Your Training Counts

Spotlight on health and wellbeing

Comhairle na nDochtúirí Leighis
Medical Council

A SPECIAL REPORT FROM THE TRAINEE NATIONAL EXPERIENCE SURVEY 2014

ACKNOWLEDGEMENTS

This report was prepared by Simon O'Hare, Research, Monitoring and Evaluation Manager at the Medical Council of Ireland.

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We are immensely grateful to Stephen Joseph, Professor in Psychology, Health and Social Care at the University of Nottingham, for giving us permission to replicate the Short Depression-Happiness Scale questionnaire in *Your Training Counts.*

We are also very thankful to the members of the Medical Council's Student and Trainee Consultative Forum, who, through their discussion with the Medical Council about their experience of medical education and training in Ireland, helped to shape ideas discussed in this report.

Finally, we are grateful to the 1,636 trainees across Ireland who took part in *Your Training Counts*. Each trainee who participated took time to share their experience by responding to approximately 100 questions.

Without their contribution *Your Training Counts* would not be a success and we are extremely grateful to everyone who took part.

PRESIDENT & VICE-PRESIDENT'S FOREWORD

Becoming a doctor is an immensely fulfilling career choice. We have the opportunity to help patients and their families through some of the most critical times they may ever face. It is important that we remind ourselves, and particularly doctors in training, the privilege which our profession affords us and the contribution which we can make to people's lives.
However, pursuing a career in medicine is not without personal challenge. These challenges can be felt hardest for those beginning their careers; doctors in training. The renowned physician Sir William Osler noted this well when he said:

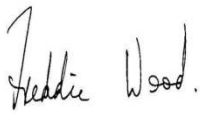
> *"A distressing feature in the life which you are about to enter, a feature which will press hardly upon the finer spirits among you and ruffle their equanimity, is the uncertainty which pertains not alone to our science and art, but to the very hopes and fears that make us men".*[1]

In 2014, following a period of consultation, the Medical Council launched *Your Training Counts,* the annual national trainee experience survey, so as to provide some 3,000 trainees with an opportunity to share their views on the places where they learn as doctors. Our goal was to enable them to put their voice at the heart of discussions regarding postgraduate medical education and training in Ireland. In December 2014, we shared the principle findings or the first wave of data from *Your Training Counts survey* and since then have begun discussions with our partner organisations involved in medical education and training in Ireland. We are doing this to try and better understand how we can take forward the agenda which doctors in training, through their participation in *Your Training Counts*, have set for continuous improvement in the sector in Ireland. Our first inspections of clinical sites – informed by the views trainees provided to us through *Your Training Counts* – performed under the powers delegated to the Medical Council under the Medical Practitioners Act 2007 will take place this year.

Besides focusing on the clinical learning environment, *Your Training Counts* provides an opportunity to spotlight other issues which trainees themselves told us were important.

We are pleased to present this first spotlight, which is a special report on the health and wellbeing of doctors in training in Ireland.

It is all too easy to confuse this as being a "soft" topic. In our view, it is critical to medical education and training and to the future of the health system since without good health, doctors in training cannot fulfil their potential for good professional practice and ensure safe, high quality care for patients. In short, this is as much an issue for our health system as it is for our profession. Through describing the health and wellbeing of doctors in training, and drawing links with other aspects of their experience, the Medical Council looks forward to opening discussion with our partner organisations on how we can better support doctors in good professional practice for the benefit of patients.



Prof Freddie Woods
President

Dr Audrey Dillon
Vice-President

[1] Osler W. *Aequanimitas, with other addresses to medical students, nurses and practitioners of medicine.* Philadelphia: The Blakiston Company, 1910.

CHIEF EXECUTIVE'S INTRODUCTION

We should never forget that people – patients, their families, and the professionals that care for them – are at the heart of the healthcare in Ireland.

Over the last few years, work like the *Medical Workforce Intelligence* reports, the *Talking About Good Professional Practice* dialogue with the public and doctors, and now the *Your Training Counts survey*, are all beginning to widen and better inform discussion about the patient-doctor relationship in 21st century Ireland and are placing this discussion in the context of the wider health system.

I am pleased to continue discussion by introducing this second report based on the views we collected from doctors in training through *Your Training Counts* 2014, which shines a spotlight on their health and wellbeing.

A strong medical workforce – doctors who are physically and mentally fit – is essential for the sustainability of the health system in Ireland. Doctors need to be supported to recognise that caring effectively and compassionately for patients and their families also requires them to pay attention to their own health and wellbeing. There is ample evidence to show that doctors with good health provide safer and more effective care to patients, are more engaged in their work, have better attendance, and are less likely to experience burnout and compassion fatigue. In short, good health and wellbeing contribute to good professional practice.

This spotlight on trainee health and wellbeing, for the first time in Ireland, develops this evidence further and places it in a local context by providing a clear, robust and comprehensive overview of the current status of doctors in training.

It is positive that the majority of trainees are in good health: over 8-in-10 doctors in training rated their health as "good", "very good" or "excellent".

It is also encouraging to note that so many trainees are highly engaged in their work with patients. Doctors in training in Ireland approach their role in patient care with dedication, vigour and positive absorption and we need to ensure this strong and positive engagement is sustained throughout their working lives.

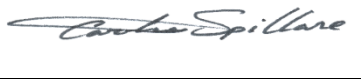
However, good health is more than physical fitness and freedom from disease. It is notable that almost 1-in-5 trainees rated their quality of life as "poor" or "very poor", and that for a similar proportion there appeared to be some evidence to suggest that they may be experiencing challenges with mental health and wellbeing. These findings among Irish trainees are consistent with similar studies on quality of life and mental health and wellbeing among trainees and doctors.

Through *Your Training Counts*, we are able to draw linkages between trainee health and wellbeing and other aspects of their training experience. A negative experience of the work environment through bullying and undermining stands-out as being strongly and consistently linked with poorer quality of life and mental health; this is unsurprising but the relationship depicted in this report is stark. Other factors like hours worked and type of working and learning environment also showed strong and important relationships with the health and wellbeing of doctors in training. Finally, lest there be any doubt but that trainee health and wellbeing is a legitimate concern in medical education and training, it is noteworthy that trainees with poorer health also reported more negative views of the clinical learning environment.

Doctors in training provide safe, effective and compassionate care for patients and families through times of great distress. They do so in an increasingly demanding health system context, while at the same time, are trying to build their future professional lives through medical education and training. Internationally, the health and wellbeing challenges faced by doctors in training are well recognised; meaning these findings are not unique to Ireland but cannot, and will not be overlooked. Doctors in training need support to maintain good health and wellbeing in the interest of patient care through building awareness of these issues skills for appropriate self-care into medical education and training curricula. But we cannot limit our focus to the individual. Issues in

the clinical environment, like experiences of bullying and undermining, challenge maintenance of good health and wellbeing and they need to be confronted. Our health system needs to consider the health and wellbeing of doctors and other caring professionals as a key to the quality agenda. At the Medical Council, we will continue to lead discussion on doctors' health and wellbeing because it is critical to good professional practice and to a strong and effective patient-doctor relationship.

Through this spotlight, the Medical Council looks forward to continuing to work with trainees, educators, healthcare organisations and policy-makers to build strong systems for doctors' education, training and practice – which include a concern for doctors health and wellbeing – in the interests of safe, effective and compassionate patient care.



Caroline Spillane
Chief Executive Officer

ABOUT THE MEDICAL COUNCIL

Through the regulation of doctors, the Medical Council enhances patient safety in Ireland. In operation since 1979, it is an independent statutory organisation, charged with fostering and ensuring good medical practice. It ensures high standards of education, training and practice among doctors, and acts in the public interest at all times. The Medical Council is noteworthy among medical regulators worldwide in having a non-medical majority. It comprises of 13 non-medical members and 12 medical members, and has a staff of approximately 70.

The Medical Council's role focuses on four areas:

MAINTAINING THE REGISTER OF DOCTORS

The Medical Council reviews the qualifications and good standing of all doctors and makes decisions about who can enter the register of medical practitioners. In December 2013, approximately 18,000 doctors were registered, allowing them to practise medicine in Ireland.

SAFEGUARDING EDUCATION QUALITY FOR DOCTORS

The Medical Council is responsible for setting and monitoring standards for education and training throughout the professional life of a doctor: undergraduate medical education, intern and postgraduate training and lifelong learning. It can take action to safeguard quality where standards are not met.

SETTING STANDARDS FOR DOCTORS' PRACTICE

The Medical Council is the independent body responsible for setting the standards for doctors on matters related to professional conduct and ethics. These standards are the basis to good professional practice and ensure a strong and effective patient-doctor relationship.

RESPONDING TO CONCERNS ABOUT DOCTORS

Where a patient, their family, employer, team member or any other person has a concern about a doctors' practice, the Medical Council can investigate a complaint. When necessary, it can take appropriate action following its investigation to safeguard the public and support the doctor in maintaining good practice.

Through its work across these four areas, the Medical Council provides leadership to doctors in enhancing good professional practice in the interests of patient safety. You can find out more about the Medical Council at www.medicalcouncil.ie.

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TRAINEE HEALTH AND WELLBEING AT A GLANCE

- The Medical Council invited trainees to share views on their health and wellbeing through *Your Training Counts* 2014.
- Over 8-in-10 (88%) trainees rated their general health as being at least good; 2-in-10 (23%) rated their general health as 'excellent'.
- Many trainees reported good levels of engagement with their work.
- However, trainee views on quality of life and mental health and wellbeing were less positive.
- 6-in-10 (62%) trainees rated their quality of life as being at least good, but 2-in-10 rated it as 'neither good nor poor' and 2-in-10 (18%) rated it as 'poor' or 'very poor'.
- While many trainees reported positive mental health and wellbeing, 2-in-10 reported scores which indicated that they may be in need of mental health and wellbeing support services.
- Some significant trends in trainee reported health and wellbeing were identified.
- Trainees who reported experiencing 'bullying' and 'undermining' also reported poorer health and wellbeing across a number of indices, including: general health, quality of life, mental health and wellbeing and work engagement.
- Trainees who reported working a greater number of hours per week also reported poorer health and wellbeing across a number of indices, including: general health, quality of life, and mental health and wellbeing.
- Trainee reported health and wellbeing indices were also linked with their views of the clinical learning environment. In general, trainees who reported better health and wellbeing also had more positive views of the clinical learning environment.
- In total, 3-in-10 (29%) trainees felt they needed to access some support services for their health and wellbeing needs. Male trainees (21%) less commonly reported feeling a need for support services than female trainees (35%).
- Despite reporting that they felt a need for support, over 8-in-10 (86%) of trainees did not report accessing support services. Not accessing support services, despite feeling a need, was more common among younger trainees.

INTRODUCTION

Key Points

- *Your Training Counts*, the annual national trainee experience survey, is a new programme, designed and delivered by the Medical Council, which aims to inform and support the continuous improvement of the quality of postgraduate medical training in Ireland.
- In 2014, the Medical Council invited trainees to share views on their health and wellbeing.
- There is already a body of international evidence describing the particular challenges which doctors in training face in maintaining good health and wellbeing, especially sustaining good mental health and avoiding burnout.
- Besides being an issue for the individual trainee, good mental health and wellbeing is important for good professional practice, for safe, high quality and compassionate patient care and for the sustainability of the health system.
- Trainees were invited to share views on their general health, their quality of life, their mental health and wellbeing, their engagement with work and their utilisation of support services.

Why *Your Training Counts*?

The Medical Council is responsible for setting and monitoring standards for medical education and training throughout the professional life of a doctor: undergraduate medical education, intern and postgraduate training and lifelong learning.

There are just over 18,000 doctors registered to practise medicine with the Medical Council in Ireland and approximately 3,000 of these are interns or specialist trainees (in general, this report will refer to both groups of doctors as "trainees", unless qualified). Training pathways for doctors are variable: following intern training (which lasts for twelve months), doctors proceed to basic specialist training (which lasts approximately 2 years) before proceeding to higher specialist training (which lasts approximately 4 to 6 years). Training in General Practice can commence following intern training and lasts for 4 years. These pathways are undergoing reform and some trainees pursue run-through training.

Your Training Counts, the annual national trainee experience survey, is a new programme, designed and delivered by the Medical Council, which aims to support the continuous improvement of the quality of postgraduate medical training in Ireland – workplace-based training for doctors which takes places across various clinical sites including hospitals, mental health services and GP practices.

Specifically, the objectives of *Your Training Counts* are:

- To monitor trainee views of the clinical learning environment in Ireland
- To monitor trainee views of other aspects of postgraduate medical education and training including preparedness for transitions, retention and career plans, health and wellbeing, and trainee perceptions of safety at clinical sites
- To inform the role of the Medical Council in safeguarding the quality of medical education and training by identifying opportunities for strengthening standards and guidance, and through focusing on its quality assessment role
- To inform dialogue and collaboration between all individuals and bodies involved in medical education and training in Ireland so as to continually improve the experience and outcomes of trainees in Ireland.

Your Training Counts collected feedback from 1,636 trainees (just over half of all trainees invited) on more than 100 questions. The Dutch Residency Educational Climate Test (D-RECT), was used to collect trainee views of the clinical learning environment in Ireland. Trainee views on inductions and orientation, preparedness for transitions, bullying and undermining behaviours, trainee safety, and quality of patient care in the clinical environment were elicited using questions from the General Medical Council's National Training Survey and questions developed by the UK Medical Careers Research Group. The survey ran from April to July 2014. Trainees provided views of their experience of training at a specific clinical site over the 12 months prior to the survey.

You can find more information about how we did *Your Training Counts*, including details on methods and the main findings at http://bit.ly/YourTrainingCounts

Why ask trainees' about their health and wellbeing?

There is a significant body of evidence describing the challenge faced by medical students and trainees in maintaining good health and wellbeing, and it especially highlights issues regarding mental health and burnout.[2] Early transitions into the clinical

[2] See for example:
Dyrbye L.N., Thomas, M.R., and Shanafelt, T.D. Systematic Review of Depression, Anxiety, and Other Indicators of Psychological Distress Among U.S. and Canadian Medical Students. *Acad Med* 2006; 81:354–373.

environment for doctors at the initial stages of training can be especially challenging as they gain new clinical responsibilities, have increased work hours and need to navigate interpersonal relationships with other healthcare professionals, patients and their families.[3] The reality of the clinical environment can be a "culture shock".[4] It can present trainees with professionalism dilemmas, which challenge how they think about being a doctor, and these differences between what they ideally expect and what they experience in reality can be especially distressing.[5]
Clearly, a challenge to maintaining good health and wellbeing creates issues for the individual doctor in training. This should not be overlooked.

However, the case for focusing on trainee health and wellbeing also relates to the wider context and relevance beyond individual trainees.

There is an emerging body of evidence which links doctors' health and wellbeing with patient care and health system outcomes. Doctors who themselves demonstrate concern for their own health and wellbeing are more likely to counsel their patients about staying healthy;[6] this is important in the context of the increasing burden of chronic disease and the need to promote population health. Burnout among doctors is associated with reduced productivity.[7] Fatigue and burnout have also been associated with error in medical care.[8,9] The linkages between doctors health and wellbeing and their capability to provide compassionate care on an ongoing basis are also important.[10]
In summary, the health and wellbeing of doctors, including doctors in training, is increasingly recognised as a medical professionalism issue and a health system "quality indicator" issue.[11,12] How did we measure health and wellbeing?

How did we measure health and wellbeing?

Your Training Counts 2014 invited trainees to respond to 11 different questions about health and wellbeing:

- one item on self-rated general health and one item on quality of life;[13]
- six items comprising the Short Depression-Happiness Scale to examine mental health and wellbeing; [14]
- nine items on engagement with work using the Utrecht Work Engagement Scale;[15]
- three items to examine utilisation of and experience with support services.

