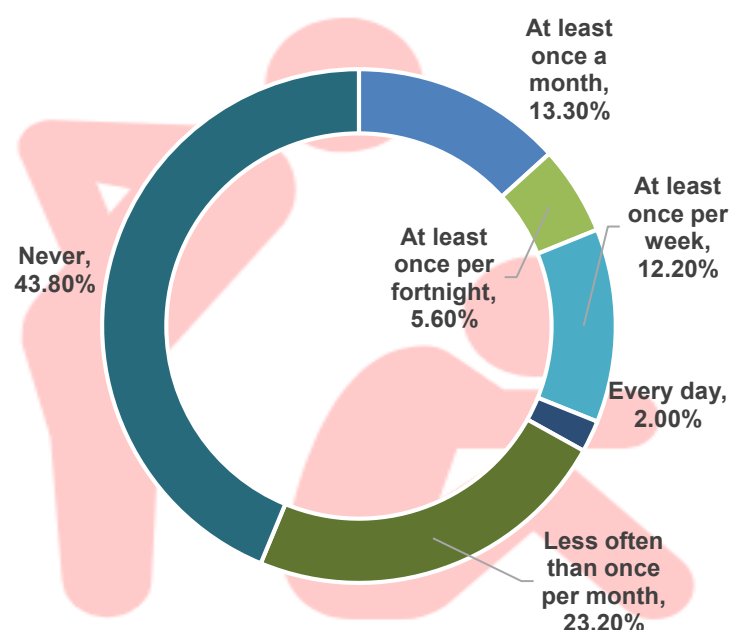


Figure 15. How often bullying was witnessed



Over half (56.2%) of respondents had witnessed a colleague being the victim of bullying or harassment, while 2% of trainee specialists reported witnessing such incidents on a daily basis. Doctors represented 58% of alleged perpetrators of bullying behaviour, while nurses and midwives represented just under one third of alleged bullying perpetrators (30%), as reported by respondents.

Figure 16. Alleged perpetrators of bullying behaviour

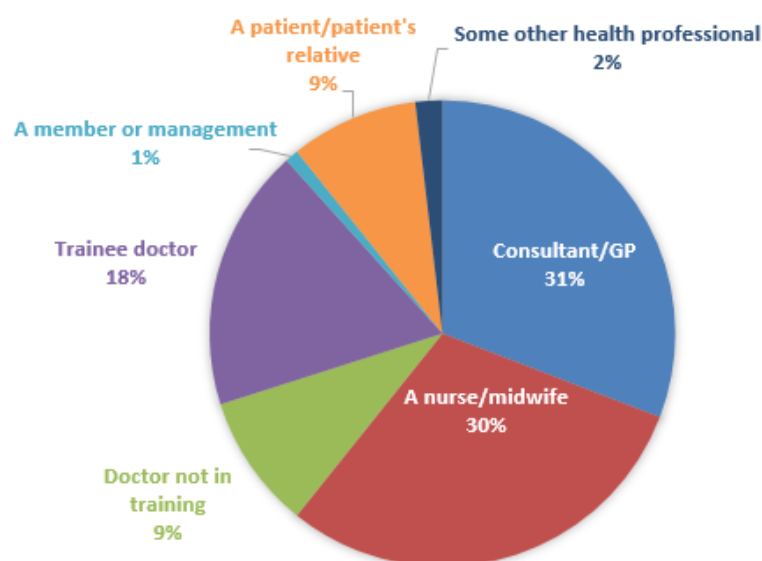


Table 9. How often, if at all, have you experienced behaviour from a consultant/GP that undermined your professional confidence and/or self-esteem? (2017)

Never	47.6%
Less often than once per month	29.2%
At least once a month	8.5%
At least once per fortnight	3.9%
At least once per week	4.8%
Every day	2.1%
Prefer not to answer	2.9%

Just under half (48.5%) of trainee respondents to YTC 2017 reported experiencing undermining behaviour from a consultant or GP.

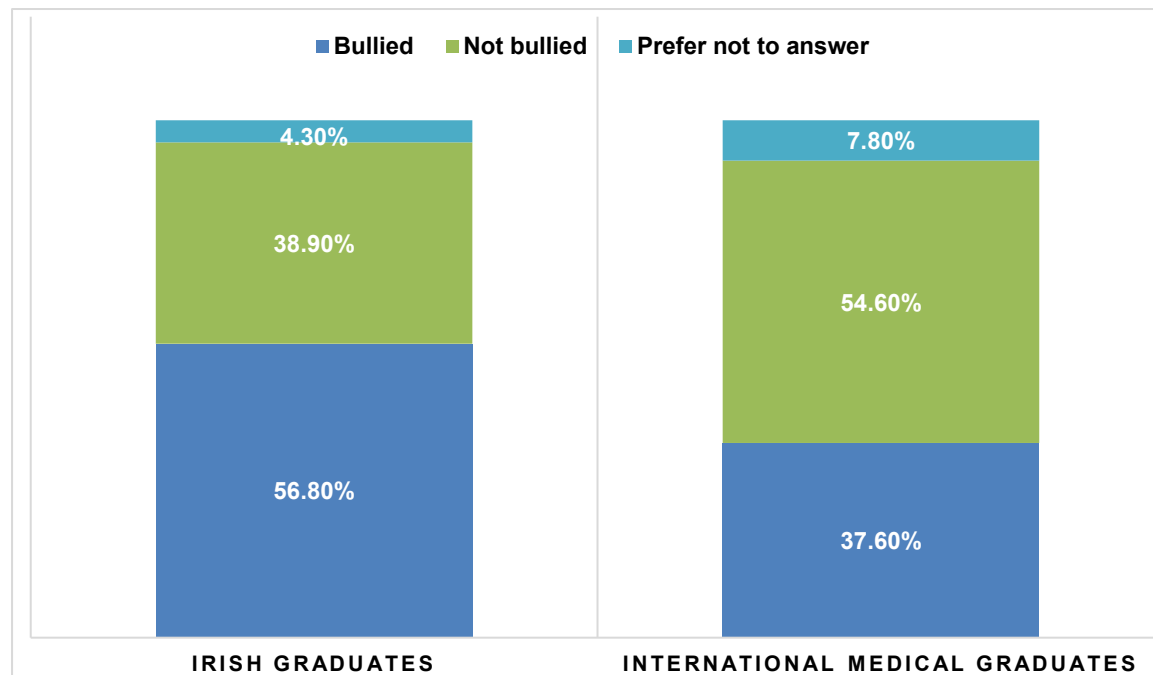
In addition, 19.3% reported that being undermined by a consultant or GP was something that occurred on a monthly or more regular basis. These figures support the recent findings of Medical Council clinical training site reports which indicated the existence of bullying behaviour by consultants.

Crowe, Clarke and Brugh, (2017), concluded that respect for hierarchy, intimidation, disillusion, anger and fear, were key themes in trainee specialists' narratives of

relationships with senior staff who oversaw their postgraduate training in the Irish health system.

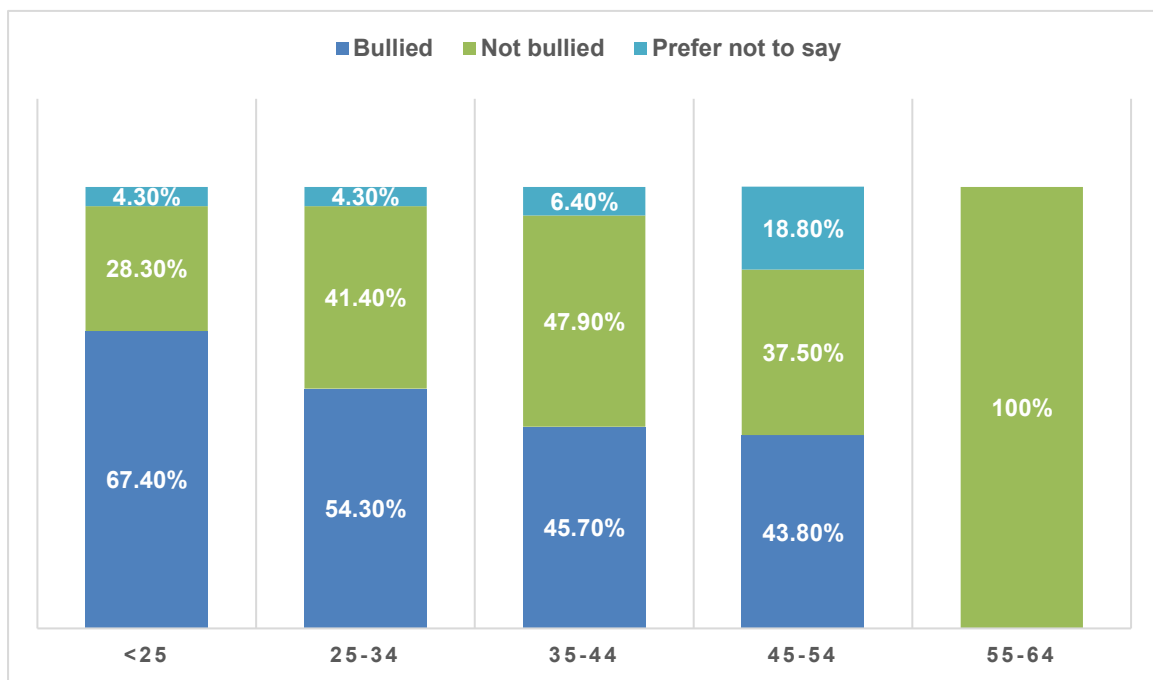
Of consultants, one participant remarked that: *“you do not cross them [consultants] because if you cross them that’s the end of your employment opportunities in Ireland”* (Crowe et al., 2017, p. 73).

Figure 17. BMQ and bullying



From Figure 17, it can be seen that a higher percentage of Irish graduates (56.8%) reported being bullied than their internationally educated counterparts (37.6%). However, it must be acknowledged that 81.1% of respondents had an Irish BMQ, compared to 18.9% of respondents having an international BMQ.

Figure 18. Age and bullying



From Figure 18, it can be observed that younger respondents were more likely to report being bullied than their older counterparts. For example, 67.4% of those under 25 reported experiencing bullying, compared to 43.8% of 45-54 year olds who reported experiencing the same.

A higher percentage (15.7%) of those who had experienced bullying reported their own health as being less than good, compared to 10.3% of those who had never been bullied as can be seen in Figure 19.

Figure 19. Bullying and health

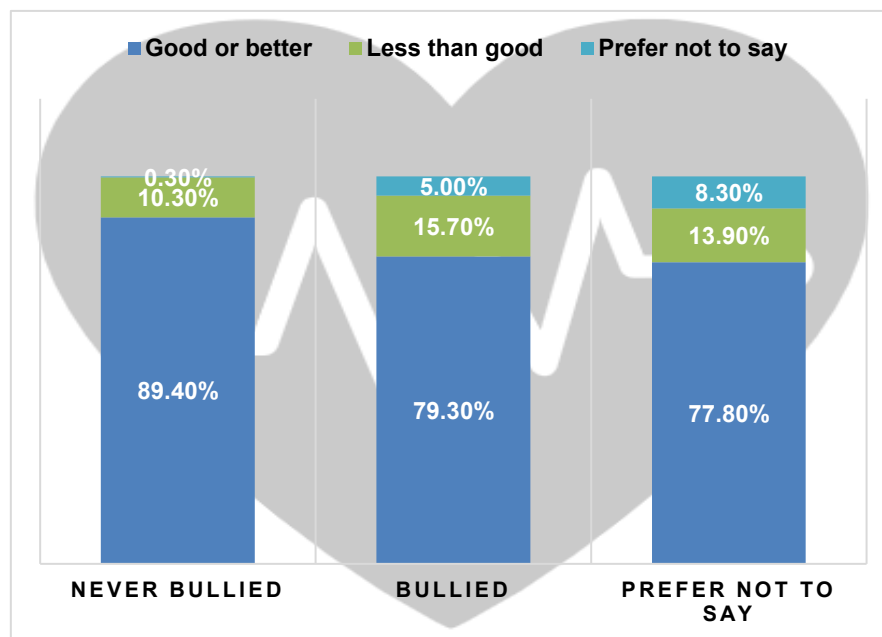
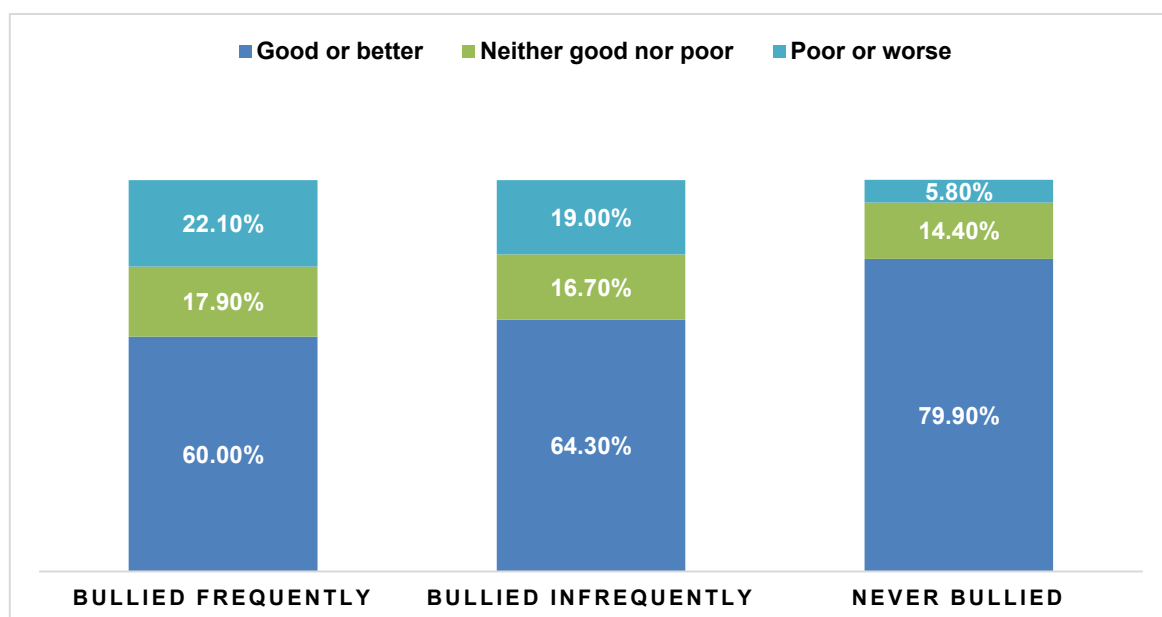


