University of Essex

Evaluation of the Wellbeing of ENT trainees

Final report
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Acknowledgements
The University of Essex would like to acknowledge and thank the following AOT members who designed the initial questionnaire, provided input into its revision and promoted the survey to their members - Tharsika Myuran, Freddie Green, Summy Bola, Kala Kumaresan, Joshua Michaels, Elizabeth Casselden and Fenella Shelton, plus Prof Nirmal Kumar who supervised from an ENT educationalist point of view

Contents

Background

The Association of Otolaryngologists in Training (AOT) is an organisation that represents all Otolaryngology and Head and Neck Surgery (ENT) trainees in the UK. It is independent and is run by trainees, for trainees. The AOT undertook a survey of ENT trainees, assessing trainee wellbeing in their ENT posts and including sections on bullying, harassment and raising concerns. They commissioned the University of Essex to undertake this survey and report on its findings.

The AOT Forum has approximately 2,000 members and includes junior doctors of all grades, including at least 350 registrars in training to become consultants.

A systematic review of published literature (primarily from the US) was undertaken in 2021 to characterise current trends of burnout and wellbeing among otolaryngology trainees. It found rates of burnout remain high among otolaryngology trainees. Implementing protected non-clinical time and formal trainee mentorship programmes have been shown to decrease burnout and stress and to increase well-being among trainees. In qualitative studies, trainees reported increased levels of distress and emotional hardening compared to attending otolaryngologists. Total hours worked per week and being female were associated with worsened wellbeing. In quantitative studies, burnout rates remain high among ENT trainees although they appear to be improving over time. (Lawlor et al., 2022)

Methodology

The AOT drafted an online survey that the University then reviewed and suggested additions/amendments. Questions assessed the working conditions for ENT trainees, and several validated inventories evaluated wellbeing, burnout, and resilience. These were: the Copenhagen Burnout Inventory (CBI) (Kristensen et al., 2007); the short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS) (Tennant et al., 2007); and the Brief Resilience Scale (BRS) (Smith et al., 2008). Demographics, including UK region, age, level of training, gender, sexual orientation, ethnicity, and religion were also recorded.

Participation was voluntary. An online survey link was circulated to AOT forum members via email. The survey was live between October and December 2022 and 190 responses were received.

At the end of the survey, links to sources of support and information were provided, including advice on whistleblowing with the NHS and both British Medical Association and NHS Employers Guidance on harassment and bullying.

Survey responses were analysed using Excel and SPSS.

Statistical analysis for the report includes descriptive and analytical sections. The descriptive section utilises categories within the wellbeing and harassment inventories to demonstrate respondents' situation. Numbers and percentages are reported for each category to emphasise the importance of wellbeing and exposure to harassment.

Descriptive statistics were used to analyse categorical variables, available in Appendix 2 of this report. This utilises scores from the questionnaire and reports the mean, standard deviation and standard error. Since the responses were categories and had not normally distributed, means between demographic groups were compared using the non-parametric Kruskal-Wallis for multiple groups comparisons and Mann-Whitney for two groups, with significance levels considered at ($p = 0.05$). Due to the number of statistical tests for pairwise comparisons, significance values were adjusted using the Bonferroni method.

To examine the difference in harassment experiences between women and men, the analysis utilised the percentage of each group to describe and calculate odds ratios for the effect size. The 95% confidence interval was estimated for the odds ratio, and the gender differences were statistically evaluated using chi-square.

Limitations

An online survey has several limitations. Firstly, response rate cannot be determined, since it is not possible to know how many trainees viewed the email invitation. A lower response rate, reduces the generalisability of the findings. Although the total ENT trainee population is unknown, 190 responses out of an estimated AOT forum junior doctor population of 350 gives an estimated response rate of 54.3%, which would be classified as a good response rate. This is on a par with the average response rate of 53.3% achieved by 1,746 online surveys of health care professionals (Meyer et al., 2022).

Secondly, there may be a sampling bias amongst responders since they are self-selecting because participation was voluntary. This may further affect generalisability. Mandatory surveys (e.g. GMC, ISCP) do not face this problem to the same extent.

Ethics

Ethical approval was provided for all elements of the project by the University of Essex Ethics Sub Committee 2.