Thomas, N.K. Resident burnout. *JAMA* 2004 Dec 15;292(23):2880-9.
[3] Lamdin R. First Clinical Attachments: Informal Learning and Stressors in the Clinical Environment. In: First so no self-harm: Understanding and promoting physician stress resilience. Figley C., Huggard P, and Rees C.E. Eds. Oxford: Oxford University Press, 2013.
[4] Wear D., Aultman J.M., Varley J.D., Zarconi J. Making fun of patients: medical students' perceptions and use of derogatory humour in the clinical settings. *Acad Med* 2006 81(5): 454-462.
[5] Rees C.E and Monreaux L.V. Narrative, emotion and action: analysing 'most memorable' professionalism dilemmas. Medical Education 2013 47(1): 80-96.
[6] Frank E. Physician Health and Patient Care. *JAMA* 2004 291(5):637.
[7] 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.
[8] West C.P., Tan A.D., Habermann T.M., Sloan J.A., and Shanafelt T.D. Association of resident fatigue and distress with perceived errors. *JAMA* 2004, 302(12): 1294-1300.
[9] Fahrenkopf A.M., Sectish T.C., Barger L.K., et al. Rates of medication errors among depressed and burnt out residents: prospective cohort study. *BMJ* 2008 336(7642): 358-367.
[10] Huggard P, Stamm BH, and Pearlman L.A. Physician Stress: Compassion satisfaction, compassion fatigue and vicarious traumatization. In: First so no self-harm: Understanding and promoting physician stress resilience. Figley C., Huggard P, and Rees C.E. Eds. Oxford: Oxford University Press, 2013.
[11] Canadian Medical Association, 1998. CMA Policy: Physician Health and Wellbeing. https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/CMA_Policy_Physician_health_and_well-being_PD98-04-e.pdf
[12] Wallace J.E., Lemaire J.B., and Ghali W.A. Physician wellness: a missing quality indicator. *Lancet* 2009 374:1714-21
[13] Self-rated general health and quality of life questions are well established, valid and reliable measures of health status and are used, for example, in the Survey of Lifestyles and Nutrition in Ireland since 2002 .
(see http://www.ucd.ie/issda/data/surveyonlifestyleandattitudestonutritionslan/).
[14] Joseph S, Linley PA, Harwood J, Lewis CA, McCollam P. Rapid assessment of well-being: The Short Depression-Happiness Scale (SDHS). Psychol Psychother. 2004 Dec;77(Pt 4):463-78.
[15] Schaufeli W and Bakker A. Utrecht work engagement scale: Preliminary Manual [Version 1, November 2003]. Accessed at http://www.beanmanaged.com/doc/pdf/arnoldbakker/articles/articles_arnold_bakker_87.pdf

Trainees invited to take part in *Your Training Counts* were provided with comprehensive information about the survey, its purposes and how their responses would be used by the Medical Council. On this basis, they could determine whether they wanted to participate or not. Furthermore, in the course of the survey, trainees could opt not to share information on health and wellbeing if that was their preference.

In this spotlight, we provide results for each item asked regarding health and wellbeing, and analyse responses by a range of personal characteristics (e.g. trainees' age, gender), contextual factors (e.g. what type of site they were located in) and other items in *Your Training Counts* (e.g. experience of bullying) to look for significant variations in experiences; which may help direct subsequent quality improvement strategies.

To help determine significant variations in trainee experiences, a range of parametric and non-parametric statistical tests were conducted. When analysing normally distributed data, parametric tests including independent samples tests (to compare scores between two groups e.g. males and females), One-way ANOVAs (for comparing scores between more than two groups e.g. age ranges) and Pearson's correlations (for comparing scores with other scale data) were used. Where scale data was not normally distributed, non-parametric tests including Mann-Whitney U test (for comparing scores from two different groups), Kruskal-Wallis tests (for comparing scores across 3 or more groups), and Spearman's rank order correlations (to check for correlations between different scales) were used. When scale data was borderline in terms of the normality of distribution both parametric and non-parametric tests were conducted with the most conservative result reported. Phi values were used to gauge the strength of association between nominal variables with two categories, Cramer's V for associations between nominal variables with more than two categories, and Gamma for describing the strength of association between ordinal variables. All tests that reported a p value of $< .05$ were considered as statistically significant; conclusions on direction or causative nature of relationships are not inferred.

A data annex that provides more detail on the charts highlighted in this health and wellbeing spotlight can be viewed at the following link: http://bit.ly/YourTrainingCounts

PROFILE OF TRAINEE GENERAL HEALTH

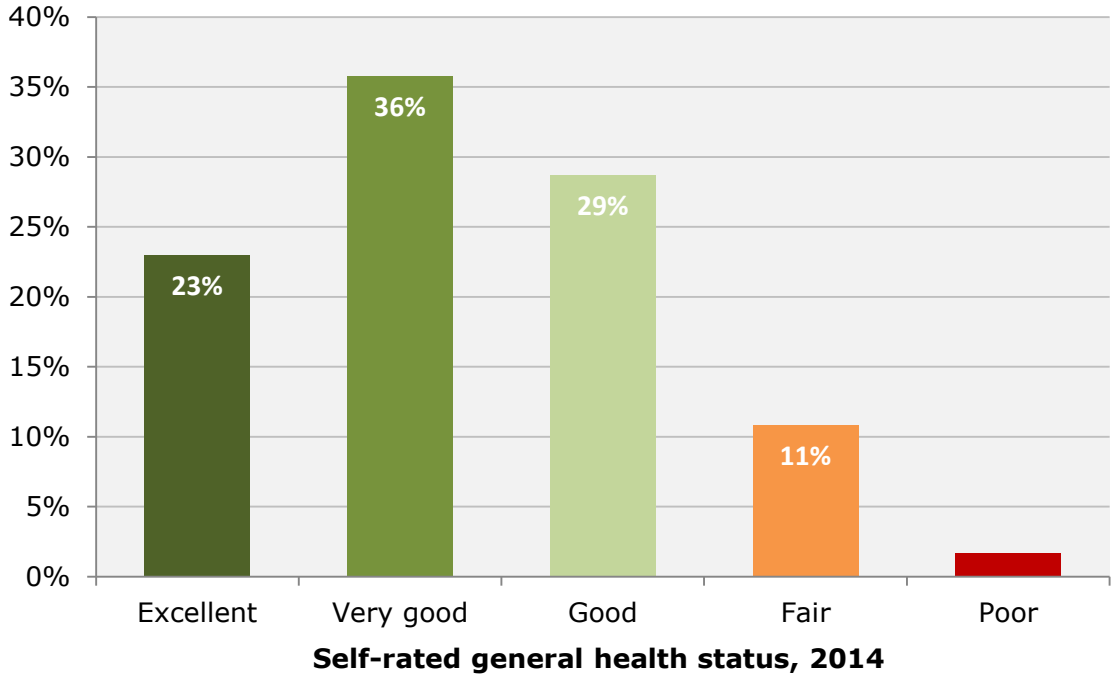
Key points

- Over 8-in-10 (88%) of trainees rated their general health as at least good; and 2-in-10 (23%) rated their health as 'excellent'.
- Most trainees shared a good experience of general health: rating did not vary with significance based on age, whether they were a direct entry or graduate entry medical student, whether they qualified with their basic medical qualification in Ireland or elsewhere, their stage of training or the type of site where they were training.
- Trainee reported experience of 'bullying' and 'undermining' was linked with self-rated general health: compared with trainees who did not report bullying or undermining, trainees who reported these experiences also rated their general health more poorly.
- Trainee reported 'hours worked per week' was also linked with self-rated general health: trainees who reported a greater number of hours worked per week also rated their general health more poorly.

Self-rated general health among doctors in training in Ireland, 2014

In 2014, 88% of trainees rated their general health as being at least good; 23% rated their general health as excellent (Figure 1).

Figure 1: Trainee views on general health - In general, would you say your health is?



Variations self-rated general health among doctors in training

There were no statistically significant associations between self-rated general health and a range of other factors: trainees' age; the region in which they gained their Basic Medical Qualification (i.e. Ireland versus elsewhere); if they entered the profession through direct or graduate entry routes; their stage of training; the type of site in which they were located; or, how well-prepared they felt for the intern year.
Significant associations were found between health ratings and trainees' (in order of strongest associations first): experience of being bullied in post; hours worked in an average week; experience of being undermined by a consultant or GP; overall views on learning environments; and, gender. These findings are presented below.

General health and reported experience of bullying and undermining in post

There was a significant, and moderate, association between trainees' general health ratings and their reported experience of bullying. Trainees who reported being frequently bullied in post were significantly more likely to rate their health as "less than good" (26%) compared to trainees who were never bullied at work (9%) (χ^2 (2, N=1361) = 49.79, $p < .001$ (see Figure 2).

There was also a significant, moderate, association between trainees' general health ratings and their reported experience of undermining behaviour from a consultant/GP in post. Trainees who reported being frequently undermined by consultants/GPs were more likely to have "less than good" health (22%), than trainees who reported that they were never undermined (9%) (χ^2 (2, N=1378) = 26.13, p < .001 (see Figure 3).

Figure 2: Trainee views on general health – variation by reported experience of bullying

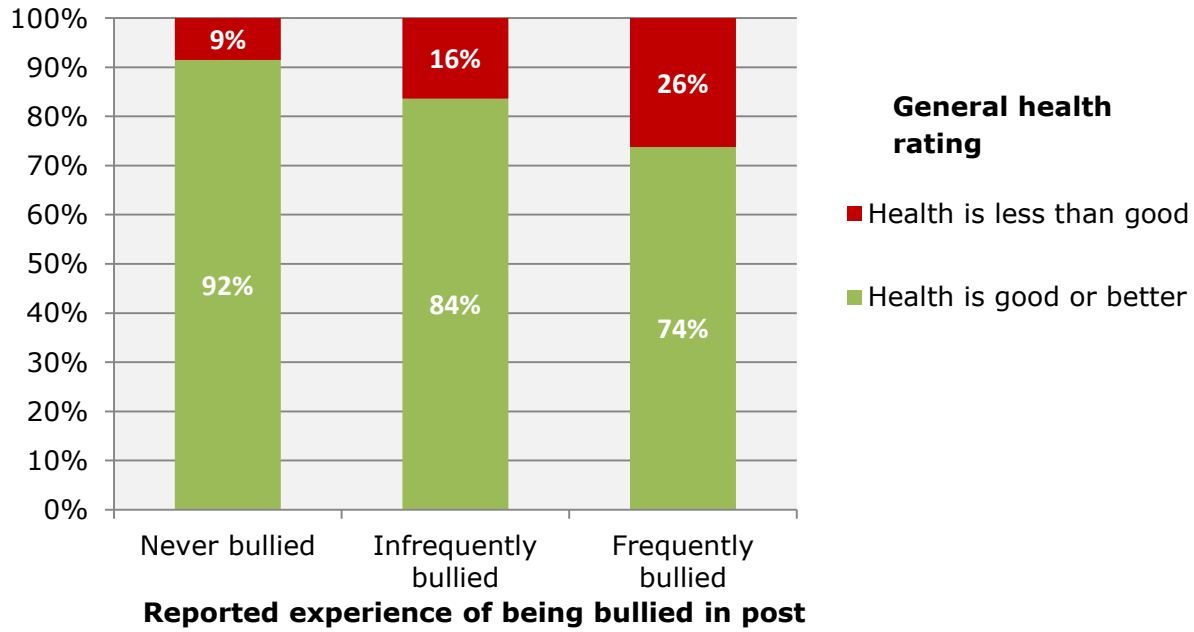
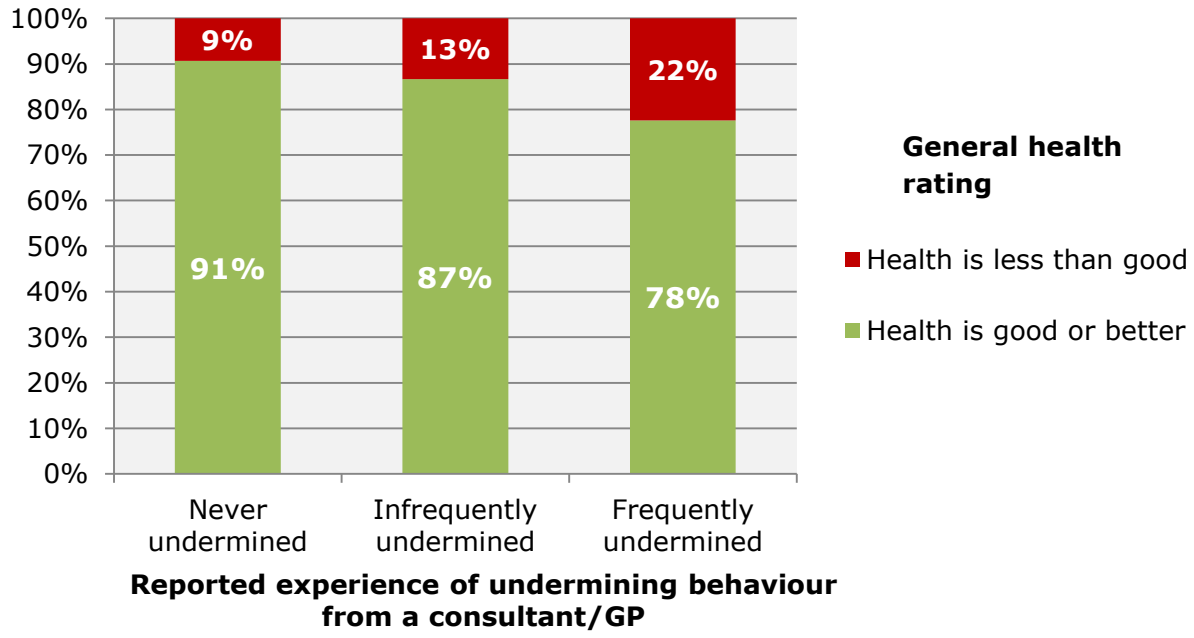


Figure 3: Trainee views on general health – variation by reported experience of undermining

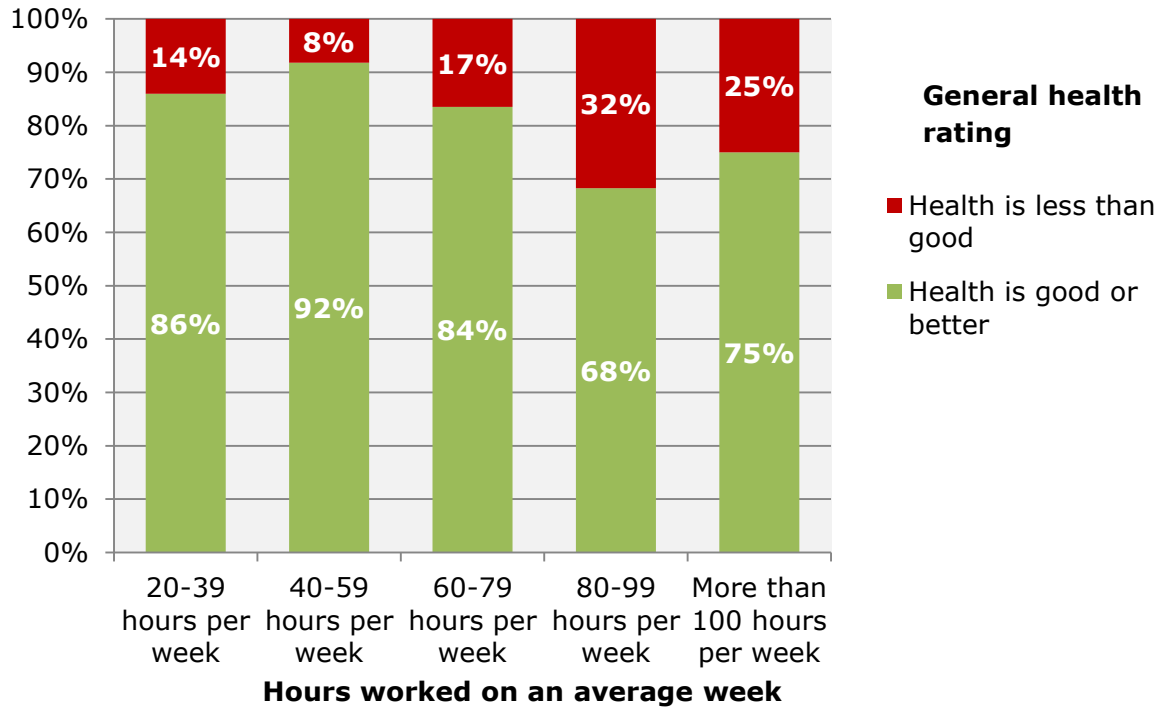


*Please note: Columns sometimes do not add up to exactly 100% because of a 'rounding up error' eg. figure 2, figure 4, figure 11, figure 12, figure 13, figure 14.

General health and reported hours worked in an average week

Self-rated general health and the number of hours trainees' reported that they worked in an average week were significantly, and moderately, associated. Trainees who reported that they worked between 40-59 hours a week were significantly more likely to also rate their general health as "good or better" (92%) than trainees who reported that they worked between 60-79 hours a week (84%), or between 80-99 hours a week (68%) (χ^2 (1, N=1432) = 28.08, p < .001; See Figure 4).