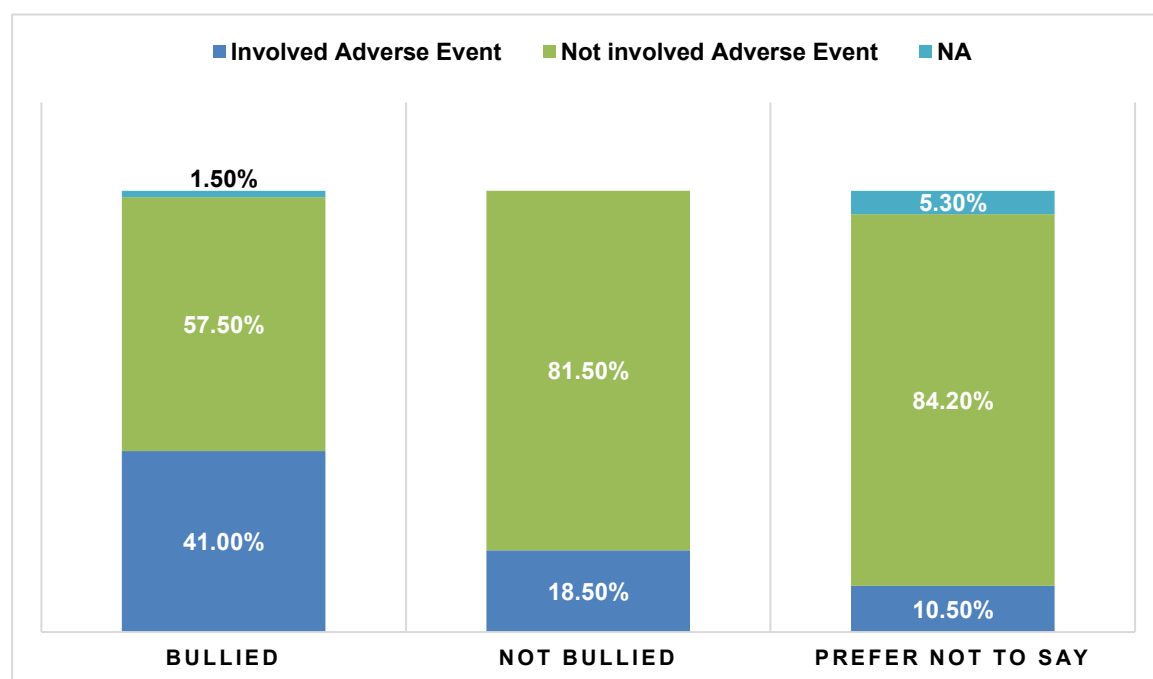
Figure 20. Bullying and quality of life



Bullying and quality of life data is presented in Figure 20. Forty percent of respondents who were frequently bullied reported a quality of life that was less than good, with just under a quarter of these individuals (22.1%) reporting a quality of life that was poor or worse. Those who reported that they were never bullied had reported a significantly higher quality of life (79.9% good or better).

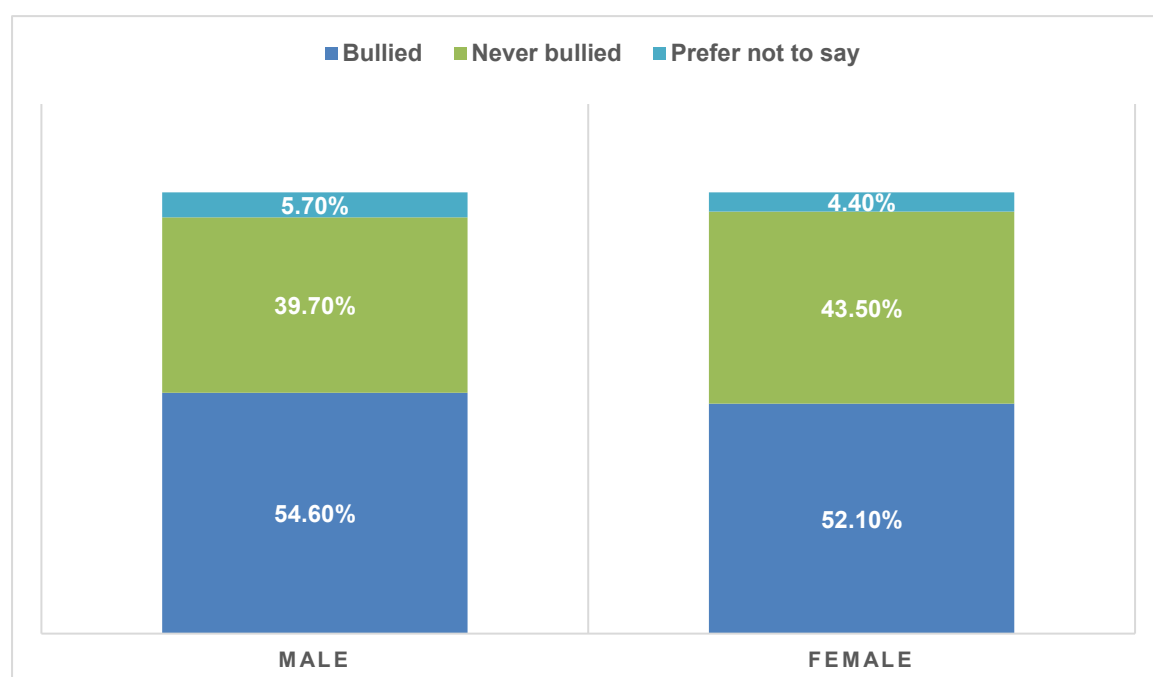
As is displayed in Figure 21, over forty per cent of respondents (41%) who were bullied were also involved in an adverse event while 18.5% of those who were not bullied were involved in an adverse event.

Figure 21. Bullying and Adverse events



As is evident from Figure 22, there were no significant gender differences in relation to those who reported being bullied.

Figure 22. Bullying and gender



Ireland East Hospital Group, RCSI Hospital Groups, Dublin Mid, South/South West, Saolta and the Children's Hospital reported greater incidences of bullying than in GP training sites (See Table 8, the Appendix). The data revealed that GPs reported instances of bullying (17.7%) significantly lower than the other Hospital Groups. In addition, GPs reported the highest instance of never being bullied (74.2%). The highest instances of bullying were reported at the Children's Hospitals (67.7%).

Trainee GPs did not report frequent bullying at all and 17.7% reported infrequent bullying. Of those bullied at the Children's Hospitals 12.9% reported frequent bullying and 54.8% reported infrequent bullying (See Table 9, the Appendix).

Mental Health

- Overall, Short Depression-Happiness Scale (SDHS) ratings show that the majority of trainee specialists (76.9%) enjoy good mental wellbeing. The mean Short Depression Happiness Scale score among trainee specialists was 12.13 (SD= 2.93).
 - 37.5% of those in the 45-54 age category had a score on the SDHS indicating that additional supports may be beneficial.
 - Just under half (47.8%) of respondents whose score on the SDHS indicated the presence of a mental health issue which may benefit from additional support were involved in an adverse event in the previous twelve months.
 - Self-rated quality of life and self-rated general health were significant predictors of a score on the SDHS which indicated the presence of a mental health issue that may require additional support.
-

Mental Health

We invited trainee specialists to rate their mental health and wellbeing using the Short Depression-Happiness Scale (SDHS), a rapid assessment screening tool of mental health and wellbeing which provides a score on a scale of 0-18.

Higher scores indicate better mental health and wellbeing. Conversely, low scores indicate poorer mental health and wellbeing that may fall within a range that would benefit from additional wellbeing supports.

The instrument is a valid and reliable screening measure of mental health and wellbeing but is not designed to diagnose mental health problems. However, a score of 9 or less (i.e. midpoint on the scale or lower) helps distinguish respondents whose mental health and wellbeing may be causing them some difficulty and for whom some support might be helpful.

Overall, SDHS ratings show that the majority of trainee specialists (76.9%) enjoy good mental wellbeing. The mean SDHS score among trainee specialists was 12.13 (SD= 2.93) as presented in Figure 23.

Figure 23. Distribution of SDHS scores 2017

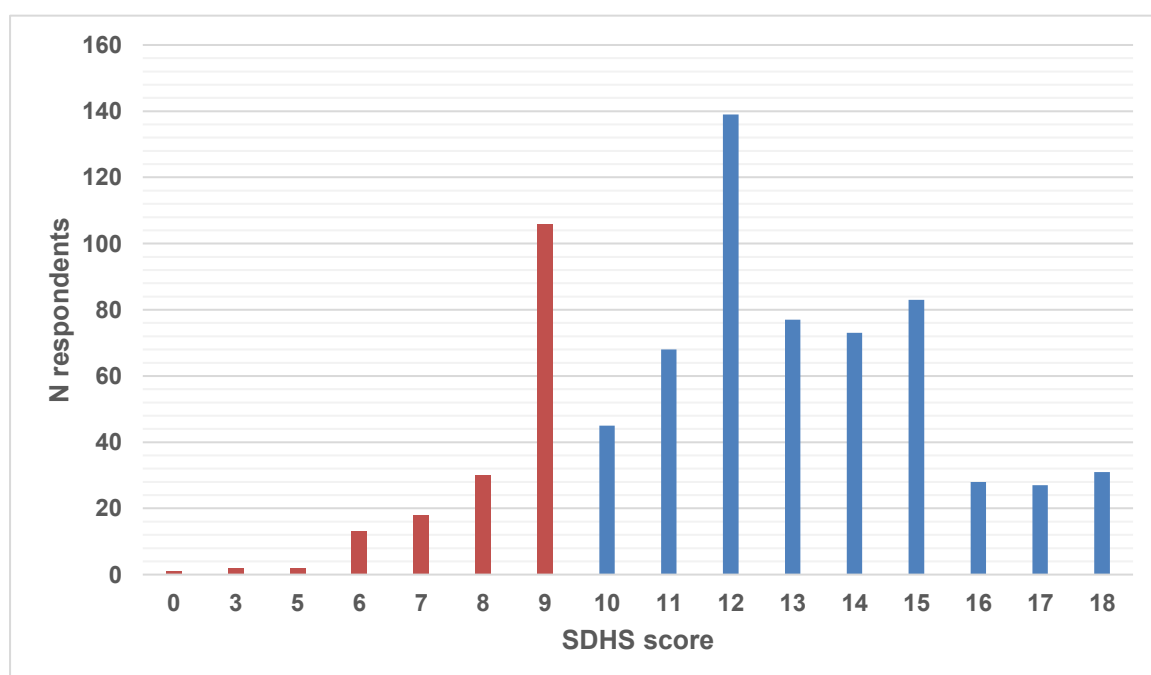
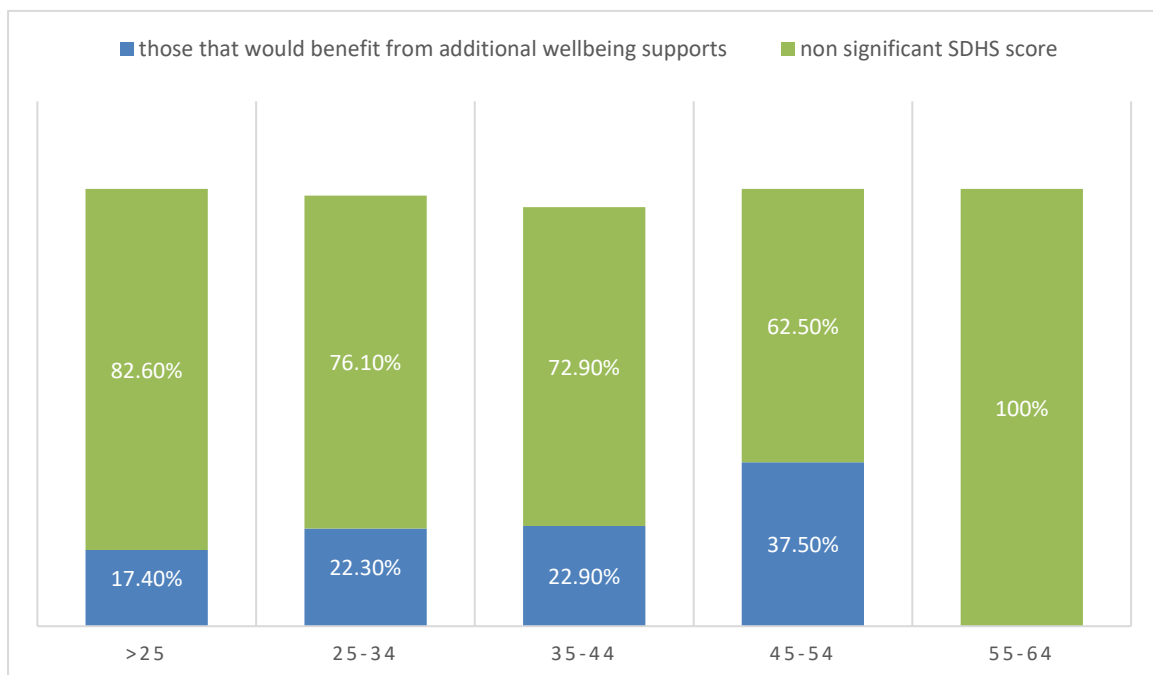


Figure 24. Age and SDHS scores



As presented in Figure 24, 37.5% of those in the 45-54 age category had a score on the Short Depression Happiness Scale indicating that additional supports may be beneficial.