Headline findings

Working conditions

- If working non-resident on-call, 26% of respondents (n=46) were not given time off the next day following less than 6 hours continuous rest during the on-call shift.

- 43% (n=57) stated that, on average in the last month, an on-call room was always or frequently available, with 19% (n=32) stating that one was never available. 29% (n=43) did not feel completely safe, secure and comfortable using on-call accommodation.

- 47% (n=71) believed that relocation expenses are insufficient.

- 90% (n=150) sought training opportunities on their days off to meet training requirements.

Wellbeing

- 61% (n=92) agreed their workplace supports their wellbeing at work and 68% (n=104) knew where to seek support for mental wellbeing. However, 11% (n=17) and 4% (n=7) respectively strongly disagreed with these two statements.

- While most respondents had low or moderate levels of burnout on all three Copenhagen Burnout Inventory domains, 15% (n=32) had high personal burnout - with 3% (n=4) having severe burnout - and 13% (n=20) had high work-related burnout. Just 1% (n=1) had high patient-related burnout.

- The mean wellbeing score for respondents was 22.8, which is lower than the whole population mean (23.5) but higher than the mean from a study of nursing professionals in summer 2020 (21.3).

- 39% (n=59) reported their mental wellbeing has been slightly affected in a negative way by their working environment and conditions in the last six months, and 26% (n= 40) reported it being significantly affected in a negative way. Of these, 43 respondents reported an impact on patient safety, citing examples.

- 67% (n=98) scored a moderate level of resilience, 8% (n=12) a high level of resilience, and 25% (n=36) a low level of resilience.

- 30% (n=45) regret their decision to become a doctor and 44% (n=65) have thought about giving up medicine for another career.

Bullying and harassment

- For 77% (n=109), their workplace makes it clear that unsupportive language and behaviour are unacceptable but 21% (n=33) disagreed.

- Many respondents have experienced or witnessed a range of bullying, harassment and sexual harassment behaviours, yet very few (5% or less) have reported them. 22% (n=31) would not feel confident in reporting bullying or harassment problems and 18% (n=24) would not feel confident in reporting sexual harassment problems. 23% (n=36) would not feel confident in reporting problems with working hours/working conditions.

- The main reasons given for not reporting problems were the fear of repercussions, being perceived as a difficult trainee/unable to cope, that no action would be/has been taken, that it is just what is expected as part of the job and doubts about confidentiality.

- 38% (n=53) do not feel safe raising concerns about bullying or harassment, and for these respondents the biggest barriers to reporting such behaviour are concerns about harming their career (94%, n=50), feeling that nothing will change (77%, n=41) and not wanting to be seen as a whistle blower (64%, n=34).

- Just 10% (n=15) said that the existing reporting mechanisms are sufficient. The most popular features for a confidential reporting system were protecting the identity of those raising concerns, clustering units to preserve anonymity and the use of investigators from other specialties, followed by logging incidents to retain records for future reference.

Recommendations

- Gaining more responses would strengthen understanding of the challenges faced by trainees, particularly for those reporting sexual assaults, and the associated impact on their mental health and wellbeing. Running the survey again and publicising it more widely to generate a higher response rate alongside a follow up qualitative study to explore some of the issues in more detail is recommended.

- Replicating the study in other specialities, as trainees are a vulnerable group, should be explored.

- Any reporting process should guarantee anonymity, confidentiality and protection for victims and reporting staff. This can be problematic as if a problem is reported that is a criminal act as anonymity is hard to maintain when following it up. There needs to be a way that victims can report mistreatment and abuse, but the system also needs to provide support for the victims and that support system should be anonymised.

- A safe reporting environment, underpinned by counselling and support services is required. Non-UK staff should be informed about such services. All trainees should be made aware of the voluntary organisations that give support and that are independent of NHS Trusts.

- Sleep deprivation, a result of poor in-hospital on-call resting facilities, adversely affects wellbeing and mental function (West & Coia, 2019). This affects patient safety and there is a need to develop a system that enables junior staff to seek help for their mental health and wellbeing.

- A buddying system or mentoring system could provide support to trainees.

Executive Summary

Working conditions
A quarter of respondents (n=36) reported that their work schedule reflects the hours they actually work. Another 36% (n=51) work up to 5 hours extra per week, 25% (n=36) work 5-10 hours extra and 8% (n=11) work over 10 hours extra per week.