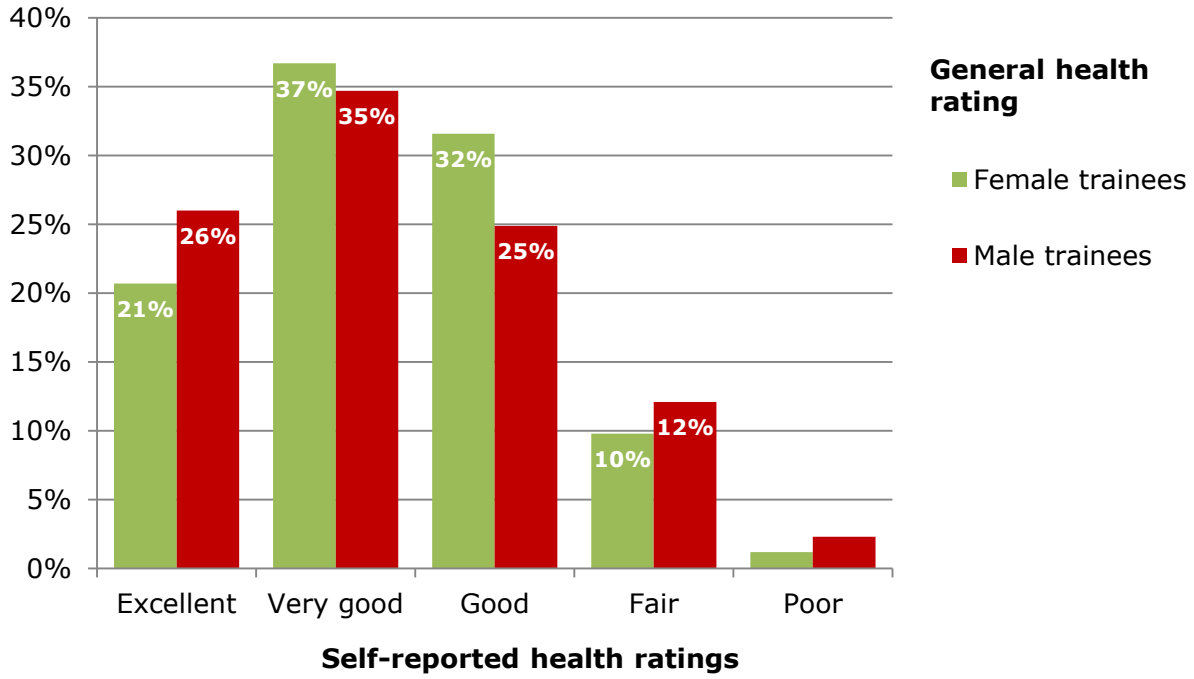
Figure 4: Trainee views on general health – variation by reported hours worked in an average week



General health and gender

There was a statistically significant, but relatively small and weak, association between trainees' self-rated general health and gender. For example, female trainees were significantly less likely to consider their health as "excellent" (21%), compared to male doctors (26%); however, it's worth noting that the pattern in gender difference varies across rating (χ^2 (4, N=1432) = 14.05, p = .007; see Figure 5).

Figure 5: Trainee views on general health – variation by gender



General health and views of the learning environment (D-RECT scores)

There was a significant, but relatively weak, association between trainees' self-rated general health and their views on clinical learning environments (i.e. D-RECT scores). The general pattern was that better general health ratings were linked with better perception of the clinical learning environment ($F(4,1280) = 23.71$, $p < .001$; see Figure 6): for example, trainees who reported "excellent" health had a mean D-RECT score of 181, while trainees who reported "poor" health had a mean D-RECT score of 144.

Figure 6: Trainee views on general health – variations in views of clinical learning environment

PROFILE OF TRAINEE QUALITY OF LIFE

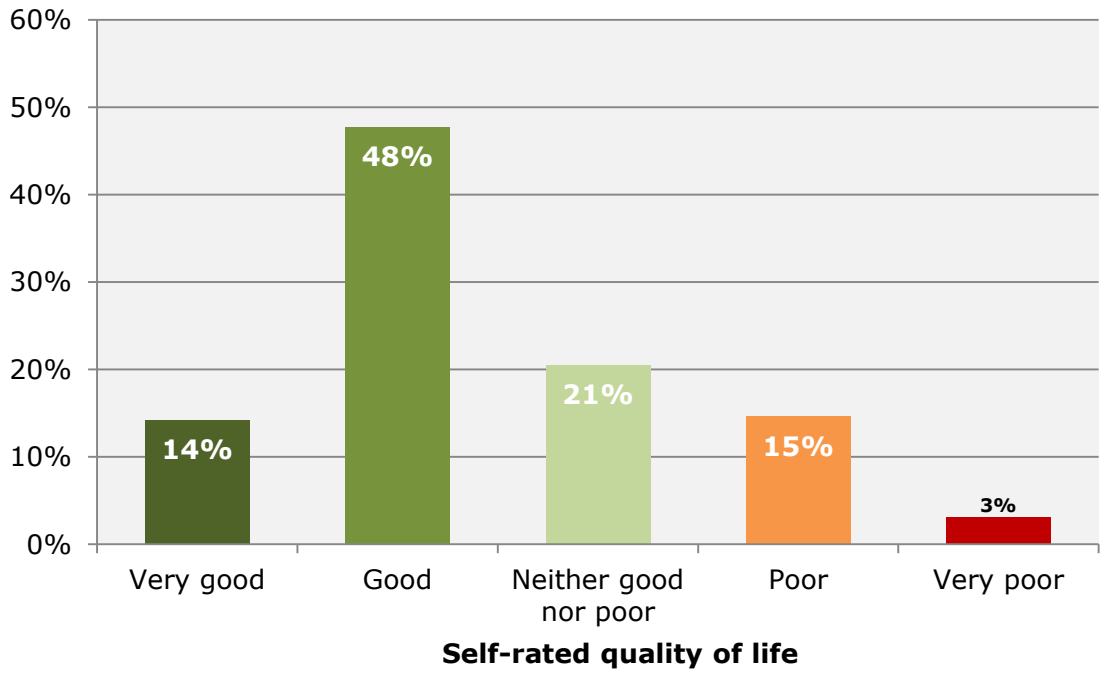
Key points

- Views from doctors in training on their quality of life were less positive than their views on general health: 6-in-10 trainees (62%) rated their quality of life as being at least good; 2-in-10 (21%) rated it as 'neither good nor poor' and 2-in-10 (18%) rated it as 'poor' or 'very poor'.
- There was also greater variation in trainees' views of their quality of life than their self-rated health: the type of site in which trainees were located, their stage of training, their age, and the whether they gained their Basic Medical Qualification in Ireland or elsewhere were all significantly associated with quality of life ratings.
- Trainees in larger hospitals were significantly more likely to rate their quality of life as less than good (43%) compared to trainees in GP practices (22%).
- Trainees who reported that they experienced 'bullying' or 'undermining' also rated their quality of life more poorly than those who did not report these experiences.
- Furthermore, the experience of working a greater number of hours per week was also associated with a more poorly rated quality of life.
- Finally, trainee views on their quality of life were linked with their views of the clinical learning environment (D-RECT score): trainees rating their quality of life poorly also had poor views of the clinical learning environment.

Self-rated quality of life among doctors in training in Ireland, 2014

In 2014, 62% of trainees rated their quality of life as being at least good; 18% rated their quality of life as poor or very poor (Figure 7).

Figure 7: Trainee views on quality of life - How would you rate your quality of life?



Variations in self-rated quality of life among Doctors in training

Trainee-related characteristics were linked with their rating of quality of life: there were significant, but relatively weak, linkages between quality of life ratings and trainee age, whether the trainee gained their Basic Medical Qualification in Ireland or overseas and the stage of training. Whether the trainee was a direct-entry or graduate entry medical student was not significantly linked with quality of life ratings (χ^2 (4, N=1128) = 9.04, p = .060).

Aspects of the environment were related to quality of life. The type of site in which trainees were located was significantly, but relatively weakly, linked with quality of life ratings.

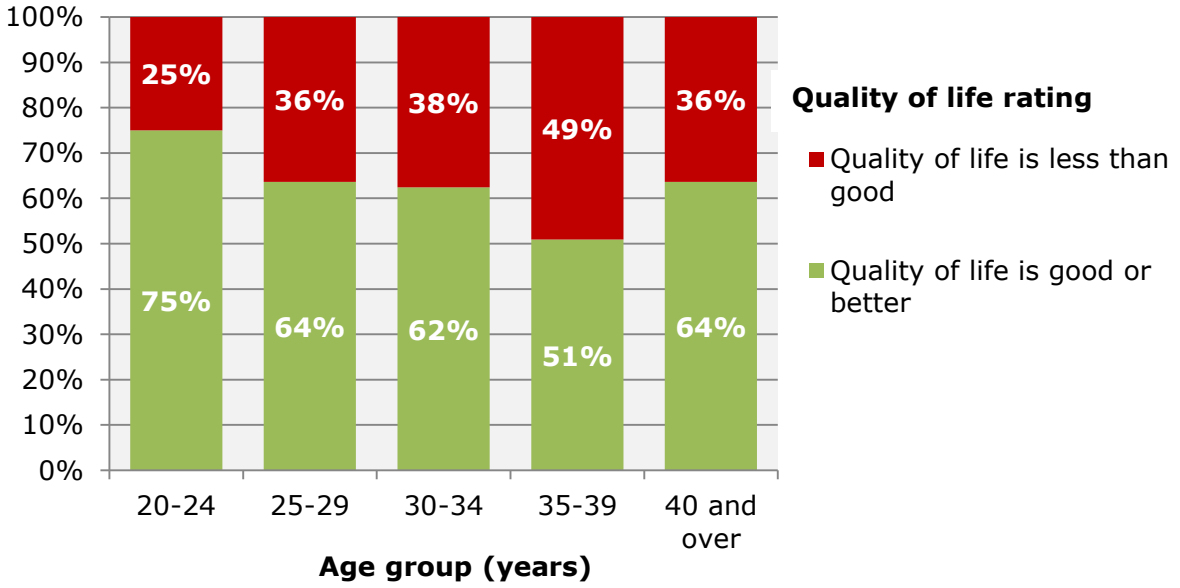
Importantly, there were significant and moderately strong linkages between quality of life ratings and (in order of strength of association, with the strongest first) reporting the experience of being bullied in post, the self-reported number of hours worked in an average week, and reporting the experience of being undermined by a consultant/GP.

Finally, views of the clinical learning environment were also significantly and moderately associated with quality of life.

Quality of life and trainee-related characteristics

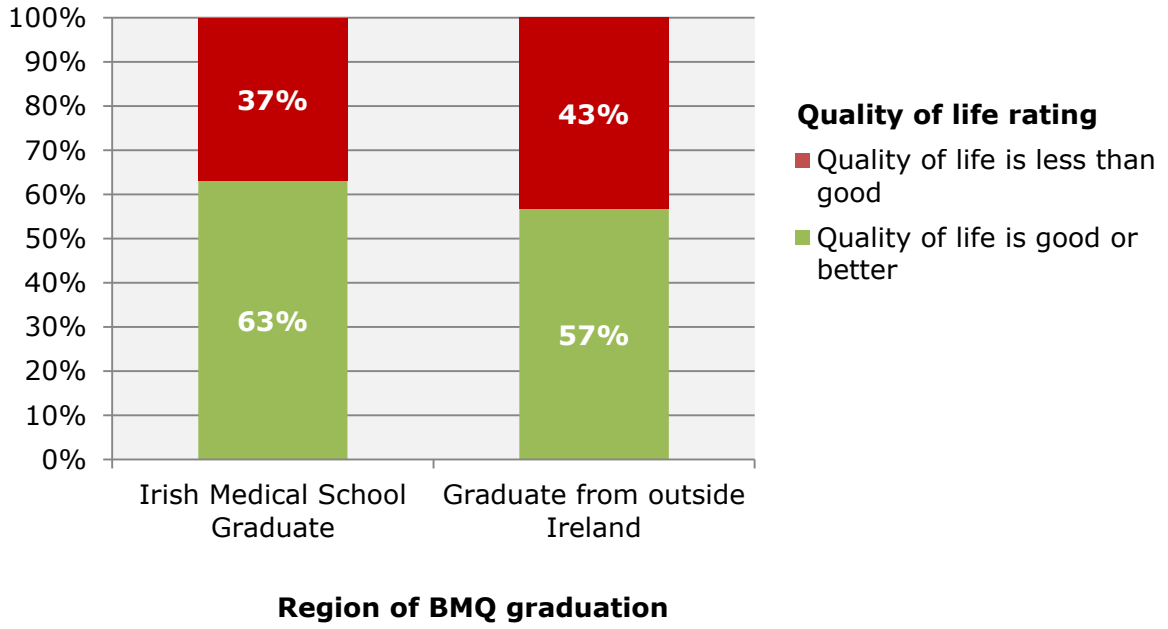
Age was significantly, but weakly, associated with trainee views on their quality of life. The general pattern is that younger trainees reported a better quality of life, χ^2 (4, N = 1427) = 16.81, p = .002. For example, trainees in the 20-24 year old category were more likely to rate their quality of life as good or better (75%), compared to trainees in the 35-39 year old category (51%).

Figure 8: Trainee views on quality of life – variation by age



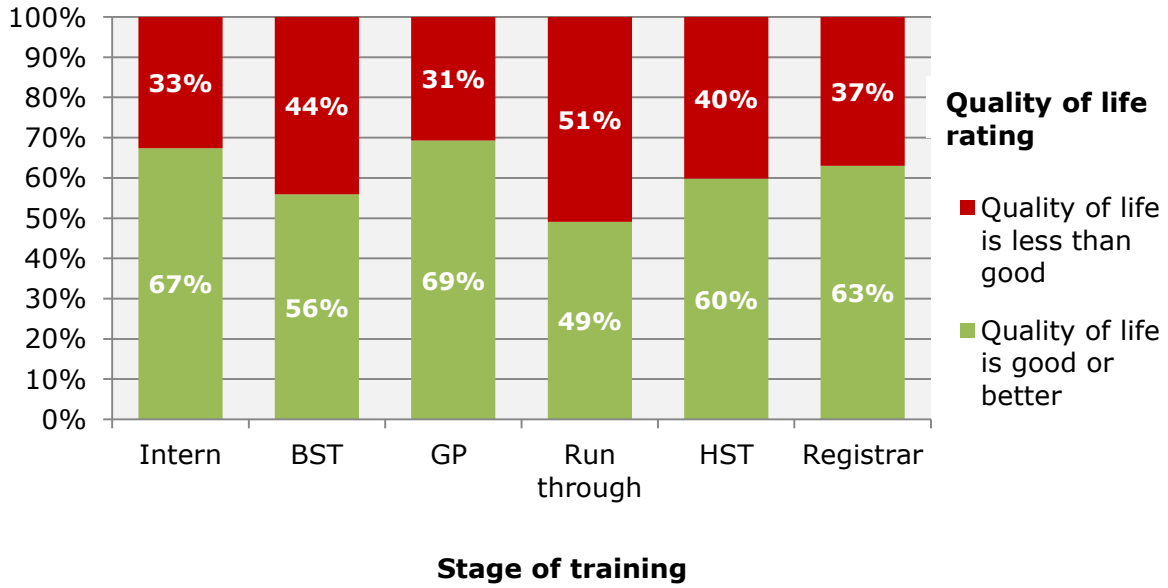
Similarly, quality of life ratings were significantly, but weakly, linked with where trainees gained their Basic Medical Qualification (BMQ). Trainees who graduated from Irish medical schools were more likely to rate their quality of life as good or better (63%) compared to trainees who graduated elsewhere (57%), $\chi 2$ (1, N=1427) = 4.15, p = .042.

Figure 9: Trainee views on quality of life – variation by country of qualification



Trainees views on quality of life were significantly, albeit weakly, associated with different stages of training. Trainees on GP training programmes were more likely to rate their quality of life as good or better (69%) than trainees on BST programmes (56%), $\chi 2$ (5, N=1425) = 20.18, p = .001.

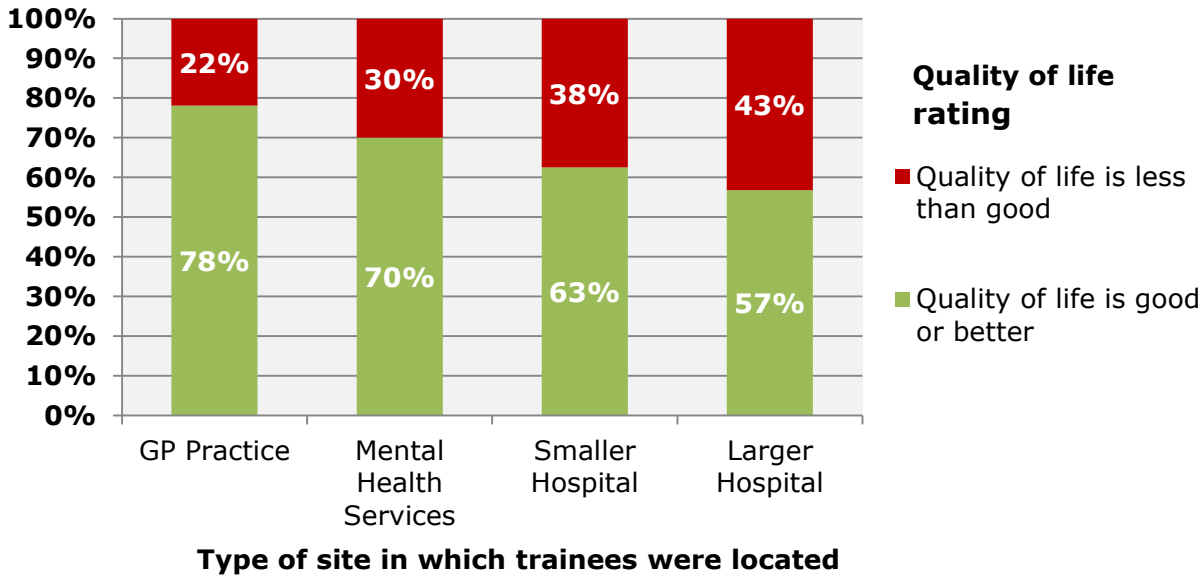
Figure 10: Trainee views on quality of life – variation by stage of training



Quality of life and clinical site-related characteristics

There was a statistically significant, but relatively weak, association between trainee reported quality of life ratings and the type of clinical site in which trainees were working and learning. Trainees in larger hospitals were significantly more likely to rate their quality of life as less than good (43%) compared to trainees in GP practices (22%) (χ^2 (3, N=1405) = 31.87, p < .001; see Figure 11).