Figure 25. SDHS/Adverse event

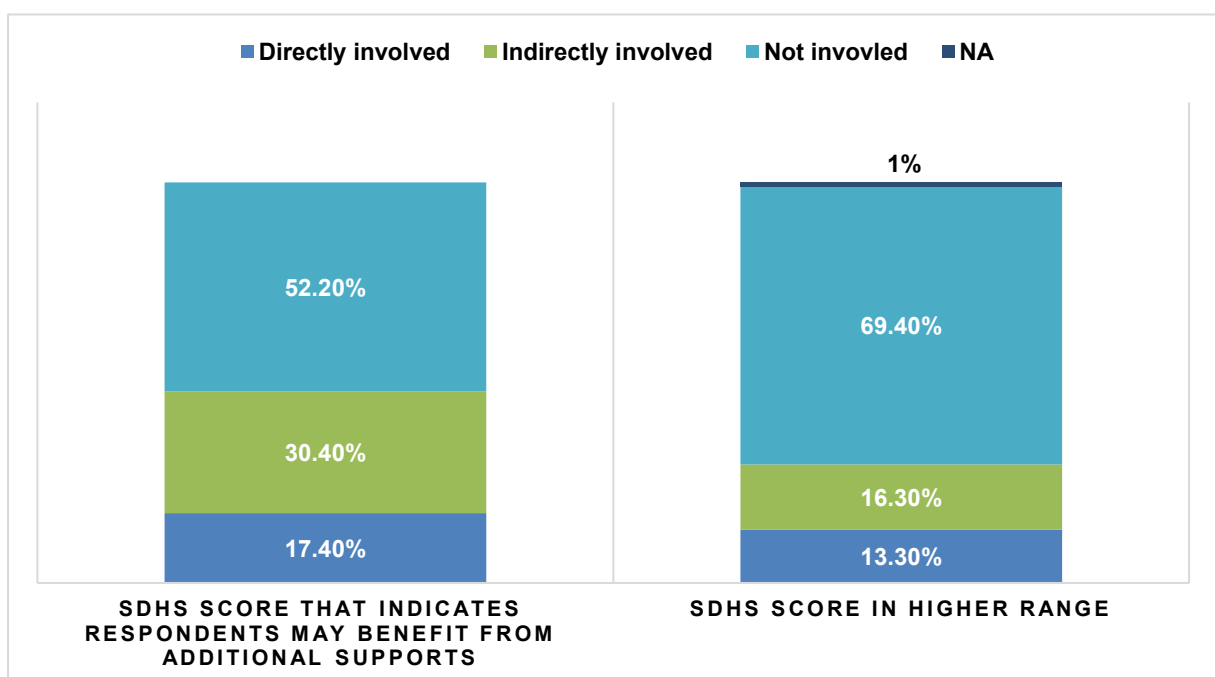
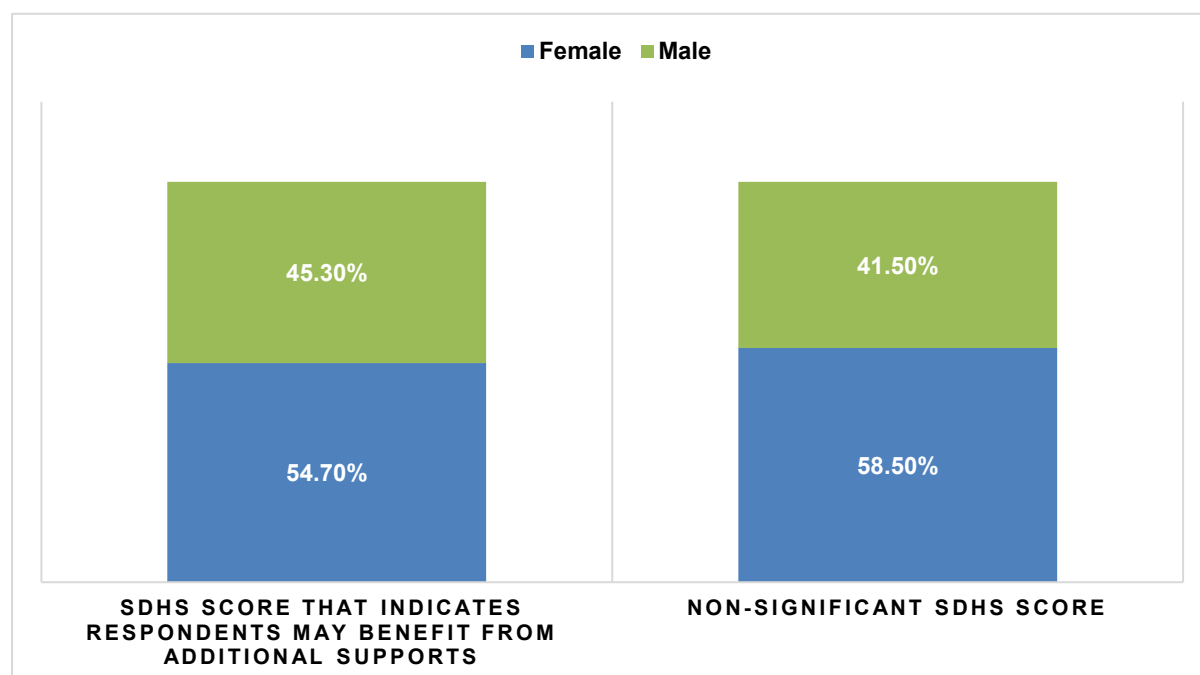


Figure 25 displays that just under half (47.8%) of respondents whose score on the Short Depression Happiness Scale indicated the presence of a mental health issue which may benefit from additional support were involved in an adverse event in the previous twelve months.

Figure 26. SDHS/Gender



As can be observed in Figure 26, over half (54.7%) of those whose score on the Short Depression Happiness Scale (SDHS) indicated the presence of a mental health issue which may require additional support were female. However, this is in line with the majority (57.3%) of respondents to this question being female.

A third multiple regression analysis was conducted to observe SDHS score as predicted by age, gender, category, division, BMQ, involvement in adverse events, self-rated quality of life, self-rated general health, experience with bullying and hours worked per week (see Table 4, in the Appendix).

It was observed that self-rated quality of life and self-rated general health were significant predictors of a score on the Short Depression Happiness Scale which indicated the presence of a mental health issue that may require additional support.

Adverse Events

- Just under one-third (30.4%) of respondents were involved in an adverse event in the twelve months prior to answering the YTC survey.
- 59% of those involved in an adverse event considered their family and friends as the main source of support in the aftermath.
- Gender, SDHS score, bullying frequency and hours worked per week were significant predictors of adverse events.

Adverse Events

Under the provisions of the Medical Practitioners Act 2007, the Medical Council is responsible 'for protecting the public by promoting and better ensuring high standards of professional conduct and professional education, training and competence among doctors'.

Complaints and investigations when adverse events occur are part of the checks and balances that should ensure appropriate oversight of a doctor's performance, with the overall aim being to protect patients and maintain appropriate clinical standards. These adverse events are defined as an injury that was caused by medical management which prolonged the hospitalisation of the patient or produced a disability at the time of discharge (Brennan et al., 1991).

However, perceived involvement in a medical error or adverse event can have significant personal consequences for the doctors' involved. These adverse events are defined as an injury that was caused by medical management which prolonged the hospitalisation of the patient or produced a disability at the time of discharge (Brennan et al., 1991). Previous research has shown that doctors' wellbeing can influence the likelihood of adverse events occurring, a doctor's ability to successfully navigate proceedings if an event does occur, and the likelihood of being involved in a future adverse event.

While the YTC survey has revealed the extent of trainee specialists' involvement in adverse events in recent years, other Irish medical bodies are equally interested in better understanding the impact of such events on patients and patient safety.

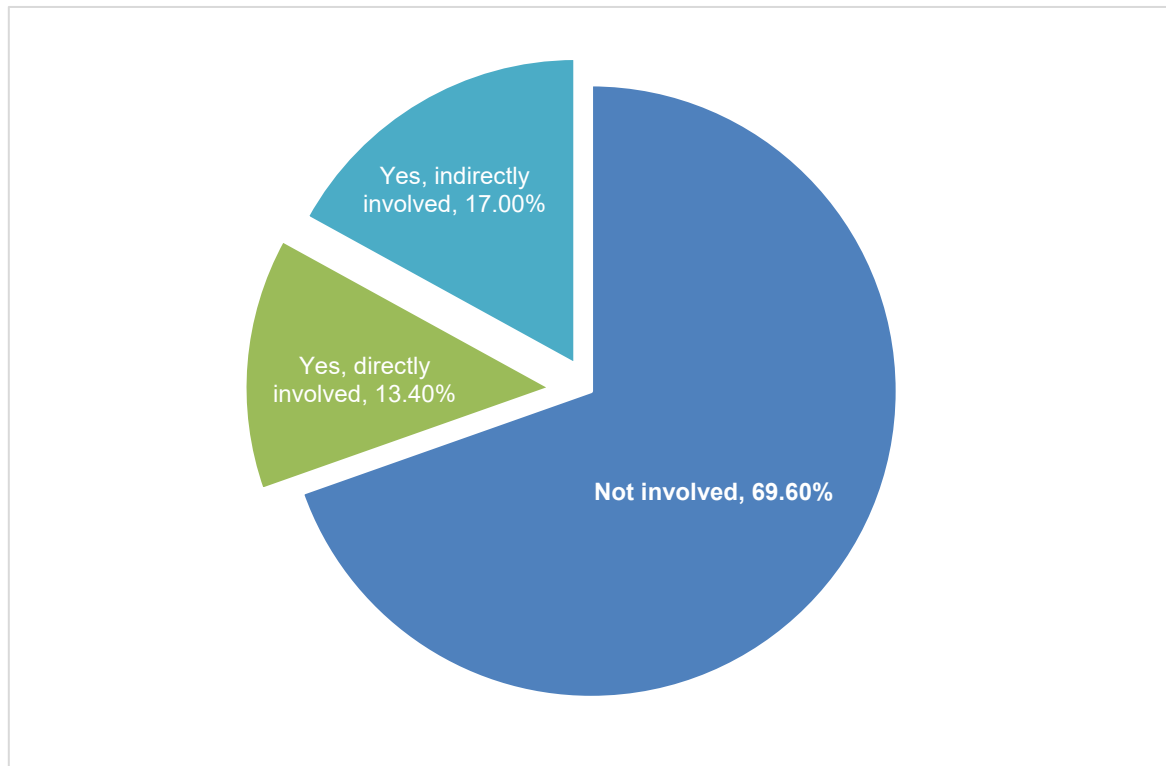
A joint RCPI/RCSI 'Irish National Adverse Events Study', published in February 2016, used patient case notes to assess the prevalence and nature of adverse events experienced by patients in Irish acute hospitals. Rafter et al (2017) have also investigated the frequency and nature of adverse events in Irish hospitals. This large-scale retrospective chart review national study shows broad consistency in the frequency and nature of adverse events, leading to the conclusion that 'patient-safety

experts should question why, after 30 years, there has been so little evidence of overall improvement' (Rafter et al., 2017, p. 118). While this study provides insight into the incidence of adverse events in Irish medicine, little is known about the impact of these proceedings on the wellbeing of doctors involved.

A number of recent studies have suggested a correlation between burnout among doctors and adverse events. Shanafelt et al. (2010) have argued that while clear explanatory factors for medical errors 'remain to be uncovered', over 70% of surgeons in their study attributed an error to a personal level factor rather than a system issue. These factors included stress, burnout and fatigue. This study concluded that efforts to reduce medical error should incorporate strategies aimed at reducing physicians' degree of emotional distress and burnout.

Jagsi et al., (2005) have argued that one of the most common reasons for mistakes, as perceived by doctors themselves, was excessive work hours and subsequent acute and chronic fatigue, which may be relevant targets for quality improvement.

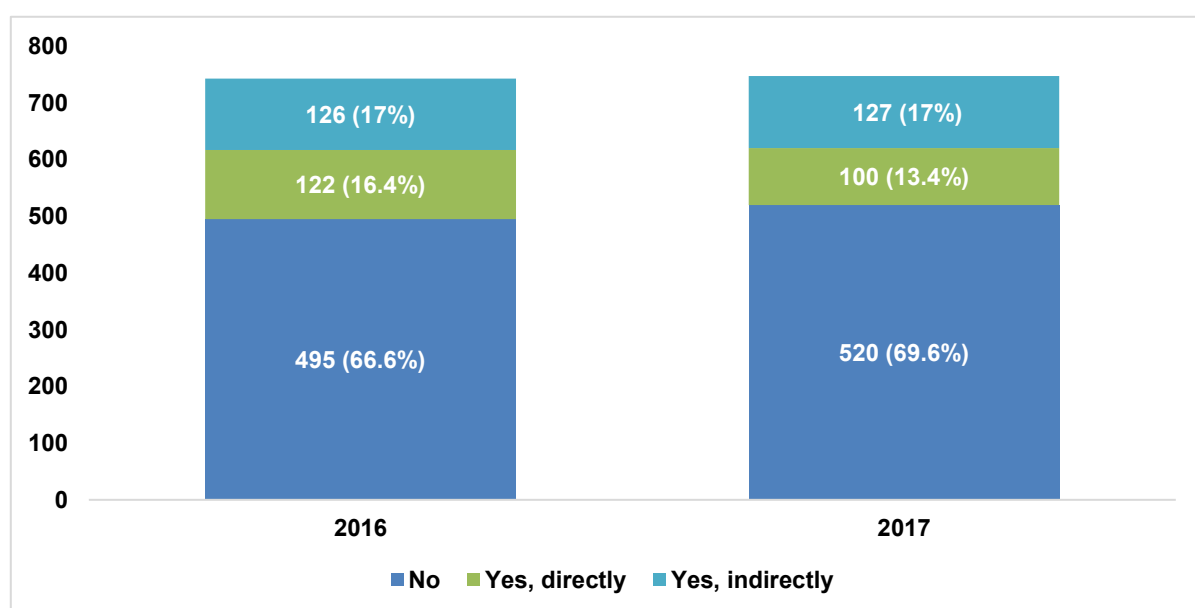
Figure 27. Involvement in adverse events, 2017



In 2017, over thirty percent (30.4%) of YTC respondents were involved in an adverse event in the previous twelve months, either directly or indirectly. Encouragingly, the

percentage of respondents reporting being involved in adverse events in 2017 was 3% lower than the previous year, while the percentage of respondents who reported direct involvement in adverse events was also down 3%.