87% of respondents (n=160) work resident on-calls. When working non-resident on-call, 39% of respondents (n=75) live within on-call distance from their hospital while 39% (n=76) do not.

24% of respondents (n=46) reported that if working non-resident on-call, they were not given time off the next day following less than 6 hours continuous rest during the on-call shift. Just 15% (n=27) were always supported in having time off the next day and 21% (n=37) were usually supported to do so.

64% of respondents (n=110) have a dedicated on-call room available where they work, although it is not pre-bookable for a proportion, but 25% (n=43) have no such room. Just over a third (n=57) reported that, on average in the last month, an on-call room was always available with another 8% (n=14) saying one was frequently available. 19% (n=32) stated that a room was never available. When no on-call room was available, 24% of these respondents (n=26) paid for a hotel (some of whom were then reimbursed) 24% (n=23) slept in their office and 15% (n=16) went home.

30% of respondents (n=45) feel completely safe, secure and comfortable using the on-call accommodation and 29% (n=44) mostly feel safe. However, 29% (n=43) do not feel safe, secure and comfortable using the accommodation. Suggested improvements to on-call accommodation included: locks on doors, or better locks; better comfort or a more comfortable bed/warm bedding; ensuite or non-communal bathrooms, better lighting and/or security support; cleaner accommodation; and accommodation being nearer to the hospital or wards.

55% of respondents (n=77) reported that there is no free parking when travelling to a different site for emergencies whilst 17% (n=25) stated there is always free parking and 17% (n=25) said that there is free parking most of the time. When travelling to another site for emergencies, 87% (n=60) had paid for parking out of their own pocket. Three quarters of respondents reported difficulties with parking at work, with 63% (n=93) reporting insufficient parking for staff, 46% (n=68) paying a premium fee for parking, 42% (n=62) not being given a parking permit and 26% (n=35) reporting unsafe places to park.

Just 15% of respondents (n=22) felt that relocation expenses are sufficient, with 47% (n=71) reporting them as insufficient (the question was not applicable for 34%, n=51).

90% of respondents (n=150) sought training opportunities on their days off to meet training requirements, with 11% (n=19) doing this every week and 19% (n=31) doing this once a month. 37% (n=40) said that they would not have met their training requirements without doing this.

Reporting problems

When asked to whom respondents would feel confident in reporting problems with working hours or conditions, the main replies were their educational or clinical supervisor followed by trainee reps and via the GMC survey.

23% (n=36) said that they would not feel confident in reporting problems to anyone. The main reason for this was the fear of repercussions or being seen as a difficult trainee/not able to cope - *"if you report you become a black sheep"*. Other significant reasons were that no action would be/has been taken and the perception that it is expected as part of the job.

Wellbeing

The Copenhagen Burnout Inventory (CBI) was used to assess burnout. Mean scores in this survey were 54.9 for personal burnout, 51.1 for work-related burnout and 25.6 for patient-related burnout. These are all higher than the scores (47.02, 49.14 and 18.67) measured for neurosurgical trainees in 2021 (Salloum et al. 2021). While the majority of respondents had low or moderate burnout on all three domains, 15% (n=32) had high personal burnout - with 3% (n=4) having severe burnout - and 13% (n=20) had high work-related burnout. Just 1% (n=1) had high patient-related burnout.

Respondents reporting they have a specific learning disability had higher burnout scores than those who said they did not on all burnout domains. Those reporting themself as having a disability had a higher score for personal burnout than those who did not. Respondents aged 30-39 had higher scores for patient-related burnout than those aged 20-29.

The short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS) was used to assess mental wellbeing (scores range from 7 to 35 and higher scores indicate higher positive mental wellbeing). The mean wellbeing score for respondents to this survey was 22.8, which is lower than the mean score of the whole population (23.5) (Ng Fat et al., 2017) but higher than the mean score for health professionals of 21.3 in summer 2020 (Gillen et al. 2022). While the percentage of the respondents to this survey was in line with population norm for high levels of wellbeing, the proportion with a low level of wellbeing was three percentage points higher than the population norm.