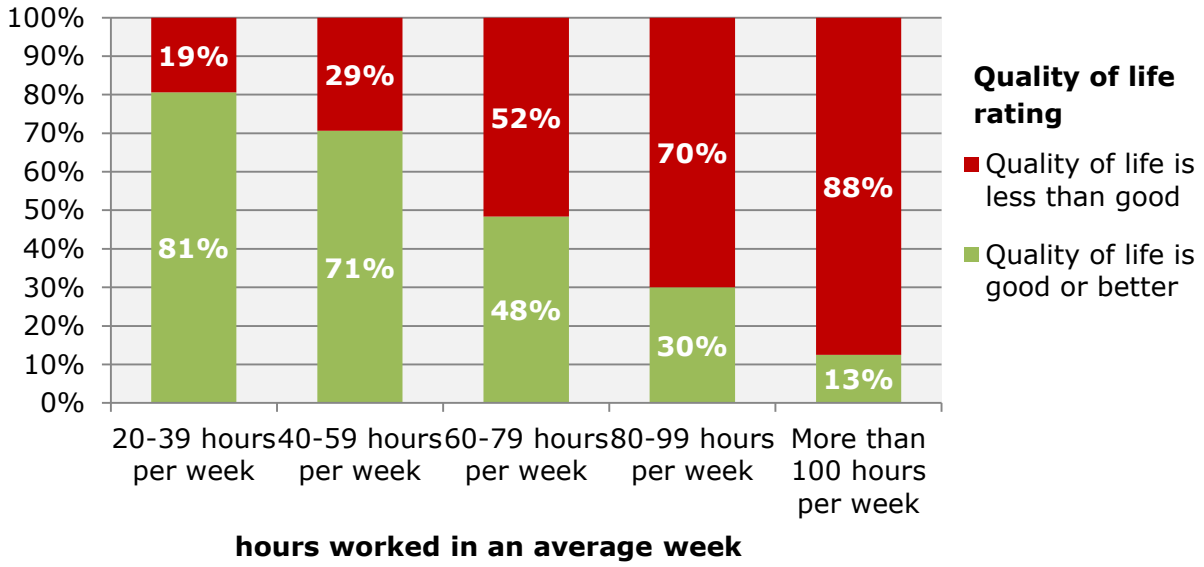
Figure 11: Trainee views on quality of life – variation by type of clinical site



Quality of life and reported hours worked in an average week

There was a significant, and moderately strong, association between trainee-reported quality of life ratings and reported hours worked in an average week. In general, the more hours trainees worked in an average week, the lower their quality of life (χ^2 (4, N=1427) = 109.92, p < .001; see Figure 12); for example, trainees who worked for 20-39 hours a week were significantly more likely to rate their quality of life as good or better (81%) than trainees who worked between 60-79 hours a week (48%).

Figure 12: Trainee views on quality of life – variation by number of hours worked



Quality of life and reported experience of bullying and undermining in post

There was a moderately strong association between trainee reported quality of life ratings and trainee reported experience of being bullied in post. Trainees who reported that they were bullied frequently were significantly more likely to rate their quality of life as less than good (66%) than trainees who reported that they were never bullied in post (28%), (χ^2 (2, 1359) = 109.47, p < .001; see Figure 13). There was also a significant, moderate, association between quality of life ratings and trainee reported experiences of being undermined by a consultant/GP in post. Trainees that were reported as being frequently undermined in post were more likely to rate their quality of life as less than good (58%) than trainees who reported that they were never undermined (31%), (χ^2 (2, N=1373) = 53.21, p <.001; see Figure 14).

Figure 13: Trainee views on quality of life – variation by reported experience of bullying

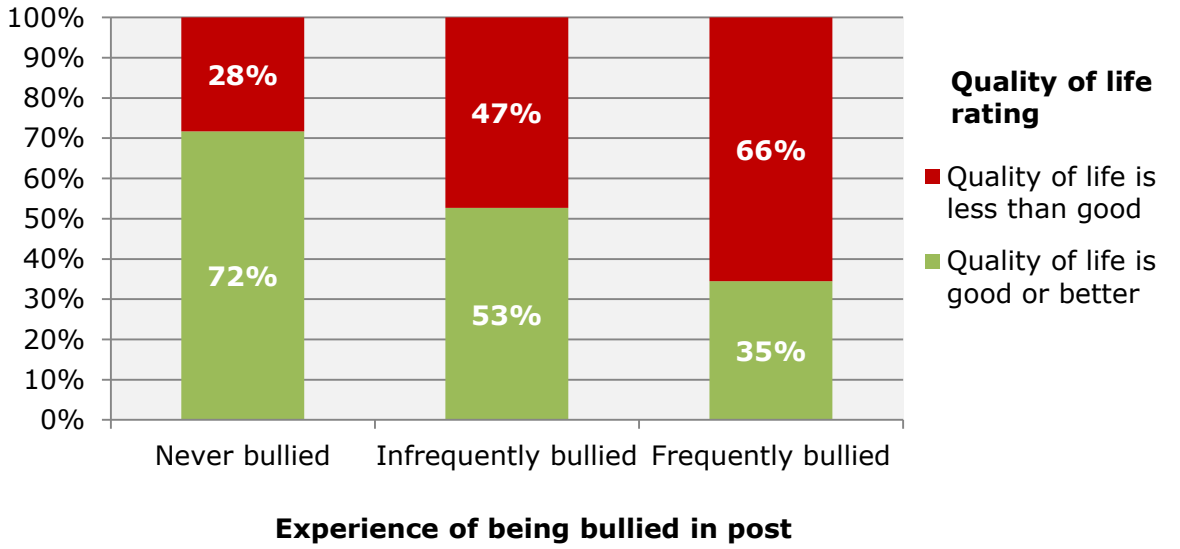
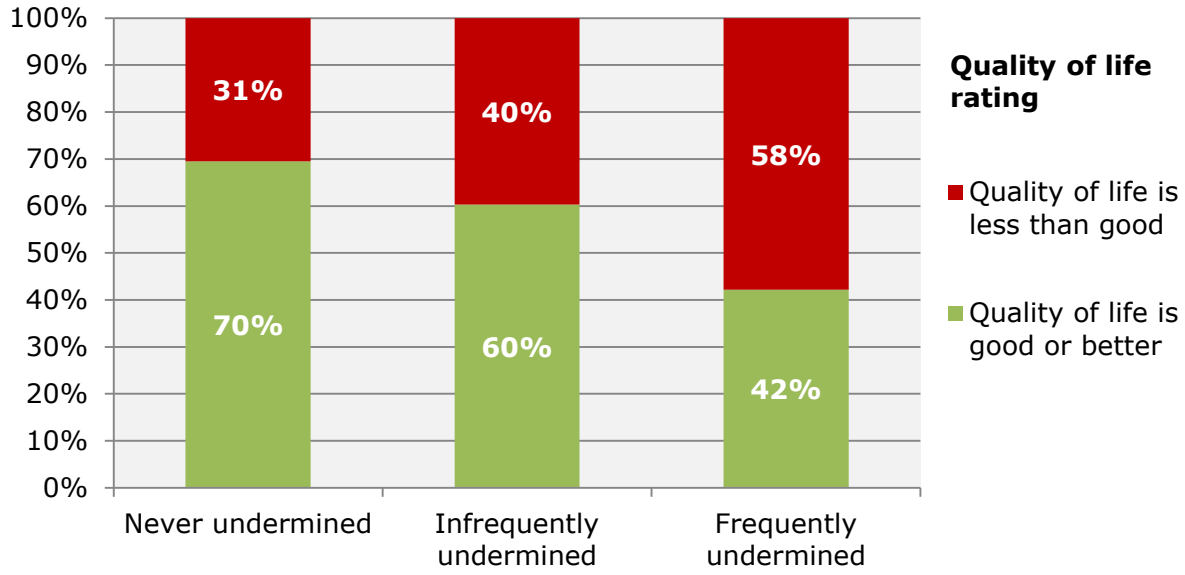


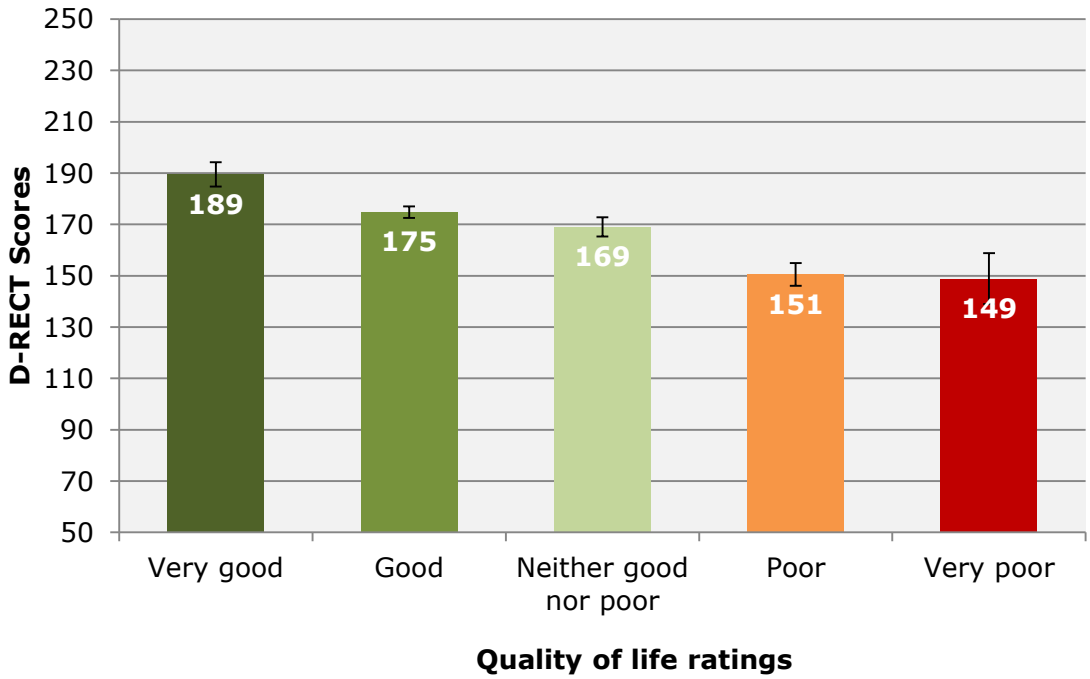
Figure 14: Trainee views on quality of life – variation by reported experience of undermining



Quality of life and views of the learning environment (D-RECT scores)

There was a significant, and moderately strong, association between trainee reported quality of life ratings and their views on learning environments (i.e. total D-RECT scores). In general, trainees who reported better quality of life rating also reported better views of the quality of learning environment. For example, trainees who reported "very good" quality of life had a mean D-RECT score of 189, while trainees who rated their quality of life as "very poor" had a mean D-RECT score of 149 ($F(4,1277) = 48.70$, $p < .001$; see Figure 15).

Figure 15: Trainee views on quality of life – variation in views of the learning environment



PROFILE OF TRAINEE MENTAL HEALTH AND WELLBEING

Key points

- We invited trainees to rate their mental health and wellbeing using the Short Depression-Happiness Scale (SDHS), a rapid assessment of mental health and wellbeing which provides a score on a scale of 0-18: higher scores indicating better mental health and wellbeing. The instrument is a valid and reliable 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 who some support might be helpful.
- Overall, SDHS ratings show that many trainees' enjoy good mental wellbeing. The mean SDHS score among trainees was 12.5 (95% CI 12.3 – 12.7).
- However, 2-in-10 (21%) trainees reported SDHS scores of 9 or less indicating that their mental health and wellbeing may be causing them some difficulty.
- Similar mental health and wellbeing was enjoyed by trainees with different characteristics. There were no significant variations in SDHS scores based on gender, whether or not the trainee gained their Basic Medical Qualification in Ireland or overseas, whether they were a direct entry or graduate entry medical student, their age, or their stage of training.
- However, SDHS scores were linked with trainee reported experience of bullying and undermining: trainees that reported experience of bullying and undermining also reported lower SDHS scores.
- SDHS scores were also linked with trainee reported hours worked in an average week: trainees that reported working a greater number of hours also reported lower SDHS scores.
- Finally, SDHS scores were linked with views of the clinical learning environment. Trainees who reported lower SDHS scores also reported poorer views of the clinical learning environment.

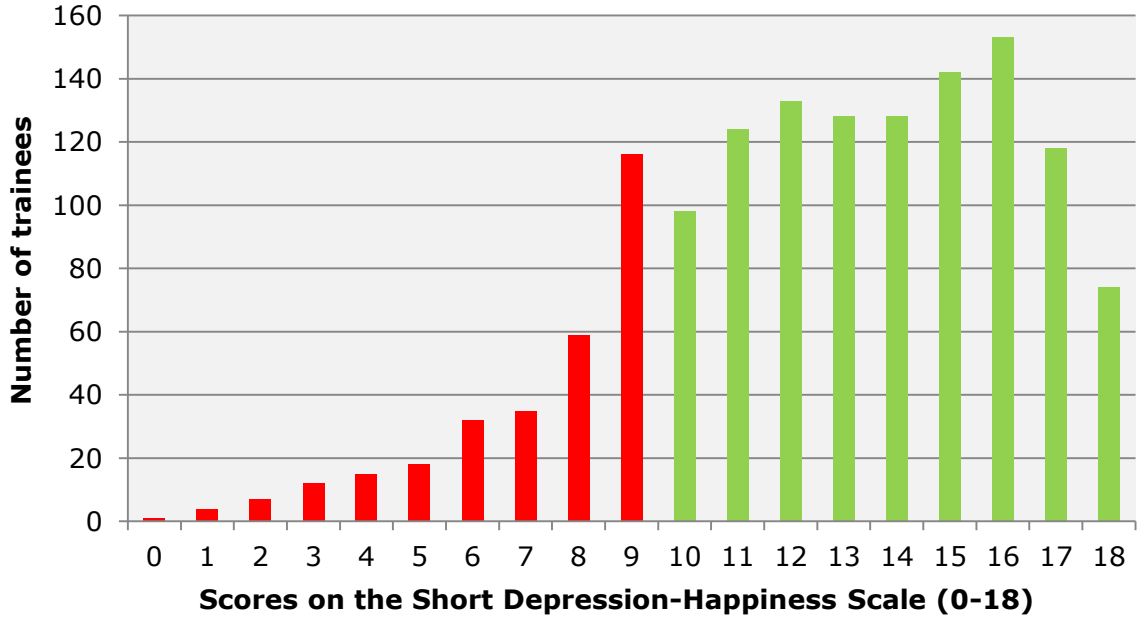
Self-rated mental health and wellbeing among doctors in training in Ireland, 2014

Trainees were invited to provide views on their mental health and wellbeing using the Short Depression-Happiness Scale (SDHS).[16] The scale includes 6 questions scored on a 3-point scale and so provides a score between 0 (poorest mental health and wellbeing score) to 18 (best possible mental health and wellbeing score). In general, higher SDHS score indicate better mental health and wellbeing. The SDHS is a rapid assessment of mental health and wellbeing and, while useful, is not designed to diagnose mental health difficulties. This is relevant to the interpretation of these findings.

Figure 16 provides an overview of trainee reported SDHS scores. The mean SDHS score among trainees was 12.5 (95% CI 12.3 – 12.7) (SD = 3.6).

Using the instrument, the mid-point score is 9, and a score of 9 or less may signify a concern for a possible mental health and wellbeing difficulty and a potential need for support. Based on this cut-off, 21% of trainees were identified as experiencing a possible mental health and wellbeing difficulty.

Figure 16: Trainee views on mental health and wellbeing – Overview of Short Happiness-Depression Scale Scores



Variations in mental health and wellbeing among doctors in training

There were no significant variations in trainee SDHS scores linked with trainees' gender, age, region in which trainees gained their Basic Medical Qualification, whether they were a direct or graduate entry medical student, or their stage of training.

There was a significant association between trainee SDHS scores and type of clinical site where the trainee worked and learned.

[16] Joseph S, Linley PA, Harwood J, Lewis CA, McCollam P. Rapid assessment of well-being: The Short Depression-Happiness Scale (SDHS). Psychol Psychother. 2004 Dec;77(Pt 4):463-78.