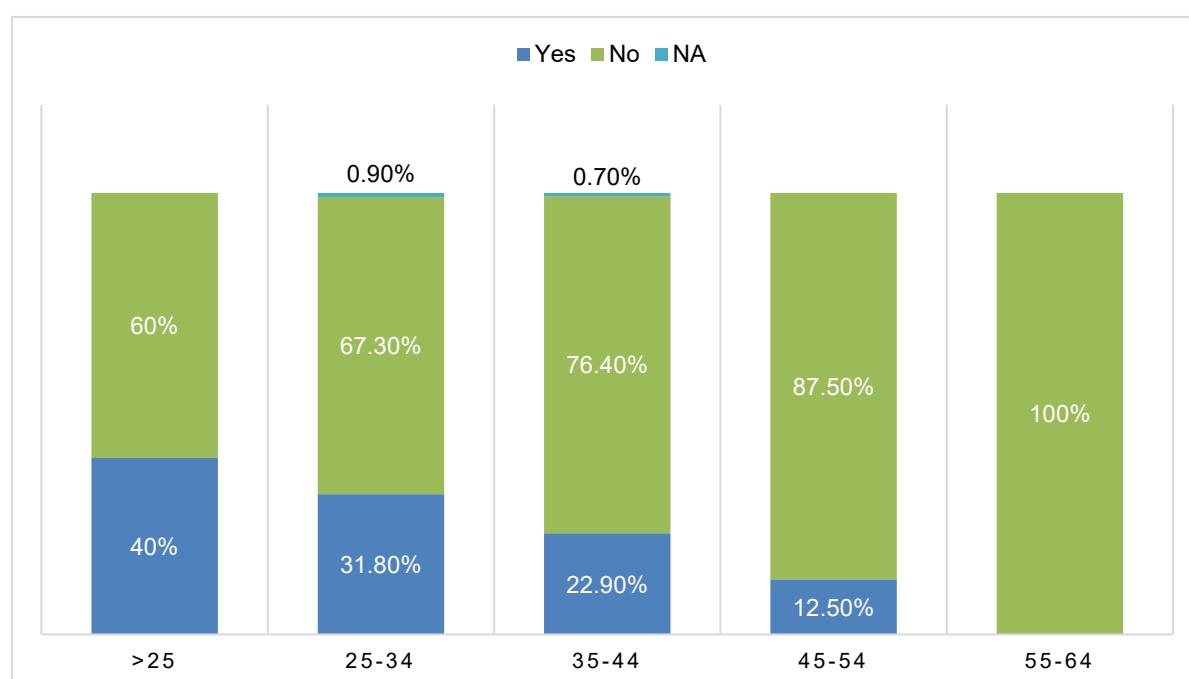
Figure 28. Involvement in adverse events 2016 and 2017



A multiple regression analysis was conducted to observe whether respondent's age, gender, category, division, BMQ, SDHS score, self-rated quality of life, self-rated general health, frequency with which they experienced bullying behaviour and hours worked per week were significant predictors of involvement in adverse events (see Table 5 in the Appendix). It was observed that gender, the frequency with which a trainee experienced bullying behaviour and hours worked per week were significant predictors of being involved in adverse events.

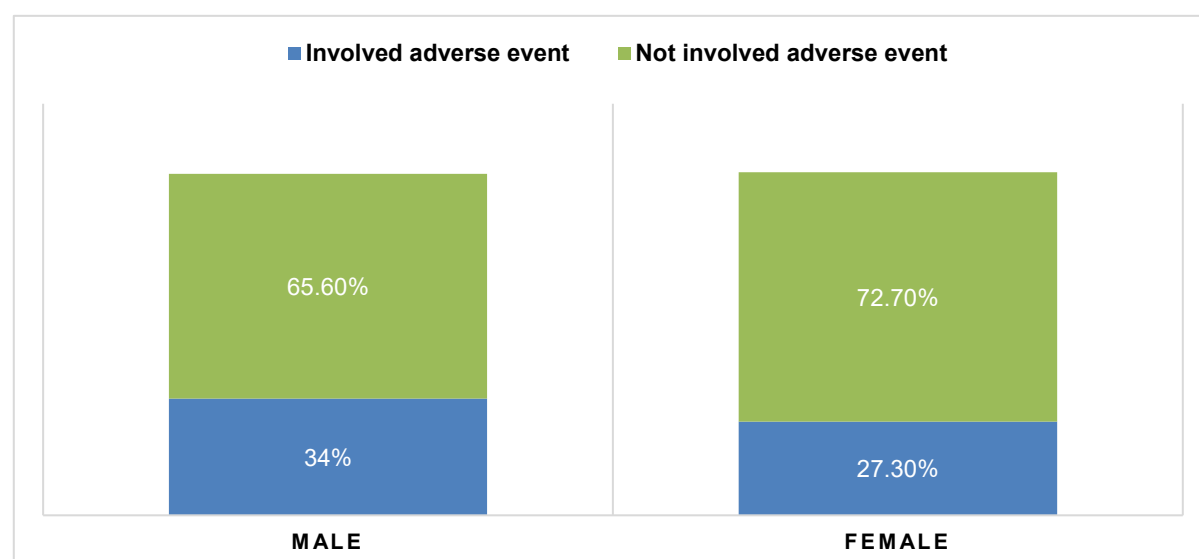
Younger trainee specialists were significantly more likely to be involved in an adverse event. Forty percent of respondents under 25 had been involved either directly or indirectly in an adverse event in the previous 12 months, while in the 45-54 age group, this figure was just 12.5%.

Figure 29. Age and adverse events



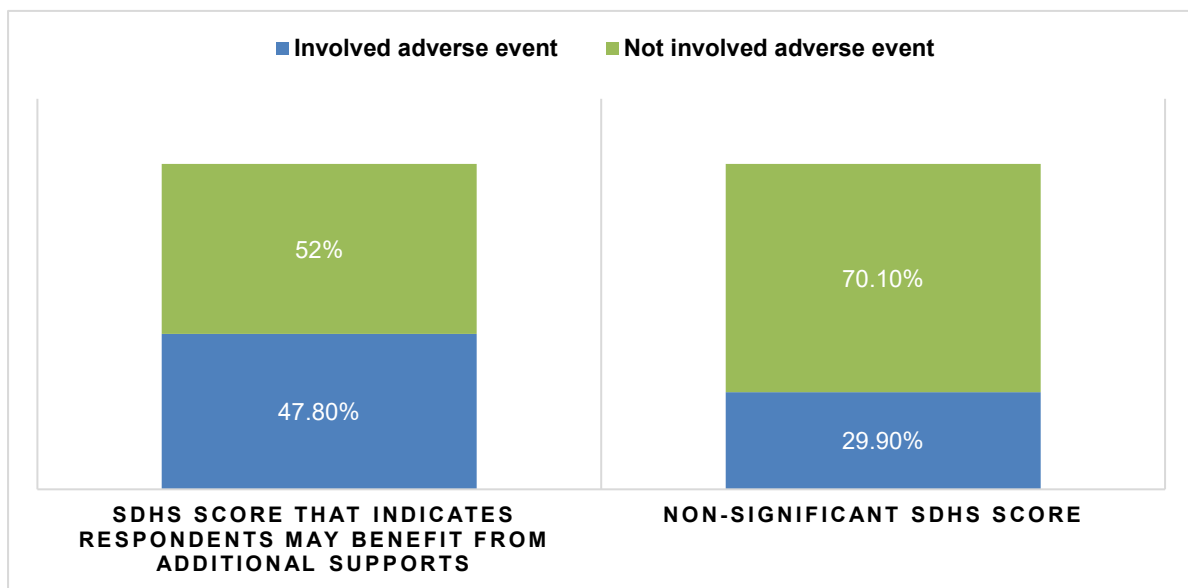
A higher percentage of male respondents (34.4%) were involved in an adverse event than their female counterparts (27.3%).

Figure 30. Adverse events and gender 2017



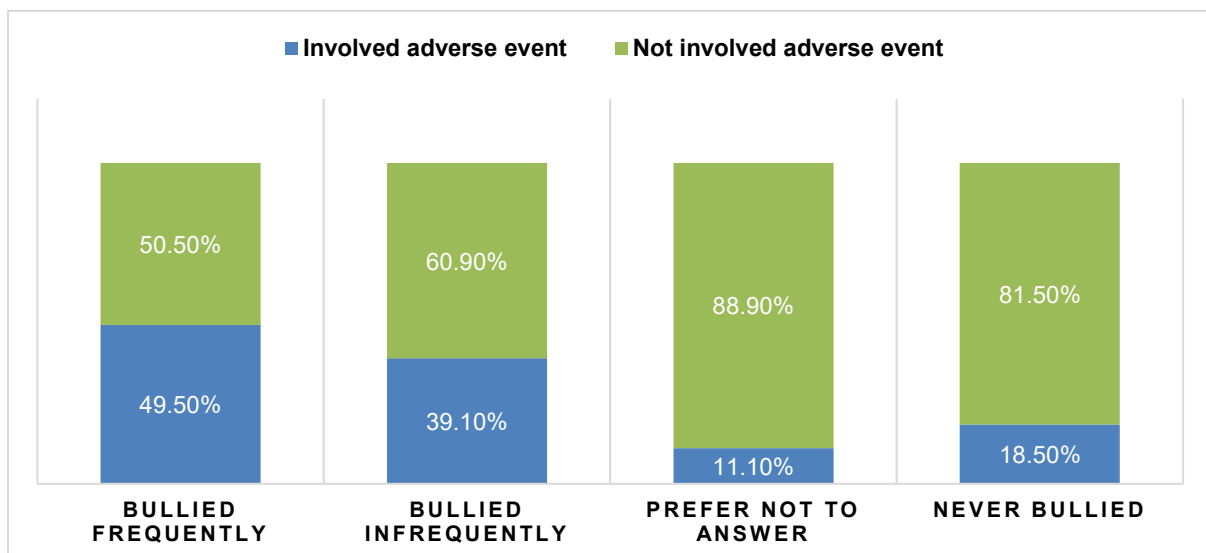
Just under half (47.8%) of respondents who had an SDHS score suggesting a mental health status that may benefit from additional supports were involved in an adverse event; for those who did not meet this score threshold, 29.9% were involved in an adverse event.

Figure 31. Adverse events and SDHS 2017



Those who reported being bullied were more likely to be involved in adverse event than those who were not bullied.

Figure 32. Adverse events and bullying frequency 2017



Those in GP Practice training reported significantly lower instances of bullying than the other models of hospitals. The data revealed 14.9% of those in GP practice reported being bullied, while 78.7% reported never being bullied. The highest instances of bullying were recorded at the Children's Hospitals (67.7%) (See Table 10, the Appendix).

As regards frequency of bullying per model of Hospital, the data revealed that 0% of those in GP Practice reported frequent bullying, with 14.9% reporting infrequent bullying. Of those who reported bullying in the Children's Hospitals, 12.9% reported frequent bullying and 54.8% reported infrequent bullying (See Table 11, the Appendix).

Those who worked longer hours were also more likely to have been involved in an adverse event than those who worked less hours.

Figure 33. Adverse events and hours worked 2017

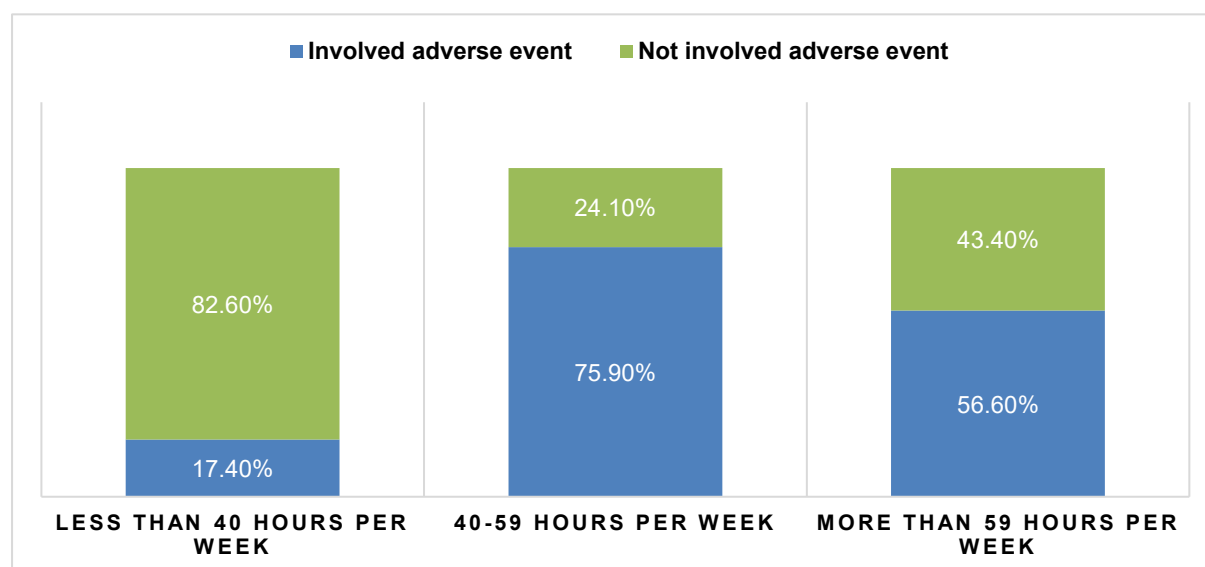
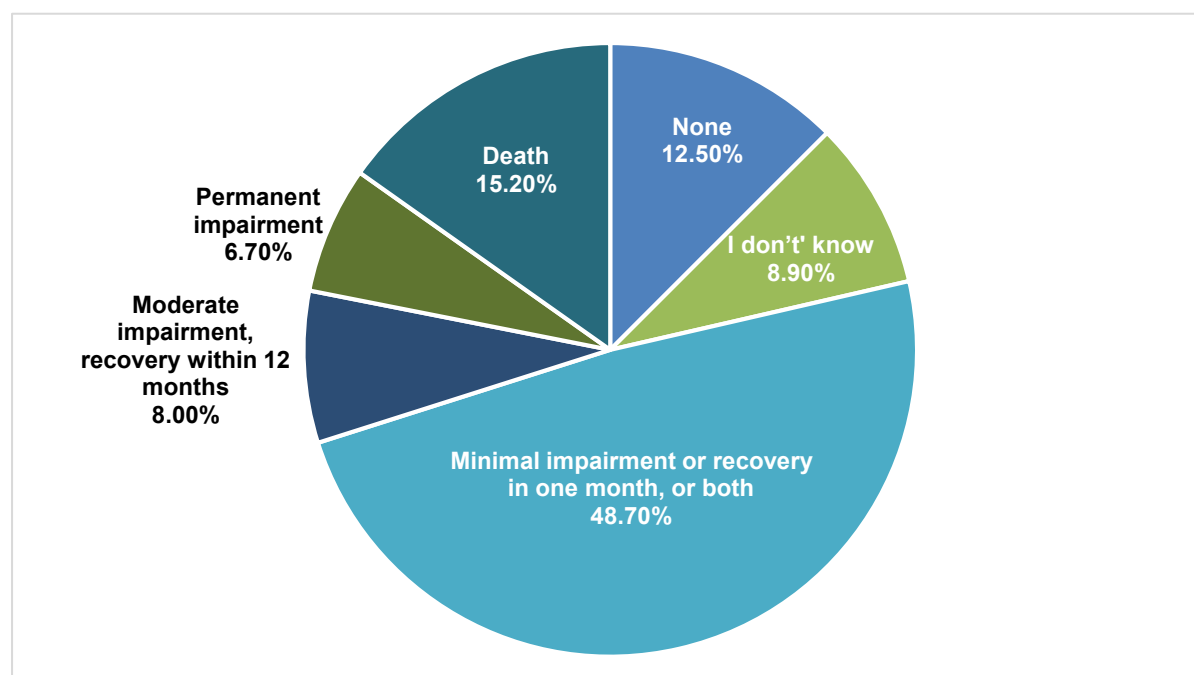


Figure 34. Thinking about the adverse event you were involved in, which of the following best describes the harm experienced by the patient?