The Brief Resilience Scale (BRS) was used to assess the self-perceived ability to bounce back or recover from stress. The mean score for respondents was 3.4, which is lower than the 3.7 mean from a national study of patients (Smith et al., 2013). 8% of respondents (n=12) showed a high level of resilience and 67% (n=98) showed a moderate level of resilience. However, 25% (n=36) showed a low level of resilience.

Female respondents had lower mean resilience scores than males while those reporting a specific learning disability had lower resilience scores than those who did not.

61% of respondents (n=92) agreed that their workplace supports their wellbeing at work and 68% (n=104) agreed that they know where to get support if their mental wellbeing is affected. However, 11% (n=17) and 4% (n=7) respectively strongly disagreed with these two statements.

39% of respondents (n=59) reported their mental wellbeing has been slightly affected in a negative way by their working conditions, whilst 26% (n=40) said it has been significantly affected in a negative way. 21% (n=32) said it has not been affected while just 6% (n=8) said it has been affected positively. Of these respondents, 43 reported the detriment to mental

wellbeing had affected patient safety. Reasons included not having enough sleep/feeling tired has an impact; making simple/careless errors and reduced efficiency and clarity of thought.

30% of respondents (n=45) regret their decision to become a doctor, and 44% (n=65) have thought about giving up medicine for another career.

There were 56 suggestions made to improve respondents' wellbeing, mainly relating to: staffing levels and/or working conditions; being valued as an employee (or not being valued) and/or better understanding or support from consultants and managers; pay and finances, including their administration and the reimbursement of travel and relocation costs; and more or better support for training.

Bullying and harassment

For 77% of respondents (n=109), their workplace makes it clear that unsupportive language and behaviour are not acceptable (e.g. condescending or intimidating language, ridicule, overly familiar behaviour, jokes/banter that stereotype people or focus on their appearance or characteristics). However, 13% (n=20) disagreed and 9% (n=13) disagreed strongly.

When questioned on specific bullying or harassment behaviours within the previous six months, 33% of respondents (n=51) reported that they had experienced unrealistic expectations about workload, responsibilities or level of competence, and 22% (n=33) had witnessed this. 25% (n=39) had experienced inadequate or absent supervision while 16% (n=24) had witnessed this. 25% (n=38) had experienced undervaluing someone's contribution (in their presence or otherwise) while 18% (n=28) had witnessed this. Very few respondents (under 5%) had reported any of these behaviours.

Female respondents (n=82) were 2.6 times more likely than males (n=88) to say that they had experienced unrealistic expectations about workload and 2.8 times more likely to say they had experienced inadequate or absent supervision.

18% of respondents (n=29) had experienced or witnessed sexual harassment behaviours at work in the last six months in the form of comments on physical appearance. 16% (n=26) had experienced or witnessed intrusive comments about personal life and 13% (n=22) had experienced or witnessed lewd comments. Just 1% had reported any of the sexual harassment behaviours.

Female respondents (n=82) were more likely than males (n=88) to say they had experienced intrusive comments about their personal life (15% compared to 1%) or comments on their physical appearance (13% compared to 5%). All of the other sexual harassment behaviours (apart from unsolicited texts/emails/pictures/social media posts) were only experienced by female respondents, not by male respondents.

When asked to whom respondents would feel confident reporting bullying or sexual harassment behaviours, the main replies were educational or clinical supervisors or training programme directors. However, 22% (n=31) would not feel confident in reporting bullying problems and 18% (n=24) would not feel confident in reporting incidents of sexual harassment. The main reasons why respondents would not feel confident about reporting these problems were that it is unlikely that any action will be taken or no action has been taken in the past and due to the fear of repercussions or being seen as a difficult trainee, including doubts about the confidentiality of the process.