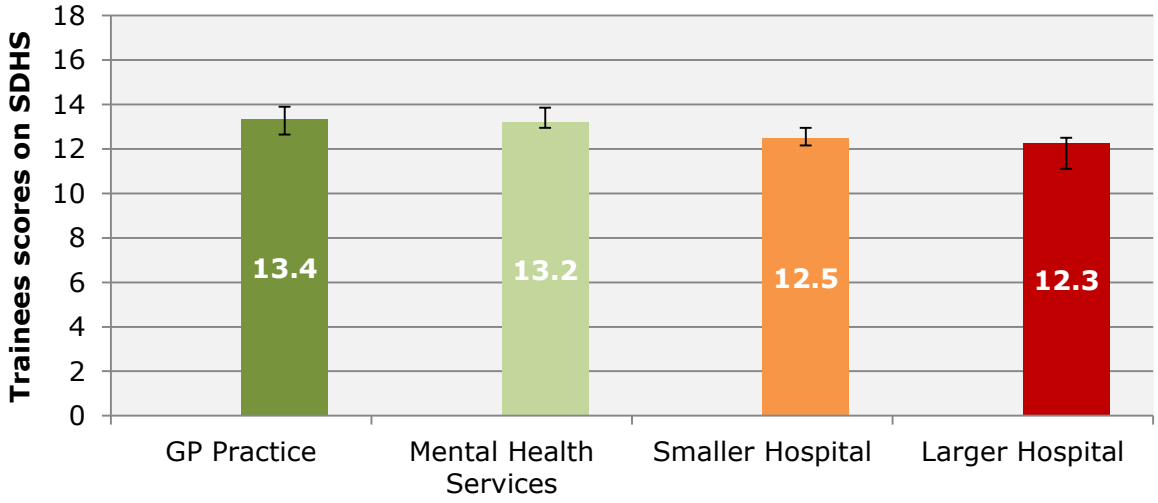
Furthermore, there were also significant variations in trainee SDHS scores linked with trainee reported experience of bullying and undermining and reported number of hours worked per week.

Finally, trainee SDHS scores were significantly associated with trainee views of the clinical learning environment (i.e. total D-RECT scores).

Mental health and wellbeing and clinical site-related characteristics

There was a significant difference in mental health and wellbeing reported by trainees working and learning in different types of clinical sites: trainees in GP practices reported significantly higher SDHS scores (13.4) than trainees in larger hospitals (12.3) ($F(3,1371) = 5.82$, $p=.001$; see Figure 17).

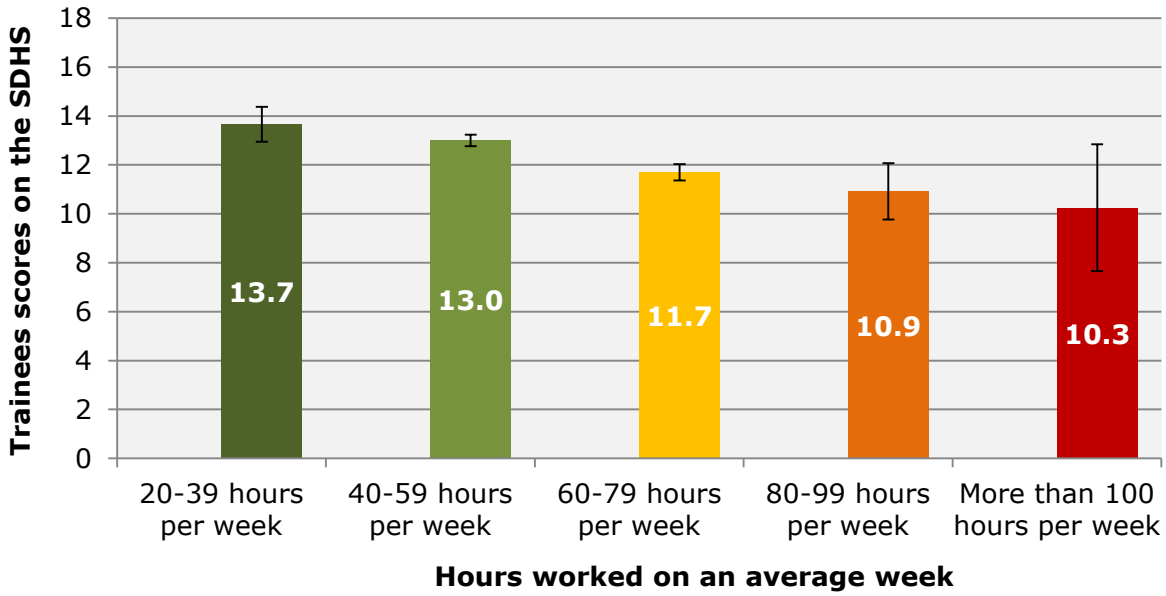
Figure 17: Trainee views on mental health and wellbeing – variation by type of clinical site



Mental health and wellbeing and reported hours worked in an average week

There was significant variation in trainee reported SDHS scores depending on the number of hours which they reported working in an average week. In general, trainees who reported working more hours in an average week also reported lower mental health and wellbeing. For example, trainees who reported that they worked between 40-59 hours a week had a mean SDHS score of 13, which was significantly higher than the SDHS score of 10.9 for trainees who reported that they worked between 80-99 hours a week ($F (4,1392) = 16.12$, $p < .001$; see Figure 18).

Figure 18: Trainee views on mental health and wellbeing – variation by number of hours worked



Mental health and wellbeing and reported experience of bullying and undermining in post

Trainee reported SDHS scores differed significantly with their reported experiences of bullying in the workplace. The general pattern was that increasing frequency of trainee-reported bullying experience was linked with decreasing SDHS scores for mental health and wellbeing ($F(2, 1332) = 86.94$, $p < .001$; see Figure 19); for example, trainees who reported that they were never bullied reported a mean SDHS score of 13.4, which was significantly higher than SDHS scores reported by trainees who also reported that they were bullied infrequently (11.7) and was also higher than the scores reported by trainees who also reported they were frequently bullied (10.1).

Similarly, there was a significant association between trainee reported SDHS scores and their reported experience of being undermined by a consultant or GP in their post ($F(2, 1348) = 78.57$, $p < .001$; see Figure 20); for example, trainees who reported that they were never undermined also reported significantly higher SDHS scores (13.5) than trainees who reported that they were infrequently undermined (11.9) and trainees who reported that they were frequently undermined (10.3).

Figure 19: Trainee views on mental health and wellbeing – variation by reported experience of bullying

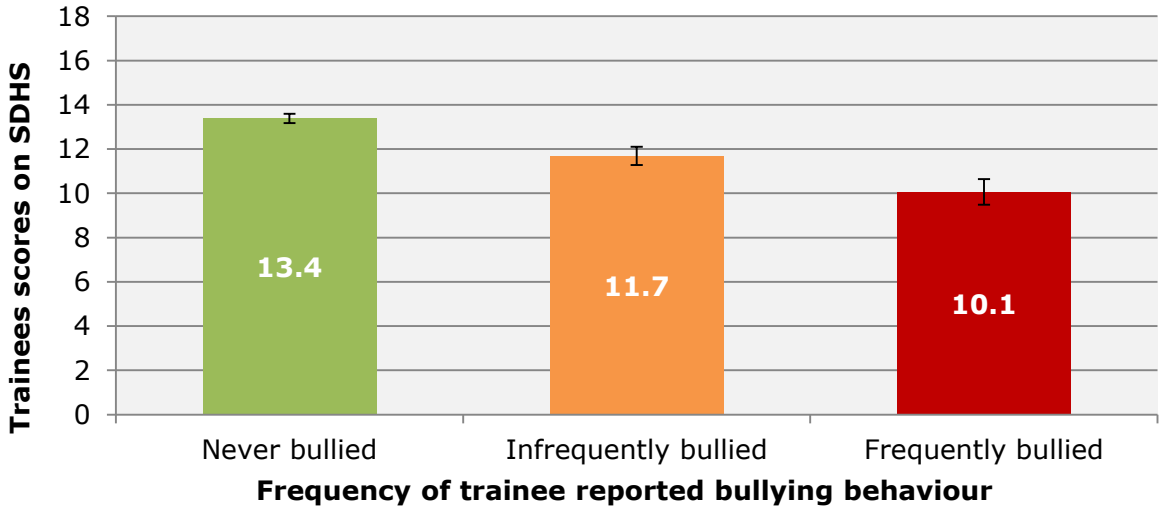
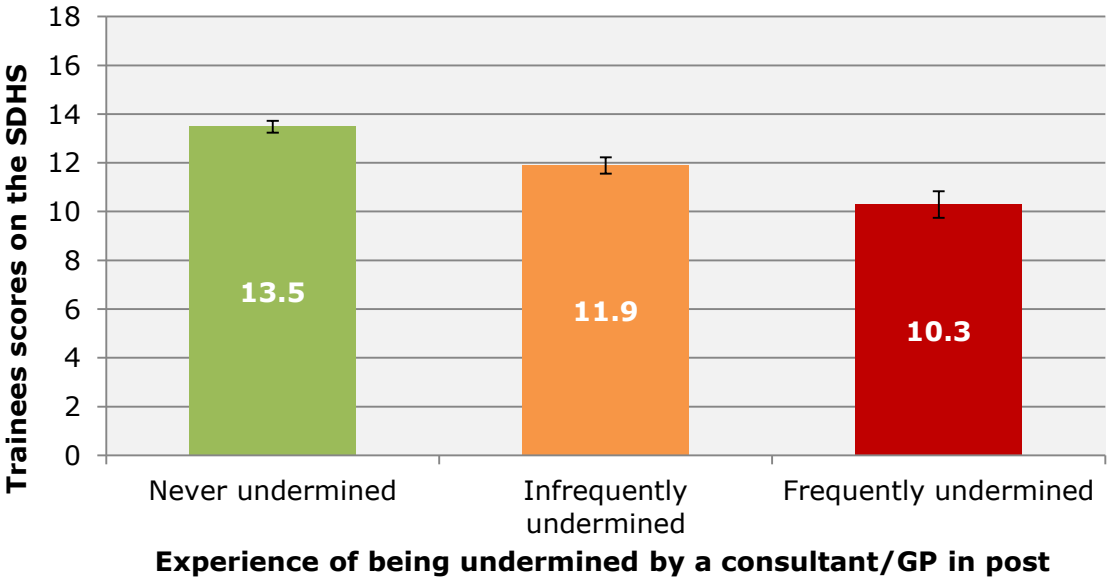


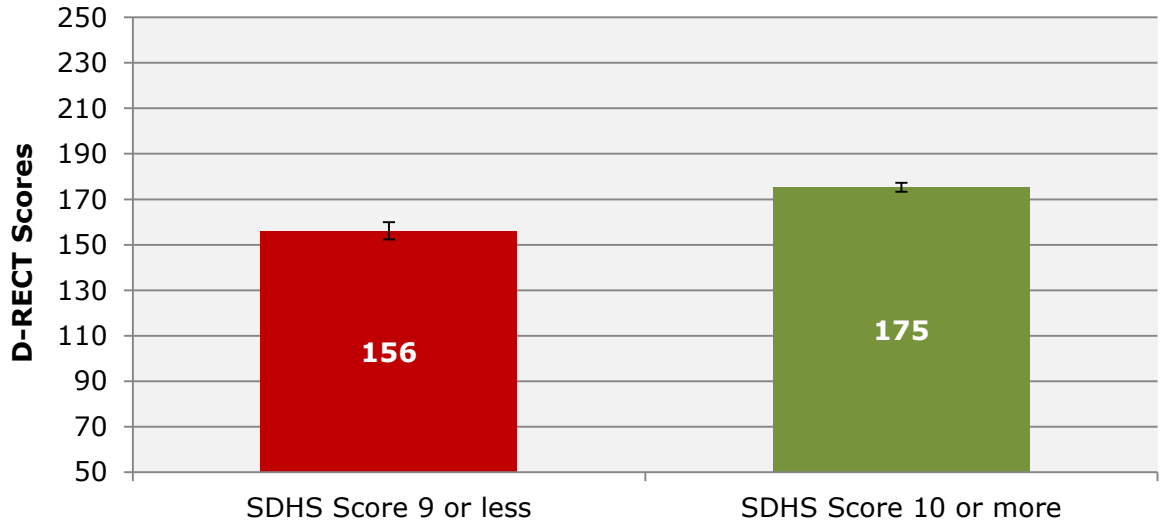
Figure 20: Trainee views on mental health and wellbeing – variation by reported experience of undermining



Mental health and wellbeing and views of the learning environment (D-RECT scores)

Finally, there was a significant positive correlation between trainee reported SDHS scores and their overall views on the clinical learning environment (as measured by the total D-RECT score) ($r\ (1254) = .354$, $p < .001$): this was a positive relationship and more positive mental health and wellbeing, measured using the SDHS was linked with more positive views of the clinical learning environment. Total D-RECT scores were compared across trainee reported SDHS scores, categorised using the cut-off of 9 (see above). Trainees reporting SDHS scores ratings that suggested there might be a concern that they were experiencing some mental health and wellbeing difficulties rated their learning environments significantly more poorly (total D-RECT score 156) than trainees reporting better wellbeing ratings (total D-RECT score 175) ($t\ (1254) = 8.74$, $p < .001$; see Figure 21).

Figure 21: Trainee views on mental health and wellbeing – variation in views of the learning environment



PROFILE OF TRAINEE WORK ENGAGEMENT

Key points

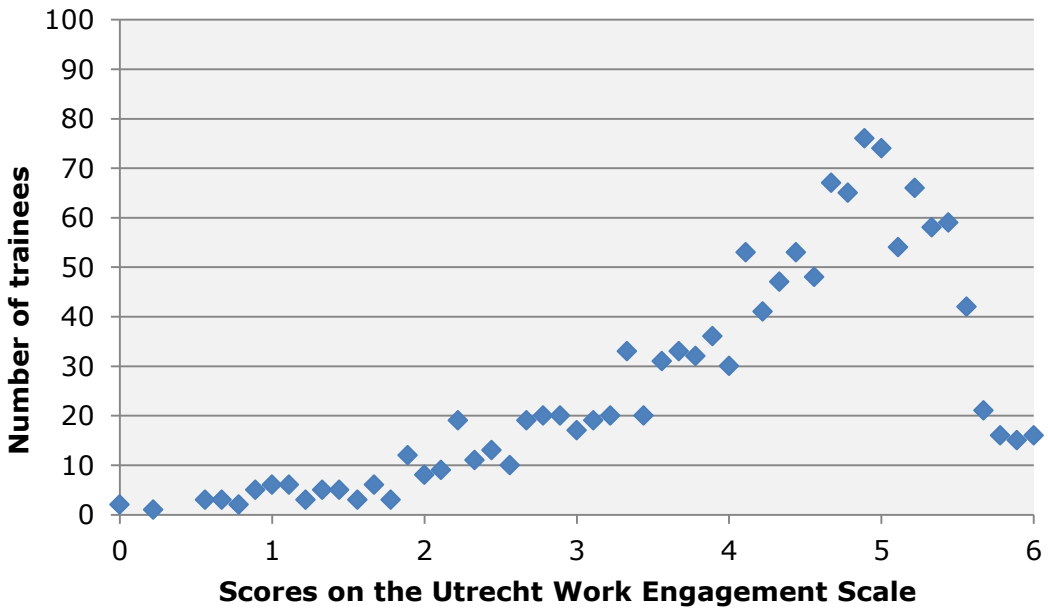
- Engagement is a positive, fulfilling, work-related state of mind characterised by vigour, dedication and absorption; energetic engagement with work is important for the individual, and in the case of medicine, is important for patient care. Engagement may be protective against burnout and provides a strength-based approach to understanding how trainees manage with work and training. We invited trainees to share views on their engagement with work using a 9-item version of the Utrecht Work Engagement Scale (UWES), which is a validated and reliable instrument for measuring engagement with work that has been used previously with doctors in training.
- Many trainees reported views which indicated that they are well engaged with their work and had high UWES scores.
- Other indices of trainee health and wellbeing were linked with engagement – trainees who reported better health and wellbeing also tended to report greater engagement with work.
- Increasing trainee age and later stage of training were, in general, linked with greater trainee reported engagement with work. Trainees who qualified outside Ireland reported greater engagement than trainees who qualified in Ireland.
- Trainee reported experience of bullying and undermining was linked with work engagement; trainees reporting more frequent experience of bullying and undermining also reported lower engagement.
- There was no strong or significant link between hours worked and work engagement.
- Work engagement and views of the clinical learning environment were linked; trainees reporting greater work engagement also reported more positive views of the clinical learning environment.

Self-rated work engagement among doctors in training in Ireland, 2014

There is growing focus on the issue of how trainees manage with work and training, and how they cope with the various stressors which confront them. The Medical Council was interested in exploring this aspect of trainee experience. Burnout is one concept relevant to this area. We chose to take a strength-based approach to trainees management by examining engagement with work, a positive, fulfilling, work-related state of mind characterised by vigour, dedication and absorption; such energetic engagement with work may be protective against burnout.[17] Understanding engagement with work offers a positive and constructive way to planning to support doctors in training. We invited trainees to share views on their engagement with work using a 9-item version of the Utrecht Work Engagement Scale (UWES), which is a validated and reliable instrument for measuring engagement with work that has been used previously with doctors in training.[18] Scores on the UWES range between 0-6, with higher ratings meaning greater work engagement. On this scale, engagement is a spectrum; that is to say, UWES distinguishes between trainees reporting greater and lesser engagement with work, but there is no particular "cut-off" that separates trainees into those who can be said to be "engaged" and those that can be said to be "disengaged".