As reported by trainee specialists, less than half of patients (48.7%) involved in an adverse event recovered within a month, while 12.5% experienced no impairment whatsoever. Eight percent of patients experienced an impairment lasting 12 months, less than seven percent (6.7%) experienced a permanent impairment, while 15.2% died as a result of the adverse event they experienced.

Support services

The results of YTC 2017 suggest that for trainee specialists, barriers exist in relation to accessing the support services being made available for staff in the health system.

The Health Service Executive (HSE) has a number of policy documents which set out a formal strategy for supporting and enhancing the wellbeing of its employees in the health system. The HSE's Corporate Plan 2015-2017 outlines five goals, two of which include the need to promote personal health and wellbeing among staff. Furthermore, the HSE's People Strategy 2015-2018 commits to developing a 'Staff Health and Wellbeing strategy to support staff in managing their own health and wellbeing'.

Despite these strategies, less than half (43.5%) of those trainee specialists who were involved in an adverse event believed that confidential support services were available

at their training site/hospital if they needed them. The reasons behind this are unknown, however it is likely that time pressures and a lack of awareness around the existence of these supports are contributing factors. What is not in doubt is that this is an area which demands closer scrutiny.

The HSE's [Integrated Employee Wellbeing and Welfare Strategy](#) assigns a central role to managers in promoting employee wellbeing and welfare by fostering a more inclusive style of management, in which managers engage effectively with their teams. However, the results of YTC 2017 show that only 40.6% of respondents agreed that their clinical line manager provided meaningful and sustained support after the occurrence of an adverse event.

Similarly, just 40.5% of trainee specialists felt adequately supported by the training site/hospital and its structures after the event. Despite the HSE's goal of providing work environment which recognises that 'well managed and engaged employees leads to better healthcare outcomes for patients', 13.3% of trainee specialists felt shunned by some of their clinical colleagues after the adverse event, and for 59% of trainee specialists involved in an adverse event, family and friends were the main source of support afterwards.

Further to this, almost half (45.8%) of respondents believed that the needs of the patient and/or family were not appropriately met by the hospital/training site after the event.

As described in Table 10, only 38.5% of those involved in adverse events were in agreement that the appropriate steps were taken by the training/site hospital to reduce the chance of it happening again. Nearly a third (29.9%) of respondents involved in an adverse event found it difficult to practice immediately after the event. For 43.4% of trainee specialists, memories of what happened during the adverse event troubled them for a long period of time following the event. Over a quarter (25.3%) of trainee specialists agreed that they had left or contemplated leaving the speciality in which they were working after the adverse event. 22.1% of trainee specialists contemplated leaving medicine altogether following the adverse event.

Table 10. Adverse event aftermath 2017

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
After the event the training site/hospital ensured that the needs of the patient and/or family were appropriately met'	7.9%	7.4%	30.5%	40.9%	13.3%
'I think that the training site/hospital learned from the event and took appropriate steps to reduce the chance of it happening again'	16.6%	19.0%	25.9%	30.2%	8.3%
'I found it difficult to continue to practice effectively immediately after the event'	28.5%	38.8%	2.8%	22.4%	7.5%
'Memories of what happened kept troubling me for a long time after the event'	26.4%	26.4%	4.7%	34.4%	8.0%
'After my experience, I left, or contemplated leaving, the specialty in which I was working'	40.0%	33.3%	1.4%	18.6%	6.7%
'After my experience, I contemplated leaving medicine altogether'	45.8%	30.7%	1.4%	16.0%	6.1%

Migration intentions

- Nearly one-third (29.7%) of those who were considering practicing medicine abroad were doing so because they found their work environment stressful.
- Nearly two thirds (57.8%) of respondents were considering leaving Ireland because they felt their employers were not supporting them in their work.
- 79.6% of respondents were considering leaving Ireland because they felt they could achieve a better work-life balance outside of Ireland.

Migration intentions

As can be seen from Figure 31, the number of doctors on the Trainee Specialist division of the register who expressed a desire to leave Ireland and practice medicine has steadily declined, falling from 21.3% in 2014 to 14% in 2017. In addition, those wishing to remain in Ireland has increased year on year, from 54% in 2014 to 67.2% in 2017.

Figure 35. Intention to practice medicine in Ireland for the foreseeable future

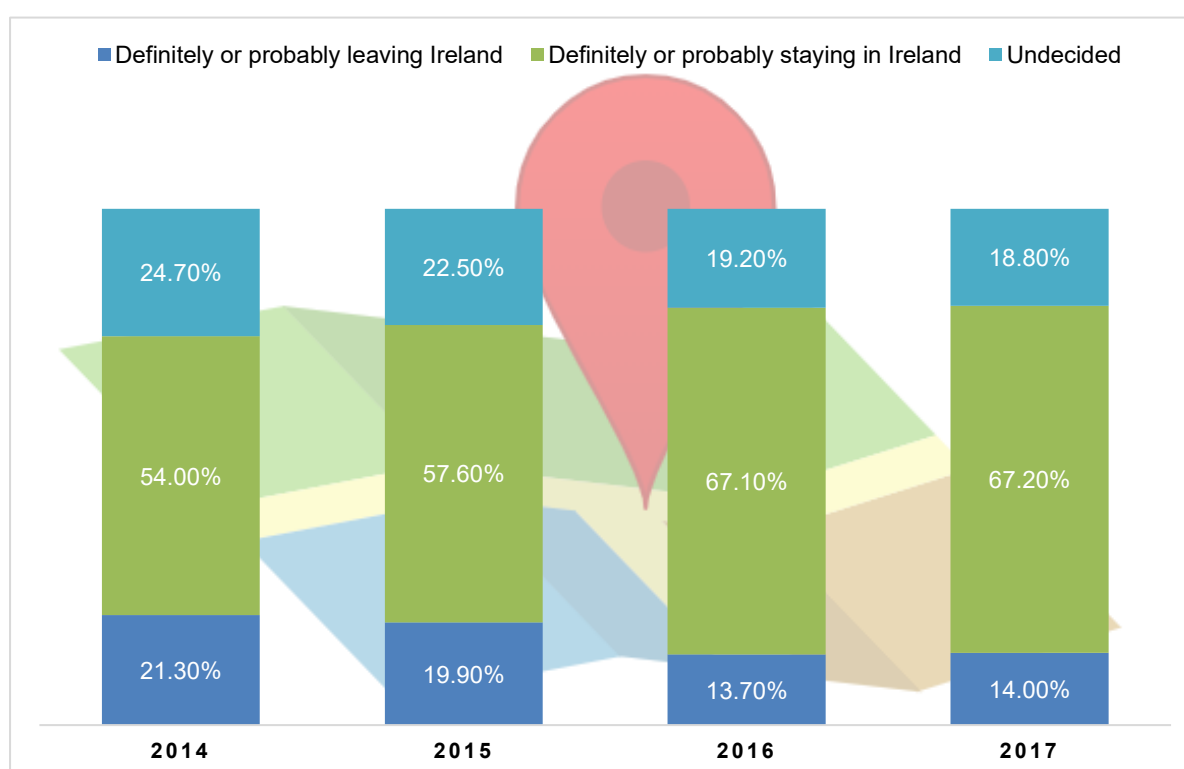
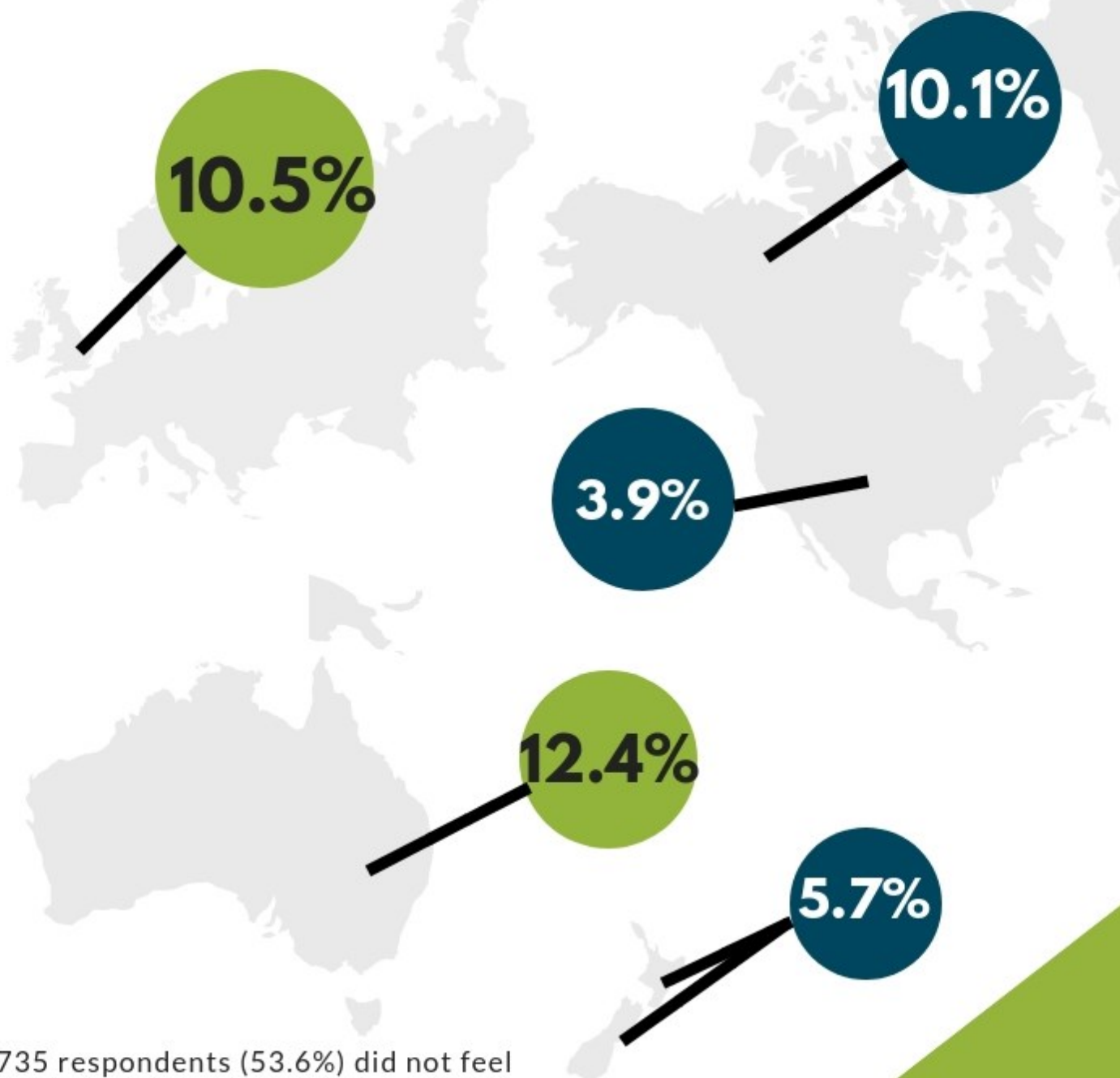


Table 11. *Apart from temporary visits abroad, do you intend to practise medicine in Ireland for the foreseeable future?*

	Frequency	Percent
Yes, definitely	265	36.8%
Yes, probably	219	30.4%
Undecided	135	18.8%
No, probably not	69	9.6%
No, definitely not	32	4.4%

WHERE DO TRAINEE SPECIALISTS AND INTERNS WANT TO PRACTISE NEXT?



- 394 of 735 respondents (53.6%) did not feel that they would practise outside of Ireland in the future
- 42.6% of respondents reported that they would consider practice in the UK, Australia, New Zealand, the USA, or Canada.
- 81% of 338 respondents agreed with the statement: "I am considering practising medicine abroad because I feel my workplace is understaffed."

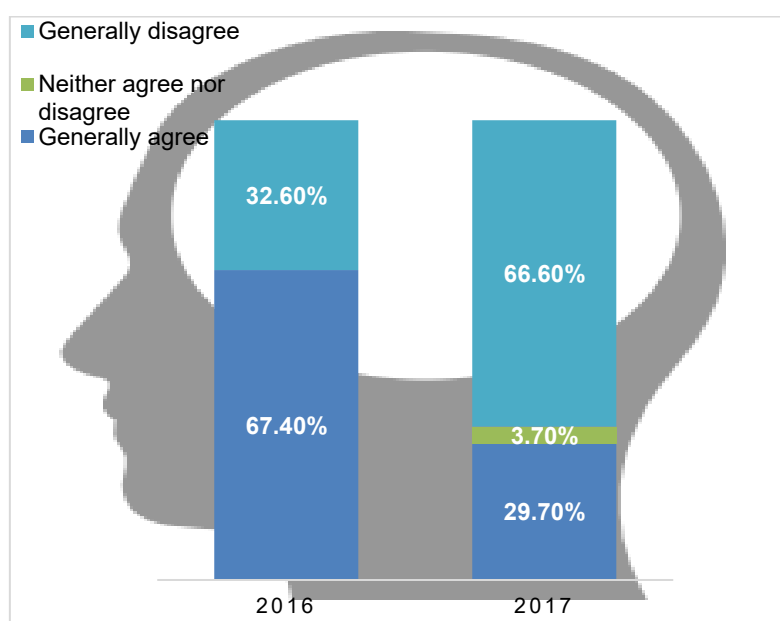
A list of the reasons trainee specialists identified as antecedents for considering practising abroad are presented in Table 9. Almost 80% of trainee specialists (79.6%) identified 'a better work-life balance' as the main predictor of emigrating, while almost two thirds (65.9%) considered practicing medicine abroad because they felt their working hours in Ireland were too long.

Table 12. Reasons for considering practising abroad

	Strongly disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly agree
<i>"I am considering practising medicine abroad because I feel the working hours expected of me here are too long"</i>	N/A	34.0%	N/A	37.9%	28.0%
<i>"I am considering practising medicine abroad because I feel I am expected to carry out too many non-core tasks"</i>	2.9%	25.1%	5.7%	38.3%	28.0%
<i>"I am considering practising medicine abroad because I feel my workplace is understaffed"</i>	1.8%	17.2%	N/A	40.2%	40.8%
<i>"I am considering practising medicine abroad because I find my work environment here is often stressful"</i>	4.6%	25.1%	3.7%	36.0%	30.6%
<i>"I am considering practising medicine abroad because I feel my employer does not support me in my work"</i>	5.1%	31.3%	5.7%	31.3%	26.5%
<i>"I am considering practising medicine abroad because I feel I am not respected by senior colleagues"</i>	13.5%	58.5%	4.9%	12.7%	10.4%
<i>"I am considering practising medicine abroad because I feel the quality of training available to me here is poor"</i>	7.2%	42.1%	6.6%	27.7%	16.4%
<i>"I am considering practising medicine abroad because I feel I do not have flexible training options"</i>	6.0%	39.4%	7.5%	25.4%	21.8%

	Strongly disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly agree
<i>"I am considering practising medicine abroad because I feel there are limited career progression opportunities available to me here"</i>	2.6%	35.9%	4.9%	31.3%	25.3%
<i>"I am considering practising medicine abroad because training pathways and duration are not predictable here"</i>	4.4%	40.4%	5.3%	28.9%	20.9%
<i>"I am considering practising medicine abroad because I can achieve a better work-life balance there"</i>	2.0%	13.2%	5.2%	33.2%	46.4%
<i>"I am considering practising medicine abroad because I feel I can earn more abroad"</i>	7.0%	16.6%	3.2%	33.2%	39.9%
<i>"I am considering practising medicine abroad for family/personal reasons"</i>	14.1%	37.1%	3.3%	26.6%	18.9%

Figure 36. 'I am considering practicing medicine abroad because I find my work environment here is often stressful'



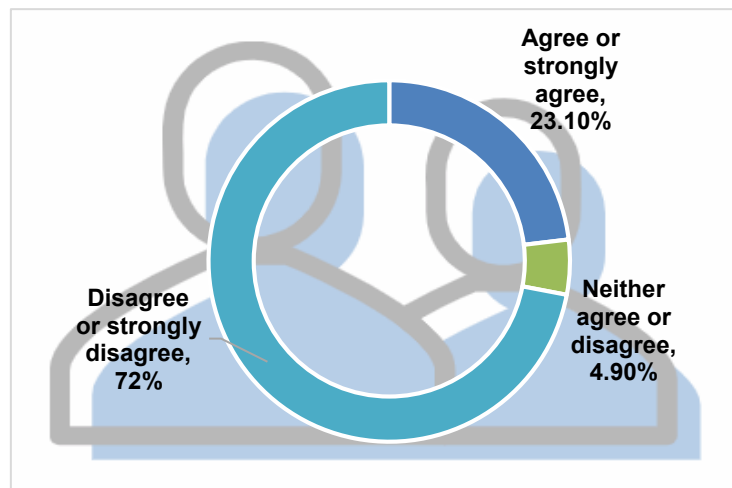
The number of trainee specialists reporting considering practicing medicine abroad because they found their work environment too stressful declined from 67.4% in 2016, to 29.7% in 2017. However, over half (57.8%) of trainee specialists flagged a lack of support from their employers as a motivating factor in their desire to practice medicine outside of Ireland.

Figure 37. 'I am considering practicing medicine abroad because I feel my employer does not support me in my work'



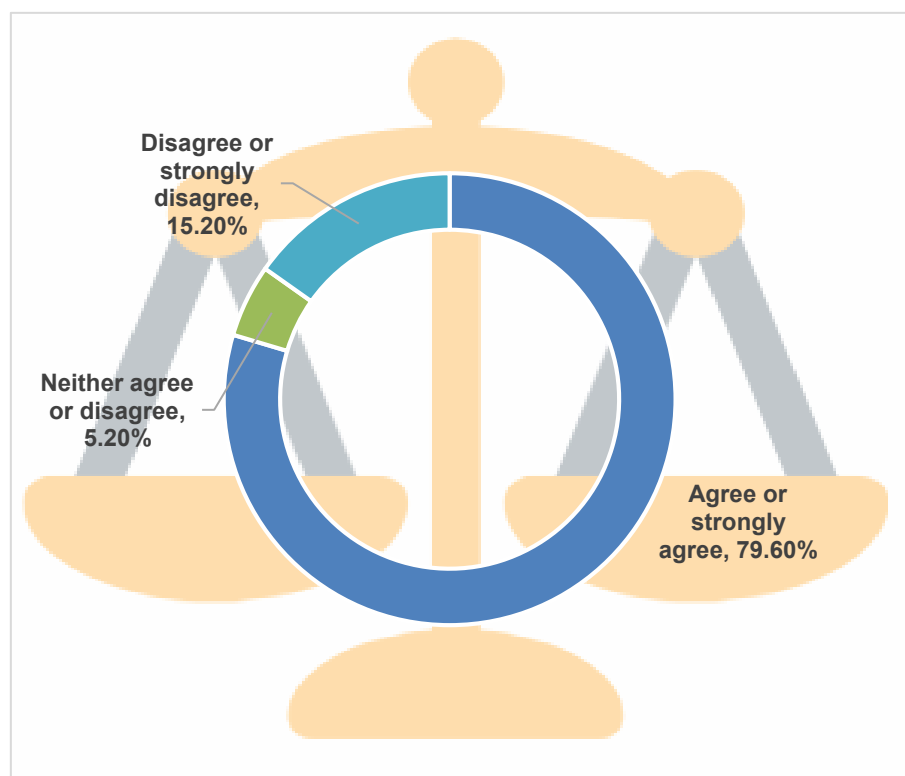
Nearly a quarter (23.1%) of respondents considered practicing medicine abroad due to a perceived lack of respect from senior colleagues.

Figure 38. 'I am considering practicing medicine abroad because I feel I am not respected by senior colleagues'



79.6% of trainee specialists agreed that the prospect of a better work-life balance was central to their considering practicing medicine outside of Ireland.

Figure 39. 'I am considering practicing medicine abroad because I feel I can achieve a better work-life balance there'



While these responses provide clarity on the aggravating factors behind trainee specialists' intentions to leave Ireland to practise medicine elsewhere, it is instructive to compare this data with Voluntary Registration Withdrawal data, in order to further assess whether these factors matched the reasons given when doctors' were leaving the register.

Respondents to YTC 2017 were drawn from four divisions of the register: 71.2% of respondents were Trainee Specialists, Interns made up a further 14.4% of respondents, while the remaining 14.6% had transferred to the General or Specialist Division.

The Medical Council's recently published report on the 2016 and 2017 Annual Registration Retention & Voluntary Registration Withdrawal Surveys have shown that 70.6% of doctors' who left the Medical Council register during this period were doing so because they wished to practice abroad. For trainee specialists, over half (52.9%) were withdrawing from the register because they wished to practice abroad. One trainee commented that: *"my workplace is understaffed. My employer does not support me in my work. Poor training quality."*

For those on the Intern Division of the register, 96.7% of those leaving wished to practice medicine abroad. Commenting on this, one intern remarked:

"different life experience, better working hours, better working conditions, better pay, amongst other reasons".

For those on the General Division of the register, this figure was 70%, while for those in the Specialist division, practicing abroad was also the primary motivation for leaving the register.

While a myriad of reasons for voluntary withdrawal were given by doctors, a number of the key factors given were either directly related to wellbeing or indirectly related to factors which could have detrimental effects on a doctor's wellbeing. These included:

- *being expected to carry out too many non-core tasks;*
- *Lack of respect by senior colleagues;*
- *Lack of flexible training options;*

- *Earning more abroad;*
- *Family/personal reasons for making a voluntary withdrawal from the register;*
- *Lack of employer support in work;*
- *Workplace understaffing;*
- *Perceived poor quality training available;*
- *Working hours expected too long.*

Crowe et al., (2017) have further explored the factors influencing trainee doctor emigration. They observed that large-scale dissatisfaction with working, training and career opportunities are systemic factors that need to be addressed by health workforce planners if Ireland is to retain and benefit from a motivated medical workforce, especially given trainee specialists' perceptions that there are better opportunities abroad.

The results of YTC 2017 support the conclusions of this research which showed that working abroad was seen as more attractive than working in Ireland, because of "better conditions abroad" (95% agreement) and "better work life balance abroad" (91%) (Crowe et al., 2017).



YOUR TRAINING COUNTS 2017:

DISCUSSION

AN INVESTIGATION OF TRAINEE
WELLBEING AND THEIR EXPERIENCES OF
CLINICAL LEARNING ENVIRONMENTS IN
IRELAND 2017

Discussion

The results of YTC suggest that trainee specialist doctors and interns, in the main, feel safe in their workplace, have good general health and self-reported quality of life. Ireland's education and training of doctors is internationally recognised, and Irish trainees hope to work primarily in Ireland in their future career. However, retaining this pool of highly qualified Irish-trained doctors in practice is proving challenging.

Resources available to clinicians are varied and should be evaluated in terms of their effectiveness. These resources should support clinicians' personal and professional wellbeing, which in turn will serve the public by ensuring a working environment that promotes clinician safety. Introducing further, more targeted and accessible mental health supports for trainee specialists, and developing appropriate workforce supports in relation to the EWTD will help to consolidate high levels of self-rated health and quality of life.

Bullying

The results of YTC 2017 suggest that the reporting and management processes for bullying is a policy area in need of urgent attention. Developing better methods of supporting both perpetrators of bullying behaviour and those experiencing bullying is essential to challenging the cultural challenges that exist regarding this in the healthcare setting in Ireland. Gauging the prevalence of bullying and capturing bullying behaviours in the healthcare system should be imperative to do this effectively. Looking to international leadership in this regard, including collaborative efforts such as the [anti-bullying](#) alliance in the UK, already working together and sharing both ethos and resources in this regard may prove as a useful model for action.

Adverse events

A key finding of this report was that the frequency with which a trainee experiences bullying and the number of hours they work in a week are directly linked to the likelihood of them being involved in an adverse event. Additionally, male respondents and those with an SDHS score suggesting the presence of mental health that would

potentially benefit from additional supports were more likely to be involved in an adverse event. This suggests that improvements in working hours, support structures for trainee specialists who are bullied, and mental health support services for trainee specialists may have far-reaching impact.

Working time

A third of Irish trainee doctors are still working hours that significantly exceed the recommendations of the European Working Time Directive. The negative implications for healthcare delivery are clear – a far higher percentage of these trainee specialists also reported involvement in an adverse event than their colleagues who worked less hours. The connection between patient safety and doctors' working hours is concerning and acknowledgment of this must be at the centre of future policy innovations concerning trainee specialists' weekly working hours. Making sweeping workforce configuration and allocating appropriate resourcing to implement this is imperative to effect change in practice.

Retention

Ireland has been replacing the doctors in the system rather than changing the system itself, which is notable through the feedback received from doctors leaving the register (Medical Council, 2019). While doctors will always travel for the sake of travel and to gain experience, the Irish health system needs to be an attractive prospect to return to.

Poorly resourced and staffed work environments, and the prospect of a better work-life balance are all key motivating factors for trainee specialists who are considering practicing medicine abroad. In response to these challenges the government has sought to address workforce challenges through Sláintecare, the ten-year programme to transform our health and social care services. "Strategic Action 9: Building a sustainable, resilient workforce" that is supported and enabled to deliver the Sláintecare vision" in particular is very relevant in directly addressing the concerns within this report. This strategic action would see increased career and role flexibility, adaptability, mobility and more efficient training. "Workstream 3: Teams of the Future" as part of the implementation plan will be particularly impactful if supported

appropriately in practice. This workstream is centred on planning, building and supporting a health and social care workforce which can deliver on the Sláintecare reform programme, as well as initiatives which promote innovation, participation and the creation of a supportive work environment. It is intended that the workforce planning framework will be progressed with a focus on engagement with the education sector and training bodies, to agree new ways of training multidisciplinary teams. The Workforce Planning Programme (3.1) and Culture Change and New Ways of Working Programme (3.3), when fully operationalised, will ensure that the right teams are available, at the right time, to deliver on the clinical and service objectives of Sláintecare reform. It is set out that effective short, medium, and long-term workforce planning will be undertaken to ensure that new Models of Care are properly planned in order to deliver integrated care.

In keeping with Sláintecare's commitments to changing workforce planning models and emphasis on flexibility in roles, a permanent doctor grade in the health service to replace the short-term contractual nature of non-training posts could be considered. From the data published in the Medical Council's Workforce Intelligence Report (2019), these posts are vital to the operation of the health service but are precarious in nature, with little support or stability for doctors. A review of the non-trainee role is a key recommendation of the MacCraith report and this may provide a path to providing stability, making this an attractive feature of the post. This would only be possible with other sweeping workforce reforms, including primarily consultant-led care, to avoid overburden and use of this role within the system. For those who wish to gain experience of the Irish health system, continued development and expansion of the IMGTI programme is to be welcomed as it is in line with Working Together for Health: A National Strategic Framework for Health and Social Care Workforce Planning (Department of Health, 2017), grounded in the WHO Global Code. Systemic, meaningful change for both doctors and patients will not be truly felt without challenging current models and cultural structures in healthcare.