Overall, trainee UWES scores suggest that many of trainees are highly engaged in their work. The mean score for trainees was 4.24 (95% CI 4.1 – 4.30, with a SD of 1.15) and the median 4.56. Figure 22 provides an overview of trainee reported UWES scores

Figure 22: Trainee views on work engagement – Overview of Utrecht Work Engagement Scores



[17] Prins J.T., Hoekstra-Weebers, J.E., Gazendam-Donofrio S.M. et al. Burnout and engagement among resident doctors in the Netherlands: a national study. Medical Education 2010 44: 236-247.
[18] Schaufeli W and Bakker A. Utrecht work engagement scale: Preliminary Manual [Version 1, November 2003]. Accessed at http://www.beanmanaged.com/doc/pdf/arnoldbakker/articles/articles_arnold_bakker_87.pdf

Variations in work engagement among doctors in training

Although trainee work engagement is high, there are significant (and moderate) differences in UWES scores for trainees with different: health ratings; wellbeing ratings; experiences of bullying and undermining in the workplace; and, views on their learning environment. There are significant, albeit weak, associations between work engagement ratings and trainee: age; stage of training; and, the region in which they graduated from medical school.

There were no significant differences in UWES scores due to hours worked in an average week, gender, or the type of site in which trainees worked.

Work engagement and other measures of trainee health and wellbeing

In general, trainee reported work engagement was associated with other measures of health and wellbeing; greater work engagement was reported by trainees who also reported more positive health and wellbeing.

Trainees that rated their general health as "excellent" reported a mean UWES score of 4.59, compared to a mean UWES score of 2.87 for trainees who rated their general health as "poor" ($F(4, 1329) = 33.01$, $p < .001$).

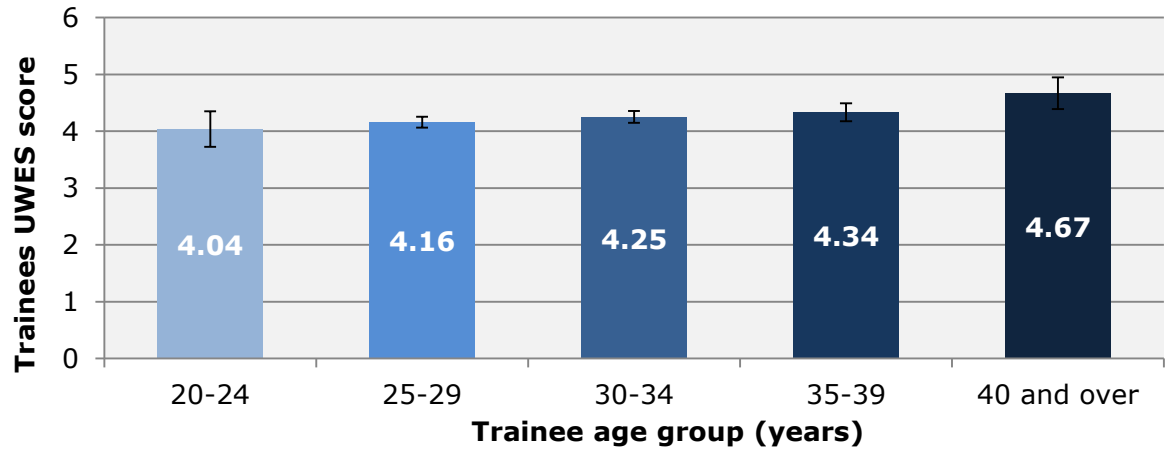
Similarly, trainees that rated their quality of life as "very good" reported a mean UWES score of 4.77, which was significantly higher than the mean UWES score for trainees that rates their quality of life as "poor" of 3.63, ($F(4, 1323) = 49.35$, $p < .001$).

Finally, trainees' ratings about work engagement were significantly correlated (positively and moderately) with perceptions of their mental health and wellbeing measured with the SDHS ($r(1312) = .493$, $p < .001$).

Work engagement and age

There was a significant link between work engagement ratings and trainee age (F (4, 1331) = 3.93, p = .004; see Figure 23); in general, older trainees reported greater work engagement and higher UWES scores.

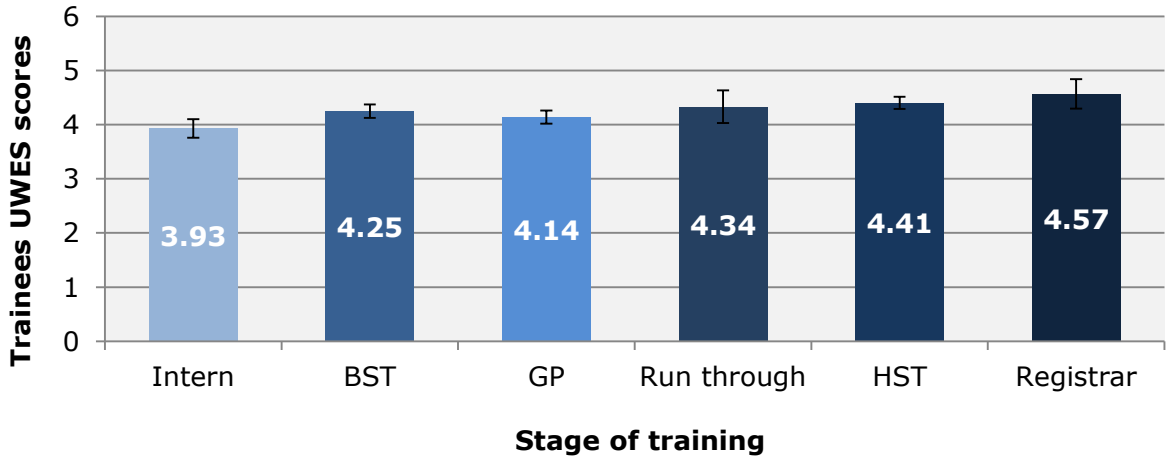
Figure 23: Work engagement – variation by age



Work engagement and stage of training

Work engagement ratings varied significantly between trainees at different stage of training (F (5, 1327) = 6.191, p < .001; see Figure 24). UWES scores were lowest among interns (M=3.93).

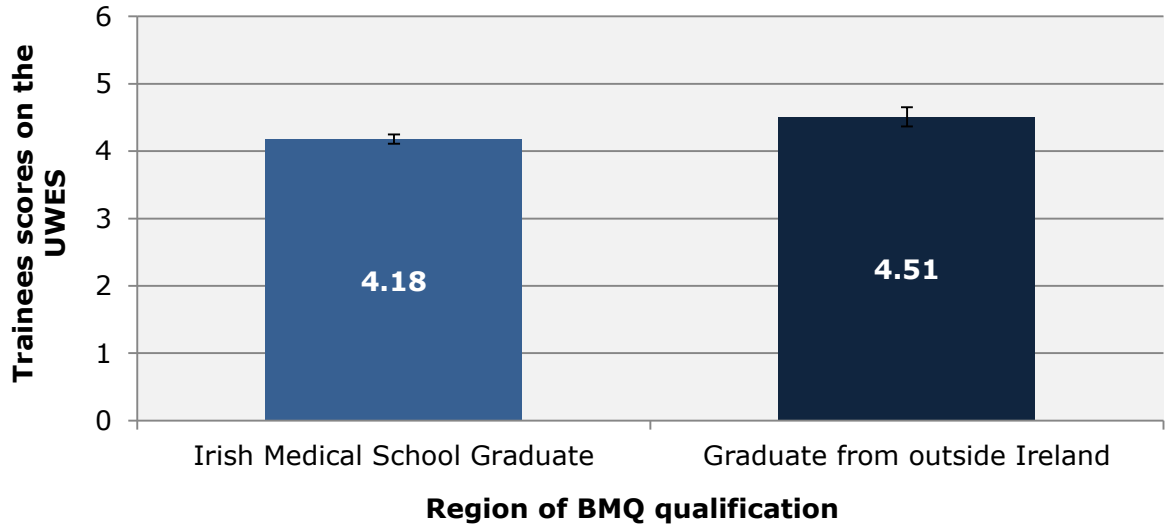
Figure 24: Work engagement – variation by stage of training



Work engagement and country of qualification

There was a significant difference in mean UWES scores between trainees who graduated from medical schools in different regions. Trainees who graduated in Ireland tended to report lower work engagement scores than trainees who graduated from other regions. Trainees who graduated from Irish medical schools had a mean UWES score of 4.18, compared to a mean UWES score of 4.51 for trainees who graduated outside Ireland ($t(1334) = 4.129$, $p < .001$; see Figure 25).[19]

Figure 25: Work engagement – variation by country of qualification



Work engagement and reported experience of bullying and undermining in post

Trainee views on work engagement varied significantly depending on their reported experience of bullying and undermining. The mean UWES score for trainees who were never bullied in post was 4.43, which was significantly higher than the mean UWES score for trainees who were infrequently bullied (M=4.10), and higher than those who were frequently bullied (M=3.64) ($F(2, 1278) = 40.39$, $p < 0.001$; see Figure 26). Similarly, trainees who reported that they were never undermined by a consultant/GP also reported significantly higher work engagement scores (M = 4.42) than trainees who reported that they were infrequently undermined (M=4.13) and trainees who reported that they were frequently undermined (M=3.78) ($F (2, 1296) = 26.63$, $p < .001$; See Figure 27).

[19] Although the age profile of trainees who graduated from Irish medical schools and those who graduated elsewhere are different (with international graduate trainees being older) significant differences in UWES scores were still found when controlling for age.

Figure 26: Work engagement – variation by trainee reported experience of bullying

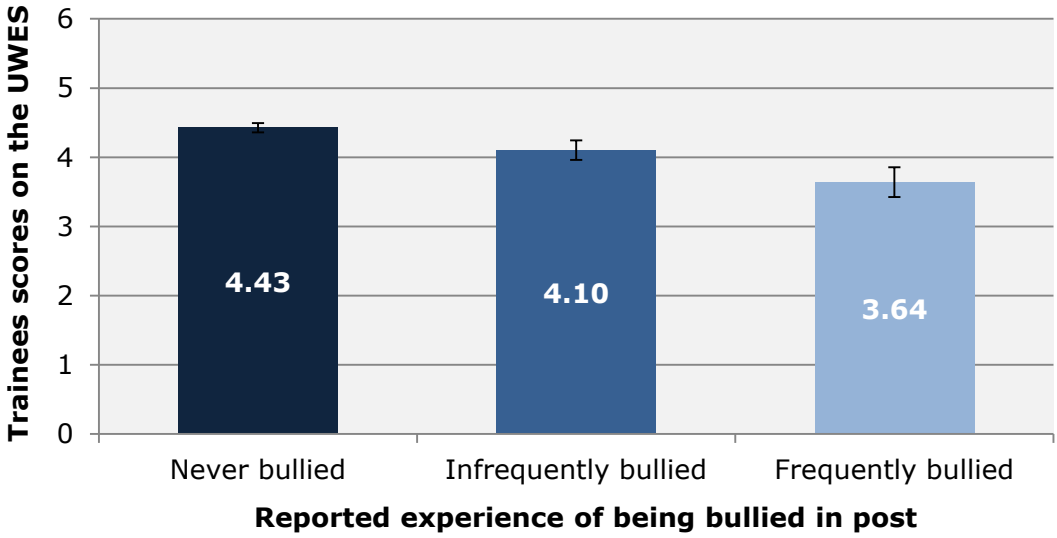
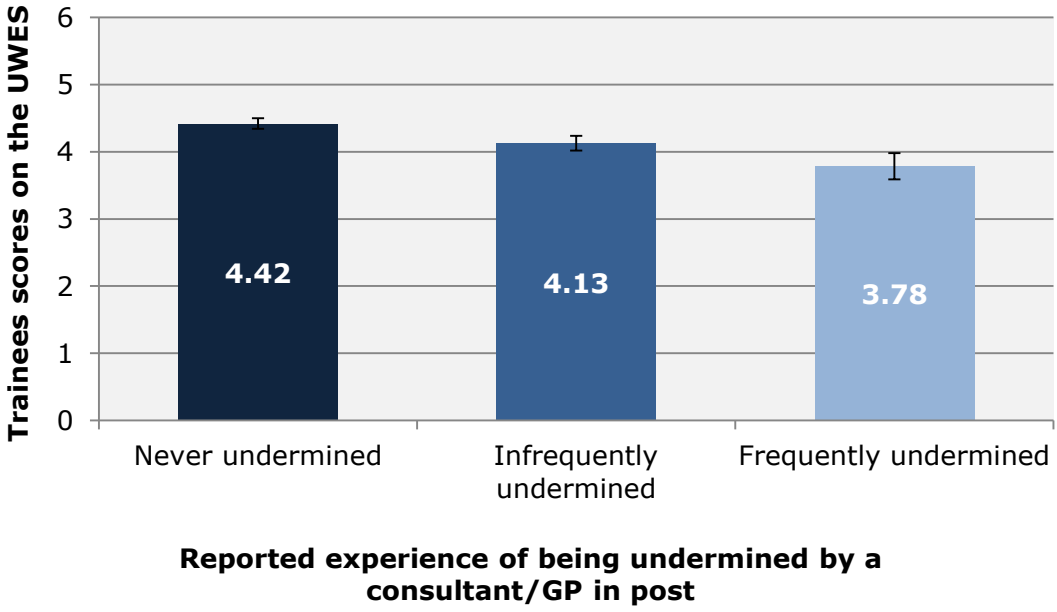


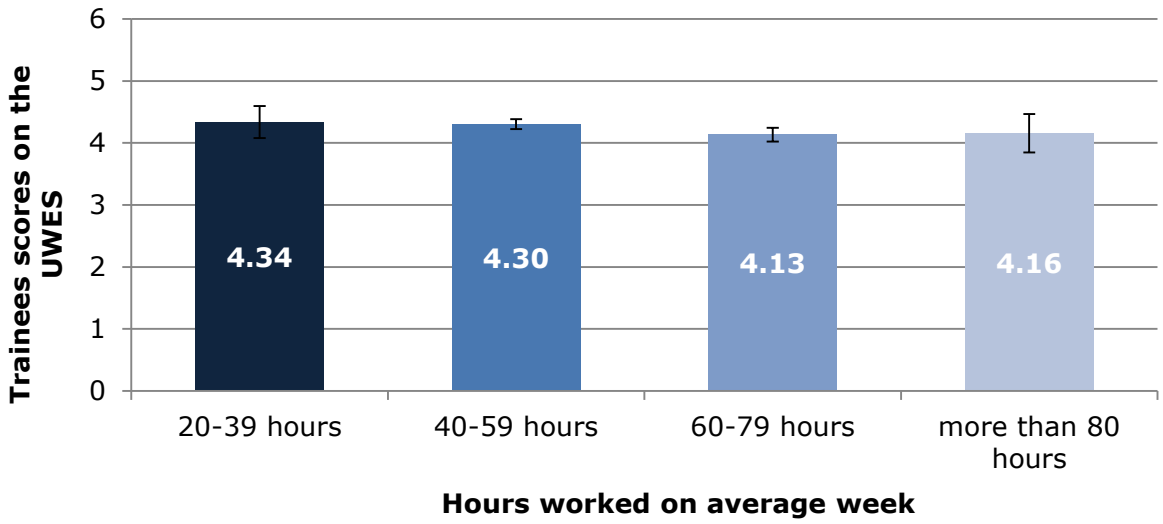
Figure 27: Work engagement – variation by trainee reported experience of undermining



Work engagement and hours worked

While there was a trend towards decreasing engagement with increasing number of hours worked, there was no significant difference identified ($F(3, 1332) = 2.39$, $p = .067$; see Figure 28).

Figure 28: Work engagement – variation by hours worked in an average week



Work engagement and views of the learning environment (D-RECT scores)

Finally, trainees reported work engagement was significantly correlated (positively and moderately) with perceptions of the learning environment; trainees with greater work engagement also tended to have more positive views of the clinical learning environment ($r(1312) = .493$, $p < .001$). To display the link between UWES scores and views on the learning environment, trainees UWES scores were converted into categories based on the distribution of scores as described by the scale developers.