To match international practice and move to a stronger model of healthcare delivery and leadership, a move to a more consultant-delivered care model must be put in place. These consultants should be on the Specialist Division of the register and provide training. Those in consultant posts currently and registered on the General

Division of the register should strongly consider assessment for enrolment on the Specialist Division as good practice. Appropriate remuneration is an incentive to this. Increasing consultant numbers and extending consultant presence outside of core working hours could be achieved through conversion of non-training posts into consultant posts as more consultant-delivered models of care are introduced into the health service to meet this need. An increase in consultant-delivered healthcare would improve training resources and support for trainees, modelling professionalism in a modern health service and providing appropriate scaffolding to growth within SPR roles. Trainee wellbeing is not achieved and maintained in isolation and the role of the trainer in the Irish context will also be examined further through survey to complement and strengthen the practical impact of Your Training Counts 2019.

Through the data gathered and published in the Medical Council's Workforce Intelligence Report (2019), providing opportunities for progression are key incentives for Irish-trained doctors to remain in Ireland and stay on the register. Continued increases in the number of training posts in national training programmes by conversion of suitable non-training posts would provide more positions for doctors to stay in Ireland. The increased number of consultant posts would mean there would be positions appropriate for these trainee doctors to aspire to working in, in a modern, consultant-led and delivered healthcare environment.

Long-pursued amendments to the Medical Practitioners Act 2007 will improve equality within the system for IMGs in NCHD non-training service roles, impacting directly on the accessibility of formal training for those who have completed their basic medical training outside of the Irish system. It is hoped that through the amendments, doctors in long-term service roles will have the opportunity to access further postgraduate education, professional development and progression within the Irish health system, rather than having to leave the jurisdiction to do so, as currently reported in the voluntary withdrawal data. This will also place value on and reward the work done by this often under-represented group of doctors that ensure the functioning of the Irish health service in partnership with their colleagues daily.

The evidence-base mirrors comments and opinions that the Medical Council is receiving from trainee specialists at the coalface of hospital medicine, and the research being undertaken by partner organisations on similar issues. These findings

should therefore act as a basis for the Council and other bodies' increased policy focus on wellbeing related issues in Irish medicine. An increased focus on wellbeing and investigating further domains of this have been expanded upon in this year's 2019 iteration of Your Training Counts, live currently, collecting data to expand the evidence base. The human nature of doctors as health caregivers and people with identities external to their professional identity must be acknowledged, supported and encouraged. Supporting doctors to self-care, reflect and access supports to bolster their wellbeing in a system that currently often challenges it is a key activity that can only serve to support doctor and patient safety and is mutually beneficial to all stakeholders in the Irish health service.

Recommendations

- Systemic, meaningful change for both doctors and patients will not be truly felt without challenging current models and cultural structures in healthcare, through the vision and action of Sláintecare reform.
- Long-pursued amendments to the Medical Practitioners Act 2007 will improve equality within the system for international medical graduates in NCHD non-training service roles, impacting directly on the accessibility of formal training for those who have completed their basic medical training in contexts outside of the Irish system.
- To address EWTD and consequent wellbeing concerns, examination and consideration of the potentiality of a well-supported permanent doctor grade in the health service, in the context of extensive workforce change to include an emphasis on consultant delivered care, to replace the short-term contractual nature of non-training posts may effect significant change in the system.
- To match international practice and move to a stronger model of healthcare delivery, training and leadership, a move to more consultant-delivered care must be put in place. These consultants, acting as trainers, should be on the specialist division of the register.
- Innovative approaches to bolstering doctor wellbeing, adopted in other countries, must be assessed and explored for use in an Irish context to facilitate culture change, with a view to improving training quality and retention. Appropriate solutions must be both identified and implemented.
- Truly supporting all doctors to self-care, reflect and access supports to bolster their wellbeing and that of trainees, in the context of a challenging system, can only serve to support doctor and patient safety and is mutually beneficial to all stakeholders in the Irish health service.

References

- Aasland, O. G., & Førde, R. (2005). Impact of feeling responsible for adverse events on doctors' personal and professional lives: the importance of being open to criticism from colleagues. *BMJ Quality & Safety*, 14(1), 13-17. Retrieved from https://qualitysafety.bmj.com/content/14/1/13?utm_source=trendmd&utm_medium=cpc&utm_campaign=bmjqs&utm_content=consumer&utm_term=0-A
- Arnold-Forster, A. (2018). Doctors' wellbeing: learning from the past can help improve the future. *BMJ*, 363. Retrieved from <https://blogs.bmj.com/bmj/2018/08/07/agnes-arnold-forster-doctors-wellbeing-learning-past-help-improve-future/>
- Bennett, D., O' Flynn, S., O'Rourke, M., & Hammond, S. (2014) Report on the Validity and Reliability of the Dutch Residency Educational Climate Test (D-RECT): As deployed by the Medical Council in the National Trainee Experience Survey 2014. UCC Medical Education Unit, School of Medicine. Retrieved from <https://www.medicalcouncil.ie/Education/Career-Stage-Postgraduate/Your-Training-Counts/D-RECT-Report-.pdf>
- Boor, K., Van Der Vleuten, C., Teunissen, P., Scherpbier, A., & Scheele, F. (2011) Development and analysis of D-RECT, an instrument measuring residents' learning climate, *Medical Teacher*, 33(10), 820-827. Retrieved from <https://www.tandfonline.com/doi/abs/10.3109/0142159X.2010.541533?journalCode=imte20>
- Bourne, T., Wynants, L., Peters, M., Van Audenhove, C., Timmerman, D., Van Calster, B., & Jalmbrant, M. (2015). The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey. *BMJ open*, 5(1). Retrieved from <https://bmjopen.bmj.com/content/5/1/e006687.short>
- Brennan, T. A., Leape, L. L., Laird, N. M., Hebert, L., Localio, A. R., Lawthers, A. G., & Hiatt, H. H. (1991). Incidence of adverse events and negligence in

hospitalized patients: results of the Harvard Medical Practice Study I. *New England journal of medicine*, 324(6), 370-376. Retrieved from <https://qualitysafety.bmj.com/content/qhc/13/2/145.full.pdf>

Canadian Medical Association, 1998. *CMA Policy: Physician Health and Wellbeing*. Retrieved from [https://www.cma.ca/Assets/assetslibrary/document/en/advocacy/policy-research/CMA Policy Physician health and wellbeing PD98-04-e.pdf](https://www.cma.ca/Assets/assetslibrary/document/en/advocacy/policy-research/CMA_Policy_Physician_health_and_wellbeing_PD98-04-e.pdf)

Cheema, S., Ahmad, K., Giri, S. K., Kaliaperumal, V. K., & Naqvi, S. A. (2005). Bullying of junior doctors prevails in Irish health system: a bitter reality. *Irish medical journal*, 98(9), 274-275. Retrieved from https://www.researchgate.net/profile/S_Altaf_Naqvi/publication/225526790_Bullyingof_junior_doctors_a_bitter_reality/links/54d656ff0cf2970e4e6b91a0.pdf

Clarke, N., Crowe, S., Humphries, N., Conroy, R., O'Hare, S., Kavanagh, P., & Brugha, R. (2017). Factors influencing trainee doctor emigration in a high income country: a mixed methods study. *Human resources for health*, 15(1), 66. Retrieved from <https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-017-0239-7>

Crowe, S., Clarke, N., & Brugha, R. (2017). 'You do not cross them': Hierarchy and emotion in doctors' narratives of power relations in specialist training. *Social Science & Medicine*, 186, 70-77. Retrieved from <https://www.sciencedirect.com/science/article/pii/S0277953617303507>

Dewa C.S., Loong D., Bonato S., Thanh N.X., and Jacobs P. How does burnout affect physician productivity? A systematic literature review. *BMC Health Services Research* 2014, 14: 325. Retrieved from <https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-14-325>

Fahrenkopf, A. M., Sectish, T. C., Barger, L. K., Sharek, P. J., Lewin, D., Chiang, V. W., & Landrigan, C. P. (2008). Rates of medication errors among depressed

and burnt out residents: prospective cohort study. *BMJ*, 336(7642), 488-491. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2258399/>

Hayes, B., Prihodova, L., Walsh, G., Doyle, F., & Doherty, S. (2017). What's up doc? A national cross-sectional study of psychological wellbeing of hospital doctors in Ireland. *BMJ open*, 7(10). Retrieved from <https://bmjopen.bmj.com/content/7/10/e018023>

Health Service Executive (2014). *Integrated Employee Wellbeing and Welfare Strategy*. Retrieved from <https://www.hse.ie/eng/staff/resources/hrppg/integrated-employee-wellbeing-and-welfare-strategy-2009-2014-.pdf>

Huggard, P., Stamm, B. H., & Pearlman, L. A. (2013). Physician stress: Compassion satisfaction, compassion fatigue and vicarious traumatization. In C. Figley, P. Huggard, & C. E. Rees (Eds.), *First do no self-harm: Understanding and promoting physician stress resilience* (pp. 127-145). New York, NY, US: Oxford University Press. Retrieved from <http://dx.doi.org/10.1093/acprof:oso/9780195383263.003.0007>

Jagsi, R., Kitch, B. T., Weinstein, D. F., Campbell, E. G., Hutter, M., & Weissman, J. S. (2005). Residents report on adverse events and their causes. *Archives of Internal Medicine*, 165(22), 2607-2613. Retrieved from <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/766866>

Jain, A., & Ogden, J. (1999). General practitioners' experiences of patients' complaints: qualitative study. *BMJ*, 318(7198), 1596-1599. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC28140/>

Medical Council of Ireland. (2019). Medical Workforce Intelligence Report: A report on the 2016 and 2017 annual registration retention & voluntary registration withdrawal surveys. Retrieved from: <https://www.medicalcouncil.ie/News-and-Publications/Press-Releases/Press-Release/Medical-Workforce-Intelligence-Report.pdf>

Medical Council of Ireland. (2018). *Regional Inspection of Saolta University Health Care Group Summary Report*. Retrieved from <https://www.medicalcouncil.ie/News-and-Publications/Reports/Saolta-Summary-Report-.pdf>

Medical Council of Ireland. (2018). *Regional Inspection of South/South West Hospital Group Summary Report*. Retrieved from <https://www.medicalcouncil.ie/News-and-Publications/Reports/SouthSouthWest-Summary-Report-2018.pdf>

Medical Council of Ireland. (2018). *Your Training Counts - Trainee experiences of Clinical Learning Environments in Ireland 2014-2016*. Retrieved from https://issuu.com/daniellesmith03/docs/your_training_counts_2016_report

Medical Council of Ireland (2016). *Your Training Counts: Spotlight on health and wellbeing 2014*. Retrieved from http://issuu.com/mcirl/docs/your_training_counts_spotlight_on_h?e=12642421/34392651

Medical Council of Ireland (2014). *Your Training Counts: Trainee Experiences of Clinical Learning Environments in Ireland 2014*. Retrieved from http://issuu.com/mcirl/docs/the_medical_council_your_training_c?e=12642421/34725762

Medical Council of Ireland. (2016). *Your Training Counts: Trainee Experiences of Clinical Learning Environments in Ireland 2015*. Retrieved from http://issuu.com/mcirl/docs/your_training_counts_report_on_lear_c606875cd2cdfd?e=12642421/34725199

Murphy, J. F. A. (2011). Burnout. *Time to Care Hearts in Healthcare*. Retrieved from <https://heartsinhealthcare.com/wp-content/uploads/2014/03/TimeToCare-Chapter1.pdf>

Murphy, J. (2009). "To err is human" ten years on. *Irish Medical Journal*, 103(2), 36. Retrieved from

<https://www.lenus.ie/bitstream/handle/10147/124876/Article3941.pdf?sequence=1&isAllowed=y>

Nason, G. J., Liddy, S., Murphy, T., & Doherty, E. M. (2013). A cross-sectional observation of burnout in a sample of Irish junior doctors. *Irish journal of medical science*, 182(4), 595-599. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/23463034>

O'Mahony, J. (2012). The perceptions of post work placement students from DBS, DIT and WIT towards their work placement experience. *Dublin Business School*. Retrieved from https://esource.dbs.ie/bitstream/handle/10788/355/ma_omahony_j_2012.pdf?sequence=1&isAllowed=y

Rafter, N., Hickey, A., Conroy, R. M., Condell, S., O'Connor, P., Vaughan, D., & Williams, D. J. (2017). The Irish National Adverse Events Study (INAES): the frequency and nature of adverse events in Irish hospitals—a retrospective record review study. *BMJ Qual Saf*, 26(2), 111-119. Retrieved from <https://qualitysafety.bmj.com/content/26/2/111>

Rich, A., Viney, R., Needleman, S., Griffin, A., & Woolf, K. (2016). 'You can't be a person and a doctor': the work–life balance of doctors in training—a qualitative study. *BMJ open*, 6(12). Retrieved from https://bmjopen.bmj.com/content/6/12/e013897?cpetoc=&utm_source=TrendMD&utm_medium=cpc&utm_campaign=BMJOp_TrendMD-0

Roche-Nagle, G. (2004). The European Working Time Directive: a survey of surgical specialist registrars. *Irish medical journal*, 97(6), 175-178. Retrieved from <http://europepmc.org/abstract/MED/15305620>

Samsudin, E. Z., Isahak, M., & Rampal, S. (2018). The prevalence, risk factors and outcomes of workplace bullying among junior doctors: A systematic review. *European Journal of Work and Organizational Psychology*, 27(6), 700-718. Retrieved from https://umexpert.um.edu.my/file/publication/00009356_163106_79021.pdf

- Shanafelt, T. D., Balch, C. M., Bechamps, G., Russell, T., Dyrbye, L., Satele, D., & Freischlag, J. (2010). Burnout and medical errors among American surgeons. *Annals of surgery*, 251(6), 995-1000. Retrieved from <https://medschool.ucsd.edu/som/hear/resources/Documents/Burnout%20and%20medical%20errors%20among%20American%20Surgeons%202010.pdf>
- Shaw, J. M., Brown, R. F., & Dunn, S. M. (2013). A qualitative study of stress and coping responses in doctors breaking bad news. *Patient education and counselling*, 91(2), 243-248. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/23206660>
- Tawfik, D. S., Profit, J., Morgenthaler, T. I., Satele, D. V., Sinsky, C. A., Dyrbye, L. N., & Shanafelt, T. D. (2018). Physician burnout, well-being, and work unit safety grades in relationship to reported medical errors. In *Mayo Clinic Proceedings* (Vol. 93, No. 11, pp. 1571-1580). Elsevier. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6258067/>
- Úallacháin, G. N. (2007). Attitudes towards self-health care: a survey of GP trainee specialists. *Irish Medical Journal*, 100(6), 489-491. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/17668680>
- Wallace, J. E., Lemaire, J. B., & Ghali, W. A. (2009). Physician wellness: a missing quality indicator. *The Lancet*, 374(9702), 1714-1721. Retrieved from <https://www.dependencias.pt/ficheiros/conteudos/files/Psiquiatria.pdf>
- West, C. P., Tan, A. D., Habermann, T. M., Sloan, J. A., & Shanafelt, T. D. (2009). Association of resident fatigue and distress with perceived medical errors. *Jama*, 302(12), 1294-1300. Retrieved from <https://jamanetwork.com/journals/jama/fullarticle/184625>

Additional sources:

Copies of the IMJ from 1980-86:

<http://archive.imj.ie/DesktopDefault.aspx?tabindex=0&tabid=666> and 1987-1989 are available at <https://www.ncbi.nlm.nih.gov/pubmed/?term=Ir+Med+J.+1987>.

The 1990-1996 issues are available at

<http://archive.imj.ie/DesktopDefault.aspx?tabindex=0&tabid=666>.

Volumes from 1997 to 2016 can be found at

<http://archive.imj.ie/DesktopDefault.aspx?tabindex=0&tabid=663>.

The 2017 issues can be viewed at

<https://www.ncbi.nlm.nih.gov/pubmed/?term=Ir+Med+J.+2017>.

Copies of the IMJ from 1980-86

<http://archive.imj.ie/DesktopDefault.aspx?tabindex=0&tabid=666>.

1987-1989 are available at

<https://www.ncbi.nlm.nih.gov/pubmed/?term=Ir+Med+J.+1987>.

The 1990-1996 issues are available at

<http://archive.imj.ie/DesktopDefault.aspx?tabindex=0&tabid=666>.

Volumes from 1997 to 2016 can be found at

<http://archive.imj.ie/DesktopDefault.aspx?tabindex=0&tabid=663>.

The 2017 issues can be viewed at

<https://www.ncbi.nlm.nih.gov/pubmed/?term=Ir+Med+J.+2017>.

Appendix

Multiple regression analyses

A multiple regression analysis was conducted to observe doctors' self-rated health (self-rated health) as predicted by age, gender, category, division, BMQ, SDHS, Self-rated quality of life, adverse events, whether the doctor was bullied or not, bullying frequency and hours worked per week. The results of the analysis are displayed below.

Table 2. Multiple Regression for the predictors of self-rated general health in Sample (N = 751)

Variable	β	R^2	Adj R^2	F
		.29	.28	24.05***
Age	.02			
Gender	.00			
Category	-.00			
Division	-.06			
BMQ	-.03			
SDHS	-.21***			
Self-rated quality of life	.00***			
Bullied	-.2			
Adverse Events	.03			
Bullying Frequency	.2			
Hours per week	.01			

* $p < .05$. ** $p < .01$. *** $p < .00$

The overall model was significant ($F_{(11, 648)} = 24.05$, $p < .00$, $R^2 = .29$, $Adj R^2 = .28$). All VIF (< 1) and tolerance (> 1) scores ensured against multicollinearity. SDHS ($\beta = -.21$, $p < .00$) and Self-rated quality of life ($\beta = .00$, $p < .00$), were significant predictors of self-rated health.

A second multiple regression analysis was conducted to observe Doctors Self-rated quality of life as predicted by age, gender, category, division, BMQ, SDHS, self-rated health, adverse events, whether they were bullied or not, bullying frequency and hours worked per week. The results of the analysis are displayed below.

Table 3. Multiple Regression for the predictors of Self-rated quality of life in Sample (N = 751)

Variable	β	R^2	Adj R^2	F
		.49	.48	56.68***
Age	.08**			
Gender	.07*			
Category	-.02			
Division	.01			
BMQ	.05			
SDHS	-.48***			
Self-rated health	.27***			
Bullied	.01			
Adverse Events	-.01			
Bullying Frequency	-.07			
Hours per week	.13***			

* $p < .05$. ** $p < .01$. *** $p < .00$

The overall model was significant ($F_{(11, 648)} = 56.68$, $p < .00$, $R^2 = .49$, Adj $R^2 = .48$). All VIF (< 1) and tolerance (> 1) scores ensured against multicollinearity. Age ($\beta = .08$, $p < .01$), Gender ($\beta = .07$, $p < .05$), SDHS ($\beta = -.48$, $p < .00$), Self-rated health ($\beta = .27$, $p < .00$) and Hours worked per week ($\beta = .13$, $p < .00$), were significant predictors of self-rated quality of life.

A third multiple regression analysis was conducted to observe doctors' score on the Short Depression Happiness Scale (SDHS) as predicted by age, gender, category, division, BMQ, Adverse Events, Self-rated quality of life, self-rated health, whether the doctor was bullied or not, bullying frequency and hours worked per week. The results of which are displayed below.

Table 4. *Multiple Regression for the predictors of SDHS score in Sample (N = 751)*

Variable	β	R^2	<i>Adj R</i> ²	F
		.44	.43	50.13***
Age	.04			
Gender	.1**			
Category	-.04			
Division	-.04			
BMQ	.01			
Adverse Event	-.07			
Self-rated quality of life	-.53***			
Self-rated health	-.17***			
Bullied	.03			
Bullying Frequency	.7			
Hours per week	.03			

* $p < .05$. ** $p < .01$. *** $p < .00$

The overall model was significant ($F_{(11, 648)} = 50.13$, $p < .00$, $R^2 = .44$, *Adj R*² = .43). All VIF (<1) and tolerance (>1) scores ensured against multicollinearity. Self-rated quality of life ($\beta = -.53$, $p < .00$) and Self-rated health ($\beta = -.43$, $p < .00$) were significant predictors of a doctor's SDHS score.

A fourth multiple regression analysis was conducted to observe adverse events as predicted by age, gender, category, division, BMQ, SDHS, Self-rated quality of life, self-rated health, and whether the doctor was bullied or not, bullying frequency and hours worked per week. The results of the analysis are displayed below.

Table 5. *Multiple Regression for the predictors Adverse Events in Sample (N = 751)*

Variable	β	R^2	<i>Adj R</i> ²	F
		.12	.1	7.78***
Age	-.65			
Gender	.08*			
Category	-.05			
Division	.01			
BMQ	-.04			
SDHS	-.1*			
Self-rated quality of life	-.02			
Self-rated health	.00			
Bullied	.11			
Bullying Frequency	-.3*			
Hours per week	.15***			

* $p < .05$. ** $p < .01$. *** $p < .00$

The overall model was significant ($F_{(11, 648)} = 7.78$, $p < .00$, $R^2 = .12$, *Adj R*² = .1). Once again, all VIF (<1) and tolerance (>1) scores ensured against multicollinearity. Gender ($\beta = -.08$, $p < .05$), SDHS ($\beta = -.1$, $p < .05$), Bullying frequency ($\beta = -.3$, $p < .05$) and Hours worked per week ($\beta = .15$, $p < .00$) were significant predictors of adverse events.

There was a statistically significant difference between Hospital groups as determined by one-way ANOVA ($F_{(8, 449)} = 6.69, p < .00$). The results of the analysis are presented below.

Table 6. *Analysis of Variance between Hospital Groups for D-RECT measure*

Measure	Hospital Group	Mean	SD
D-RECT	Ireland East Hospital Group	162.05	32.78
	RCSI	164.05	28.7
	Dublin Mid	176.86	32.94
	UL	171.96	37.04
	South/South West	174.43	29.58
	Saolta	173.69	29.81
	Children's Hospital	172.78	25.82
	GP	198.27	40.5
	Other	198.78	34.74

Ireland East Hospital Group ($M = 162.05, p < .00$), RCSI Hospital Groups ($M = 164.05, p < .01$) and Saolta ($M = 173.69, p < .05$) each reported D-RECT scores that were lower than GPs ($M = 198.78, SD = 34.74$) in a manner that was statistically significant. In addition, the Ireland East Hospital Group ($M = 162.05, p < .00$), RCSI ($M = 164.05, p < .00$), Dublin Mid ($M = 176.86, p < .05$), UL ($M = 171.96, p < .05$), South/South West ($M = 174.43, p < .01$) and Saolta ($M = 173.69, p < .01$) reported D-RECT scores that were lower than those who reported “another” training site in a manner that was statistically significant ($M = 198.78, SD = 34.74$).

A statistically significant difference between Model of Hospital as determined by one-way ANOVA ($F_{(7, 450)} = 5.77, p < .00$). The results of the analysis are presented below.

Table 7. *Analysis of Variance between Model of Hospital for D-RECT measure*

Measure	Model of Hospital	Mean	SD
D-RECT	GP Practice	197.78	40.98
	Model 2	180.84	40.05
	Model 3	167.53	29.96
	Model 4	171.12	31.81
	Children's Hospitals	172.78	25.81
	Mental Health Services	197.68	35.14
	Private Hospitals	193.5	42.07
	Model 8	175.25	33.15

Model 3 Hospitals ($M = 180.84, p < .01$) and Model 4 Hospitals ($M = 171.12, p < .05$) recorded D-RECT scores that were lower than GP Practice ($M = 197.78, SD = 40.98$) in a manner that was statistically significant. In addition, Mental Health Services ($197.68, SD = 35.14$) recorded greater D-RECT Scores than Model 3 Hospitals ($M = 180.84, p < .00$) and Model 4 Hospitals ($M = 171.12, p < .00$) in a manner that was statistically significant.

An analysis was conducted to observe the instances of bullying between Hospital Groups. The results of the analysis are presented below.

Table 8. *Analysis of instances of Bullying between Hospital Groups*

Bullied	Yes	Prefer not to say	Never Bullied
Hospital Group			
Ireland East Hospital Group	58.8%	5.9%	34.3%
RCSI	59%	1.2%	39.8%
Dublin Mid	53.3%	3.8%	42.9%
UL	48.5%	6.1%	45.4%
South/South West	42.1%	4.4%	44.7%
Saolta	52.8%	5.6%	41.6%
Children's Hospital	67.7%	0%	32.3%
GP	17.7%	8.1%	74.2%
Other	43.9%	3.5%	52.6%

The data revealed that GPs reported instances of bullying (17.7%) that were significantly lower than the other Hospital Groups. In addition, GPs reported the highest instance of never being bullied (74.2%). The highest instances of bullying were reported at the Children's hospitals (67.7%).

An analysis was conducted to observe the frequency of bullying between Hospital Groups. The results of the analysis are presented below.

Table 9. Bullying Frequency between Hospital Groups

Bullying Frequency	Frequent	Infrequent	Prefer not to say	Never Bullied
Hospital Group				
Ireland East Hospital Group	12.7%	47.1%	5.9%	12.7%
RCSI	16.9%	42.2%	1.2%	39.8%
Dublin Mid	9.5%	43.8%	3.8%	42.9%
UL	6.1%	42.4%	6.1%	45.4%
South/South West	10.5%	31.6%	4.4%	44.7%
Saolta	12.4%	40.4%	5.6%	41.6%
Children's Hospital	12.9%	54.8%	0%	32.3%
GP	0%	17.7%	8.1%	74.2%
Other	8.8%	35.1%	3.5%	52.6%

The lowest rate of bullying was observed in GPs, with no reporting of frequent bullying and 17.7% reporting infrequent bullying. Further to this, 74.2% reported never being bullied. The highest frequency of bullying was observed in the Children's hospital groups, with 67.7% reporting being bullied (12.9% frequently and 54.8% infrequently).

An analysis was conducted to observe the instances of bullying between Models of Hospital. The results of the analysis are presented below.

Table 10. *Analysis of instances of Bullying between Model of Hospital*

Bullied	Yes	Prefer not to say	Never Bullied
Model of Hospital			
GP Practice	14.9%	6.4%	78.7%
Model 2	35.7%	7.1%	57.1%
Model 3	62.3%	3.6%	32.9%
Model 4	48.9%	4.9%	43.6%
Children's Hospitals	67.7%	0%	32.3%
Mental Health Services	40.4%	3.8%	55.8%
Private Hospitals	45.8%	8.3%	45.8%
Model 8	50%	0%	50%
Other	52.7%	6.2%	8.5%

GP Practice training sites recorded significantly lower instances of bullying than the other models of hospitals. The data revealed 14.9% of those in GP practice reported being bullied, while 78.7% reported never being bullied. The highest instances of bullying were recorded at the Children's Hospitals (67.7%).

An analysis was conducted to observe the frequency of bullying between Hospital Groups. The results of the analysis are presented below.

Table 11. *Bullying Frequency between Hospital Groups for Bullying Frequency*

Bullying Frequency	Frequent	Infrequent	Prefer not to say	Never Bullied
Model of Hospital				
GP Practice	0%	14.9%	6.4%	78.7%
Model 2	3.6%	32.1%	7.1%	57.1%
Model 3	16.2%	46.1%	3.6%	32.9%
Model 4	10.2%	38.7%	4.9%	43.6%
Children's Hospitals	12.9%	31.6%	4.4%	44.7%
Mental Health Services	12.4%	54.8%	0%	32.3%
Private Hospitals	8.3%	37.5%	8.3%	45.8%
Model 8	9.1%	40.9%	0%	50%
Other	18.6%	34.1%	6.2%	8.5%

The lowest rate of bullying was observed in GPs, with no reporting of frequent bullying and 14.9% reporting infrequent bullying. The highest frequency of bullying was observed in the Children's Hospital groups, with 12.9% reporting frequent bullying and 54.8% reporting infrequent bullying.



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