Figure 29: Work engagement – variations by perceptions of clinical learning environments

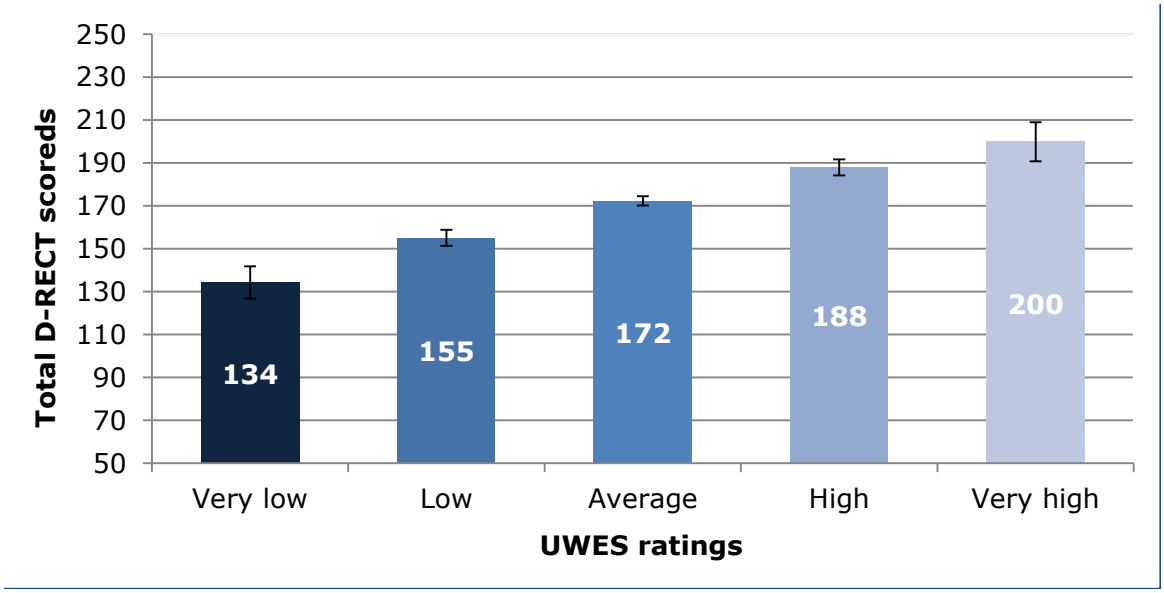


Figure 29 shows that for each different UWES category (between Very low to High), trainees gave significantly different D-RECT scores. The pattern suggests that the higher trainee work engagement, the higher the perception of the quality of learning environments, $F(4, 1150) = 80.31$, $p < .001$.

PROFILE OF TRAINEE UTILISATION OF SUPPORT SERVICES

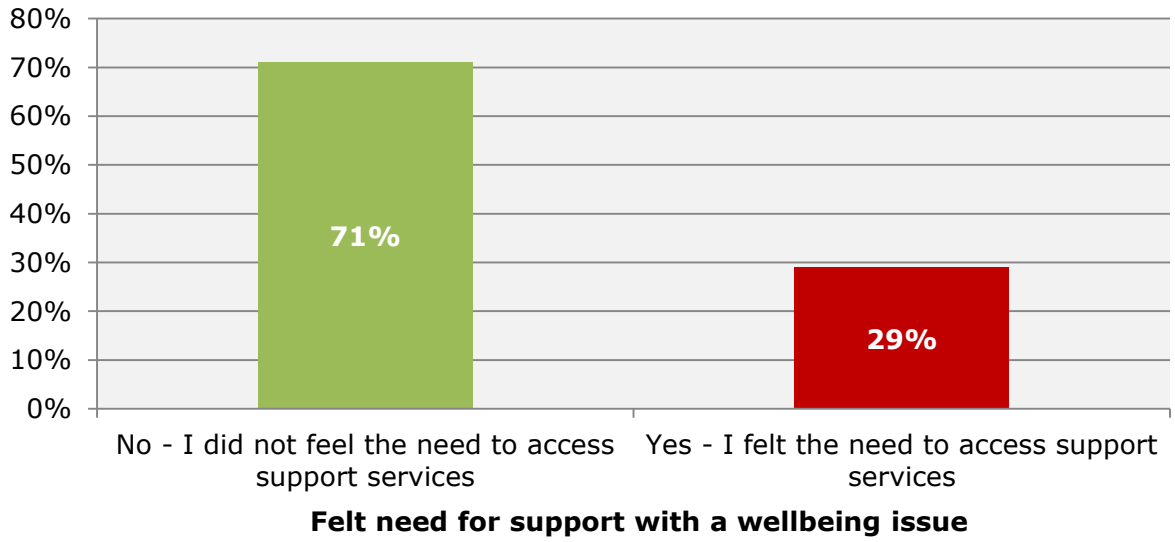
Key points

- 3-in-10 (29%) of trainees felt that they needed to access some sort of support service to assist them with their health and wellbeing needs.
- Many trainees reporting poor health and wellbeing did not feel a need to access support services; for example, 4-in-10 (43%) of trainees that reported lower mental health and wellbeing scores (SDHS scores of 9 or less) did not feel a need to access support services.
- Compared with male trainees (21%), more female trainees (35%) felt that they needed to access some sort of support service to assist them with their health and wellbeing needs.
- A need to access some sort of support service to assist them with their health and wellbeing needs was also more common among trainees who reported an experience of bullying or undermining behaviour. Among trainees who reported frequently experiencing bullying and undermining, almost 5-in-10 also felt a need to access some sort of support service.
- Despite a felt need for support, over 8-in-10 (86%) of trainees did not make contact with support services.
- Compared with older trainees, younger trainees less commonly reported making contact with support services despite reporting that they felt they needed support.
- Of those trainees who did contact support services, over 6-in-10 (62%) found them to be 'quite' or 'very' useful; 2-in-10 (19%) did not find them useful.

Felt need for support services among doctors in training

The results reported in the preceding sections of this spotlight report highlights need among trainees with respect to their health and wellbeing. Many training organisation and healthcare organisations offer support services such as access to counselling or occupational health services. We asked trainees to report their views as to whether or not they felt a need to access such services; 29% felt this need (see Figure 30).

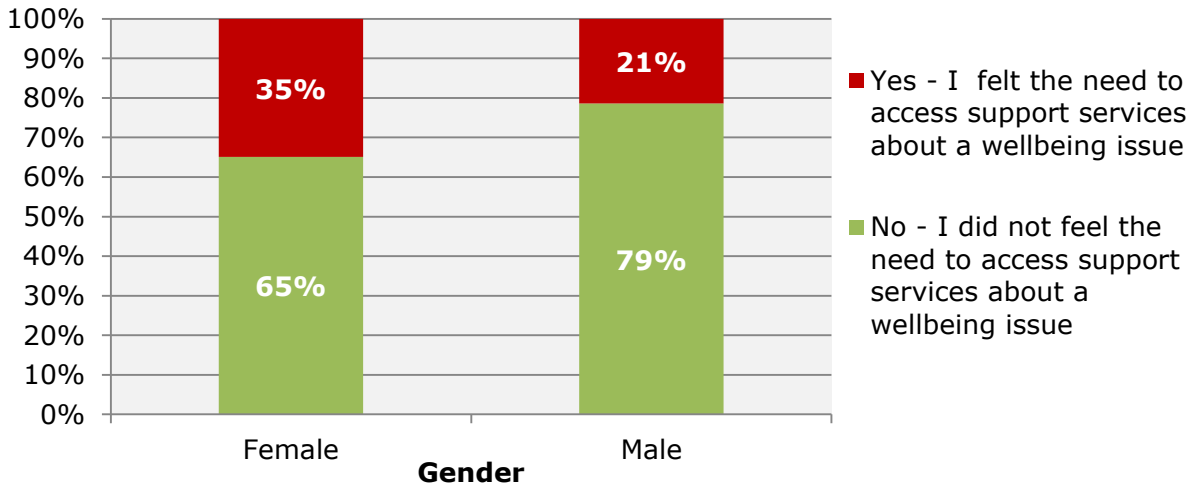
Figure 30: Felt need – "Have you ever felt the need to use support services about a wellbeing issue you experienced while on training?"



Trainees' who felt the need to access support services was examined across trainees categorised by their measures of self-reported health and wellbeing. While trainees reporting poorer health and wellbeing tended, in general, to more commonly report a felt need to access support services, significant numbers with poor health and wellbeing did not report a feeling of need for support. In total, 35% of trainees reporting poor self-rated health, 44% reporting a very poor quality of life and 43% reporting poorer mental health and wellbeing (i.e. SDHS scores of 9 or less) also reported that they did not feel a need to access support services.

Female trainees more commonly reported that they felt the need to access support in relation to a wellbeing in comparison to males (35% versus 21%, χ^2 (1, N=1360) = 29.32, $p < .001$; see Figure 31).

Figure 31: Felt need, by gender – "Have you ever felt the need to use support services about a wellbeing issue you experienced while on training?"



Trainee reported experience of bullying and undermining behaviour was also linked with felt need to access support services: 39% of trainees who reported that they experienced infrequent bullying in the workplace, and 49% of trainees who reported that they experienced frequent bullying in the workplace, also reported that they felt they needed support with a wellbeing issue, compared to 22% of trainees who reported that they were not bullied (χ^2 (2, N=1302) = 71.48, p < .001; see Figure 32); similarly, trainees who reported that they were never undermined were also less likely to report that they felt the need for support services (22%) compared to trainees who were infrequently undermined (34%) and frequently undermined (46%), (χ^2 (2, N = 1317) = 49.23, p < .001; see Figure 33).

Figure 32: Felt need, by reported experience of bullying – "Have you ever felt the need to use support services about a wellbeing issue you experienced while on training?"

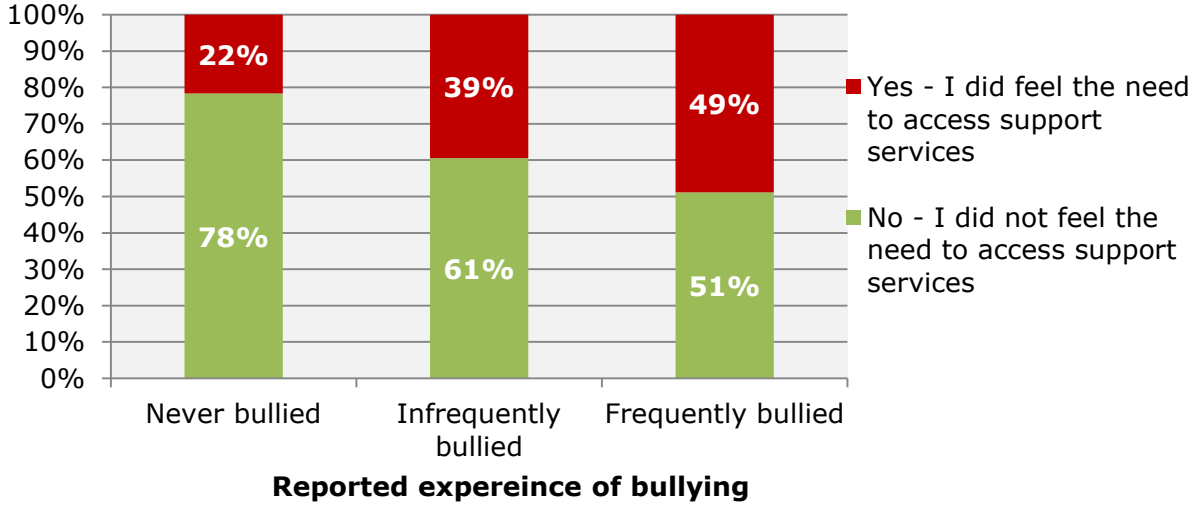
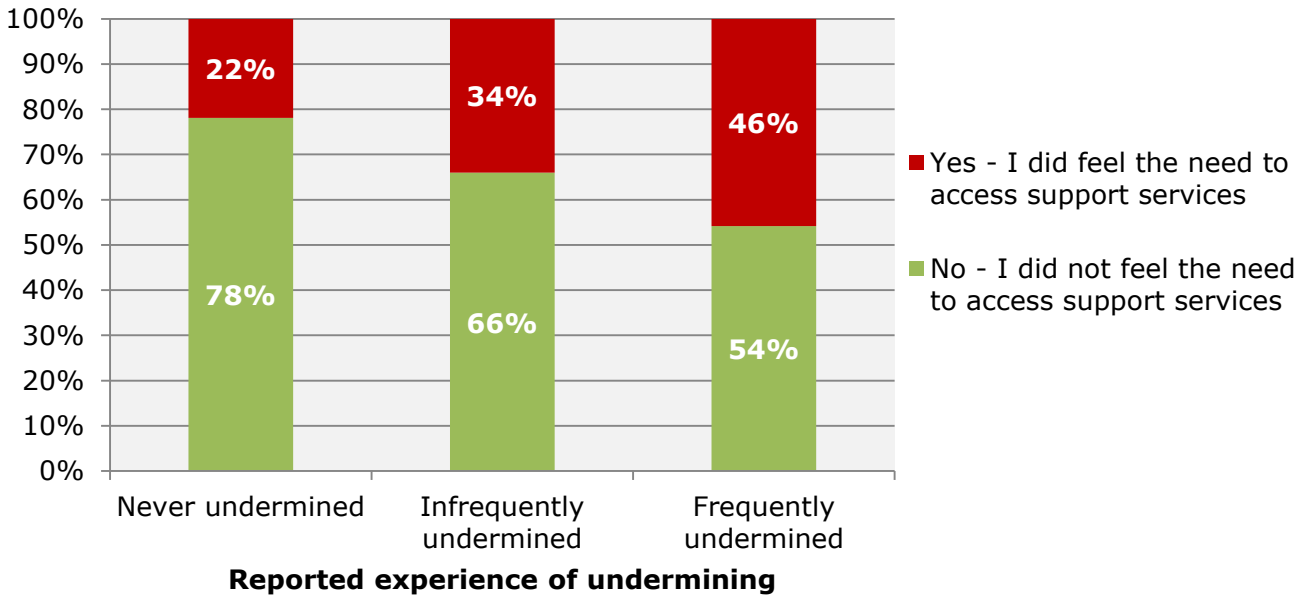


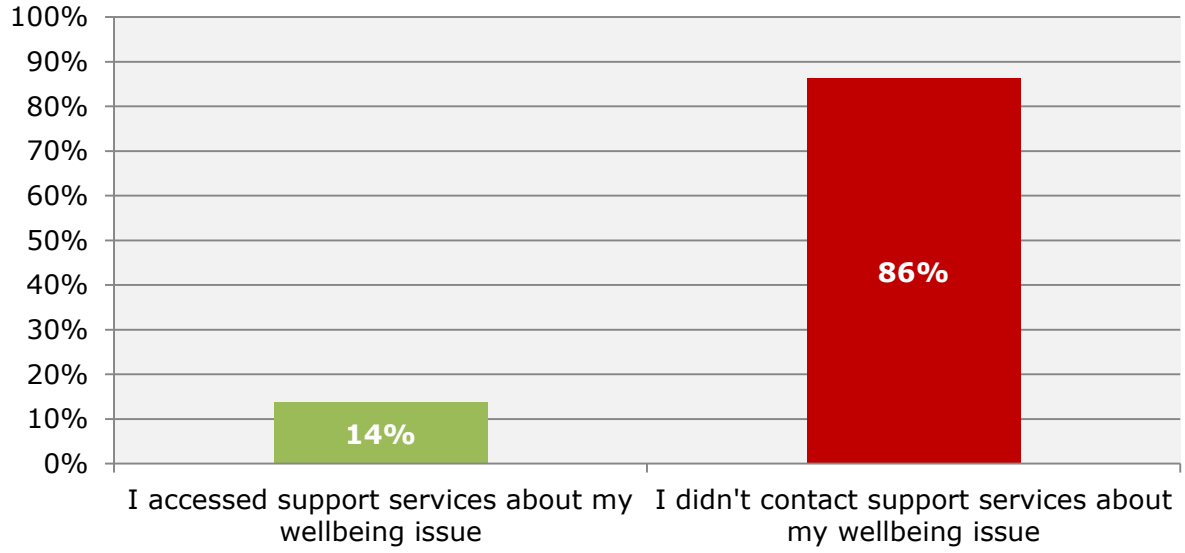
Figure 33: Felt need, by reported experience of undermining – "Have you ever felt the need to use support services about a wellbeing issue you experienced while on training?"



Access of support services among doctors in training who felt a need support services

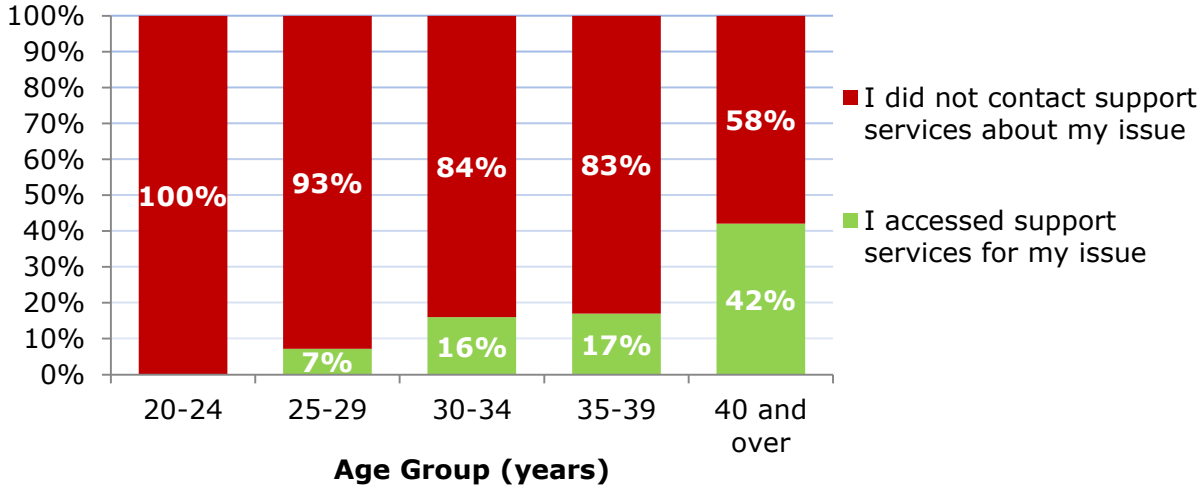
We asked trainees who said they felt they needed support with a wellbeing issue during training whether or not they accessed a support service: 14% of trainees who felt a need for support also reported that they accessed support services (see Figure 34).

Figure 34: Accessing support services in response to a felt need – "Did you contact support services about your wellbeing issue?"



Trainee age was linked with whether or not they accessed a support service in response to a felt need. In general, the older the trainee, the more likely they would seek support with a wellbeing issue. For example 42% of trainees aged over 40 sought support with a wellbeing issue, compared to 7% of trainees in the 25-29 age category (χ^2 (4, N=394) = 21.38, $p < .001$; see Figure 35).

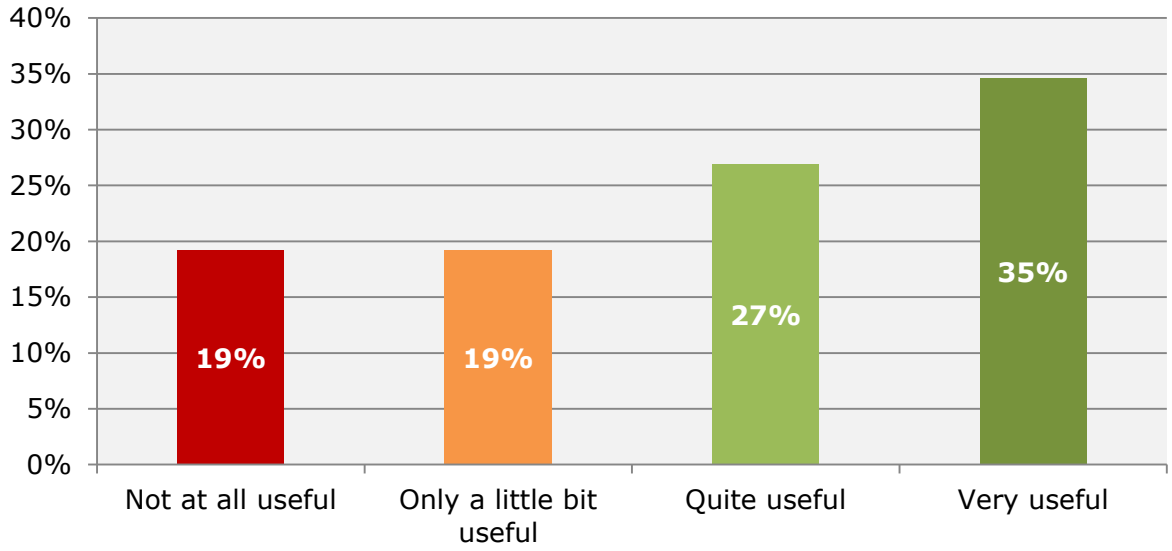
Figure 35: Accessing support services in response to a felt need, by age group – "Did you contact support services about your wellbeing issue?"



Experience of support services among doctors in training

Finally, we asked trainees who utilised support services to report their experience; the majority of trainees that accessed support services, about a wellbeing issue, reported the service as quite or very useful (62%, see Figure 36).

Figure 36: Experience of support services – "How useful were the support services you received at work"?



CONCLUDING COMMENTS

Key points

- This report from the 2014 national trainee experience survey shines a spotlight on the health and wellbeing of doctors in training in Ireland.
- Generally good self-reported health is an important positive finding.
- Furthermore, it is a testament to the dedication of trainees that they generally report good engagement with their work. It is important to acknowledge and better understand the strengths which many trainees bring to their experience of working and training.
- However, a small but significant minority are clearly struggling to maintain good quality of life and mental health and wellbeing.
- The linkages between indices of trainee health and wellbeing and key features of the clinical environment point to the importance of focusing on the settings where trainees work and learn. Hospitals appear to present particular challenges to maintaining good health and wellbeing. Unsurprising, but importantly, this report finds a strong, significant and consistent link between the experience of bullying and undermining and poorer health and wellbeing among trainees.
- Linkages between hours worked and trainee reported health and wellbeing are evident. *Your Training Counts* will provide an important framework to monitor how trainees experience European Working Time Directive implementation: if and how their experience of the clinical learning environment changes; if and how their health and wellbeing changes.
- There are shared responsibilities for everyone involved in medical education and training in responding to what we have heard from trainees.
- There is a role for organisations that design and deliver curricula to ensure that self-awareness, self-care, and skills to navigate stressors in the clinical environment are fostered to help trainees maintain good health and wellbeing are promoted.
- But a wider response involving policy-makers and healthcare organisations is required to ensure that the clinical environments where trainees work and learn are designed and manage to prevent unnecessary challenges for trainee health and wellbeing so problems are prevent.
- The Medical Council will continue to raise awareness of doctors' health and wellbeing in the interests of good professional practice for safe, effective and compassionate patient care.

A spotlight on trainee health and wellbeing

This report, for the first time, provides a comprehensive overview of the health and wellbeing of doctors in training in Ireland. There is continuing discussion on issues related to the medical workforce and medical education and training. Through placing a spotlight on trainee health and wellbeing, the Medical Council wants to ensure that this critical aspect of trainee experience is considered in decisions that affect trainees. Besides being an issue for individual trainees, good health and wellbeing among doctors needs to be prioritised as a factor in how we foster good professional practice through medical education and training, in how we ensure safe, effective and compassionate care for patients, and in how we design strong and sustainable health system into the future.

Trainees with good general health and positive engagement with patient care

It is positive to note the high levels of general health reported by trainees. Other studies of doctors' health and wellbeing have shown that they enjoy good physical health – despite well-recognised challenges with maintaining good quality of life and good mental health and wellbeing.[20]

This spotlight examined work engagement among trainees in Ireland.

It is immensely positive to find that so many doctors in training approach their role in patient care and in training with high levels of dedication, energy, and positive absorption. Their strength is to be commended and supported. In the context of an increasingly challenging clinical environment for doctors, this finding stands out as a tribute to the dedication of trainees. This strong engagement is an important finding since, if sustained, it may protect against burnout, a phenomenon which is bad for doctors, bad for patients and bad for the health system. While the causes of failures in the quality and safety of healthcare are complex and manifold, when caring professionals are engaged in their work, patient care is better and failures may be avoided. The strengths of individual doctors in training need to be better understood – as well as how engagement is shaped by environment – so as to identify how all trainees can be supported to sustain positive engagement throughout their professional lives.

Challenges with quality of life and mental health and wellbeing

This spotlight highlights specific challenges experienced by a significant proportion of trainees in maintaining a good quality of life and good mental health and wellbeing.

While the findings presented in this spotlight regarding trainees in Ireland are stark, they are consistent with published studies examining quality of life, mental health and wellbeing and burnout among doctors in training.[21] For example, a recent study of US trainees found that 14.8% reported their quality of life to be poor; high levels of burnout were also reported.[22] Similar experiences have been reported among Trainees in Europe.[23] We rightly expect doctors not just to provide effective care, but to relate to patients and their families with compassion. Compassion fatigue is an increasingly

[20] Frank E, Biola H, Burnett CA. Mortality rates and causes among US physicians. *Am J Prev Med.* 2000;19:155-159.
[21] Dyrbye L.N., Thomas, M.R., and Shanafelt, T.D. Systematic Review of Depression, Anxiety, and Other Indicators of Psychological Distress Among U.S. and Canadian Medical Students. *Acad Med* 2006; 81:354–373.
[22] West C.P., Shanafelt T.D., and Kolars J.C. Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. *JAMA*. 2011 306(9):952-60.
[23] Prins J.T., Hoekstra-Weebers J.E., Gazendam-Donofrio S.M. et al. Burnout and engagement among resident doctors in the Netherlands: a national study. *Med Educ* 2010 44(3):236-47.

recognised phenomenon among caring professionals, related to their professional quality of life, which describe a gradual erosion of capacity to care with consideration, empathy and kindness. Maintaining quality of life and good mental health and wellbeing among trainees is a critical agenda since trainees experiencing significant challenges in these areas may develop compassion fatigue. For this reason, trainee quality of life and mental health and wellbeing have implications for medical professionalism and for the safety and quality of patient care.

Addressing the environment which shapes trainee health and wellbeing

While this report concerns the individual experience of trainees, supporting good health and wellbeing must begin with a focus on the clinical environment where the trainee works and learns.

This spotlight demonstrates clear, consistent and strong linkages between trainee health and wellbeing and stressors in the clinical environment.

Trainees in hospitals tended to report poorer quality of life and mental health. What can hospitals learn from the strengths of other settings, like general practice and mental health services, where trainees report better quality of life?

It is significant to note that trainee reported experience of bullying and undermining was associated with poor health and wellbeing across a number of indices in this spotlight; importantly, more frequent experience of bullying and undermining was associated with poorer health and wellbeing. The phenomena of bullying and undermining in medical education and training are well described in *Your Training Counts*, and are consistent with published evidence.[24] Meaningful progress in addressing these phenomena is possible and could affect significant improvement in trainee health and wellbeing.

Reforming working hours for trainees – a complex issue

The average working hours per week reported by trainees was associated with most health and wellbeing indices in this spotlight; general health, quality of life and mental health and wellbeing all decreased increasing hours worked per week.

Regulation of working hours for doctors, especially doctors in training, is a complex issue and is much debated nationally and internationally. Across Europe, the European Working Time Directive aims to protect the health and safety of workers through controlling work hours, and in the US the Accreditation Council for Graduate Medical Education, which oversees the quality of postgraduate training has instituted mandatory work hour restrictions.

What do these interventions mean for doctors in training and for patients?

Reducing working hours appears, as might be expected, to improve trainee's quality of life.[25] A recent overview of published studies examining the impact of reduced working hours on medical education and training found mixed results;[26] a recent evaluation of

[24] Fnais N, Soobiah C, Chen M.H., et al. Harassment and discrimination in medical training: a systematic review and meta-analysis. Acad Med. 2014 89(5):817-27.
[25] Fletcher K.E., Underwood W, Davis S.Q. et al. Effect of work hour reduction on residents' lives: a systematic review. *JAMA* 2005 294:1088-1100.
[26] Moonesinghe S.R., Lowery J, Shahi et al. Impact of reduction in working hours for doctors in training on postgraduate medical education and patient outcomes: systematic review. *BMJ* 2011 342:d1580.

working hours reform for US trainees found that it had no effect on examination scores.[27] Nevertheless, many leaders in medical education and training, and even some trainees themselves, remain concerned about the educational impact of these reforms.[28,29,30] Through its effect on trainee fatigue, there is understandable concern that longer working hours may reduce the quality of patient care and may increase medical error.[31] While patient safety is a commonly cited reason for control of trainee working hours, studies examining the effect of trainee working hour reform on healthcare outcomes, quality of care and patient safety have not demonstrated improvements.[22,23,32]

Reform of trainee working hours is a contentious and complex area. Benefits for patients and for trainees will be maximised – and adverse effects minimised – if implementation is carefully planned and managed through collaboration between stakeholders. The quality of educational experience for trainees must be maintained and, where possible, enhanced as working time reduces.

Your Training Counts will monitor trainee reported working hours, their views of the clinical learning environment, and their health and wellbeing. As European Working Time Directive implementation progresses in Ireland, it will provide a critical framework for monitoring and evaluating impacts across a range of important indicators and to reflect the trainee perspective.

Health and perception of the clinical learning environment

It is noteworthy that, across a range of metrics examined in this spotlight, better trainee health and wellbeing was linked with more positive views of the clinical learning environment. This link is complex, and it cannot be inferred that the good health causes a positive view of the clinical learning environment, or vice versa. However, it underscores the legitimacy of spotlighting trainee health and wellbeing in the context of monitoring the quality of medical education and training.

Preparing the individual trainee, as a whole person, for the clinical environment

While efforts to support good health and wellbeing must focus on the clinical environment where the trainee works and learns, the skills and attitudes of individual trainees should not be overlooked.

Transitioning to the clinical environment introduces the doctor in training to a set of new and challenging situations. By its nature, a learning environment will test a trainee and will facilitate progress towards increasing proficiency as a doctor. This spotlight finds some, but not consistent, evidence that younger trainees at earlier stages of training

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[27] Rajaram R, Chung J.W., Jones A.T. et al. Association of the 2011 ACGME resident duty hour reform with general surgery patient outcomes and with resident examination performance. *JAMA* 2014; 312(22): 2374-2384.
[28] Shea J.A.,Willett L.L., Borman K.R., et al. Anticipated consequences of the 2011 duty hours standards: views of internal medicine and surgery program directors. Acad Med. 2012;87(7): 895-903.
Drolet B.C., Sangisetty S, Tracy T.F., Cioffi W.G. Surgical residents' perceptions of 2011 Accreditation Council for Graduate Medical Education duty hour regulations. JAMA Surg. 2013 148(5): 427-433.
[29] Antiel R.M., Thompson S.M., Reed D.A., et al. ACGME duty-hour recommendations—a national survey of residency program directors. N Engl J Med. 2010; 363(8):e12.
[30] Drolet B.C., Sangisetty S, Tracy T.F., Cioffi W.G. Surgical residents' perceptions of 2011 Accreditation Council for Graduate Medical Education duty hour regulations. JAMA Surg. 2013 148(5): 427-433.
[31] Kohn L.T., Corrigan J.M., and Donaldson M.S. To err is human: building a safer health system. Washington DC: National Academy Press; 2000.
[32] Ahmed N, Devitt K.S., Keshet I et al. A systematic review of the effects of resident duty hour restrictions in surgery: impact on resident wellness, training, and patient outcomes. *Ann Surg*. 2014 259(6):1041-53.

may experience greater challenges with maintaining good health and wellbeing as they transition into the clinical environment.

While it is necessary to focus on addressing remediable stressors in the clinical environment, the individual trainee must also be adequately prepared for all aspects of their clinical learning experience.

Education and training bodies need to plan to support the trainee as a whole person if they are to be enabled to fulfil their future potential as doctors providing safe, effective and compassionate care.

It is important that self-awareness and self-care are fostered through curricula at undergraduate, internship and postgraduate levels to ensure that trainees have the knowledge, skills and attitudes to effectively identify and negotiate stressors in the clinical environment and to maintain good health and wellbeing. This focus meets the needs of the health system since it contributes to a sustainable medical workforce and to safe, compassionate and high quality patient care.

Raising awareness and building a culture for good health and wellbeing among doctors

A striking finding in this spotlight is the mismatch between trainee need for support with health and wellbeing, their felt need, and their access of services. Inattention to self-care is well described among doctors and trainees.[33] But it is particularly concerning to note that reproduction of a culture of poor self-care is strong among doctors at the earliest stages of training, especially considering the set of challenges that these doctors face in transitioning into the clinical environment, which have been well described in *Your Training Counts*.

Through providing evidence and promoting dialogue, the Medical Council is interested in raising awareness to build a culture for good health and wellbeing among doctors.[12]

Balancing prevention and response – sharing responsibility

As a professional regulator, the Medical Council plays a role in responding to concerns about doctor's practice.

While it is important that there is an effective response to problems downstream, this report highlights opportunities to prevent problems upstream through ensuring the quality of doctors education and training is safeguarded and, in particular, through supporting trainees to maintain good health and wellbeing.

These opportunities are best realised through sharing responsibilities.

The Medical Council is raising awareness through this report of trainee health and wellbeing in the interests of good professional practice for the benefit of patients. Organisations involved in doctors education and training must continue to ensure that trainees understand the importance of maintaining good health and wellbeing, are supported to develop necessary skills and attitudes, and are able to access appropriate support services when needs arise. Policy-makers and healthcare organisations must ensure that the clinical environments where trainees work and learn enable them to

[33] Uallachain G.N. Attitudes towards self-health care: a survey of GP trainees. *Ir Med J* 2008 100: 489-91.

maintain good health and wellbeing in the interests of safe, effective and compassionate patient care.

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Comhairle na nDochtúirí Leighis
Medical Council

Medical Council, Kingram House, Kingram Place, Dublin 2.

T: +353 1 4983100
F: +353 1 4983102
E: info@mcirl.ie
www.medicalcouncil.ie

A SPECIAL REPORT FROM THE TRAINEE NATIONAL EXPERIENCE SURVEY 2014