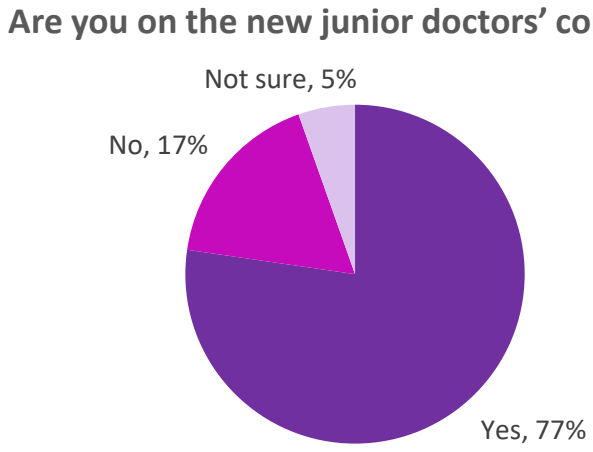
Around two fifths of respondents were aware of mechanisms for reporting concerns about bullying, harassment and sexual harassment but just over a third were not and around a quarter were unsure. While 52% of respondents (n=71) reported that they feel safe about raising concerns about bullying or harassment, 38% (n=53) do not feel safe. The biggest barriers to reporting any inappropriate behaviour that respondents have witnessed or experienced are not wanting to potentially harm their career, feeling that nothing will change and not wanting to be seen as a whistle blower.

Just 10% of respondents (n=15) stated that existing mechanisms of reporting are sufficient. The most popular features that respondents would like to see in a confidential reporting system were protection of the identity of those raising concerns, clustering units to preserve anonymity and the use of investigators from other specialties, followed by logging incidents to retain records for future reference.

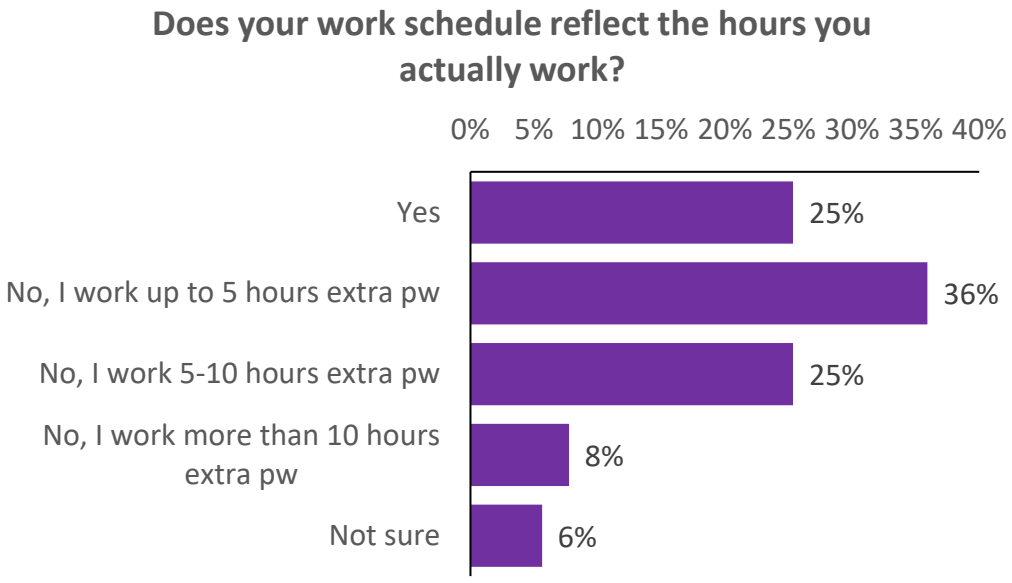
Detailed Findings

Working conditions

77% of respondents (n=143) said they were on the new junior doctor's contract, 17% (n=32) said they were not and 5% (n=10) were unsure.

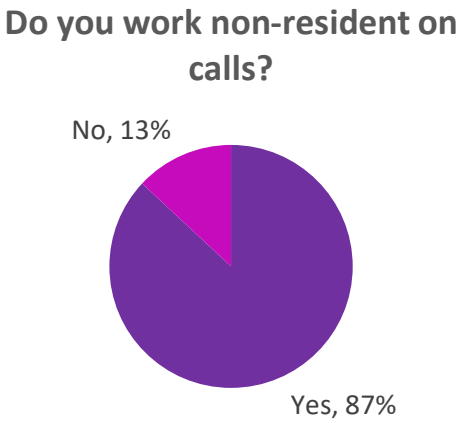


A quarter of respondents (n=36) said that their work schedule reflects the hours they actually work. Another 36% (n=51) said they work up to 5 hours extra per week, 25% (n=36) that they work 5-10 hours extra and 8% (n=11) that they work more than 10 hours extra per week.

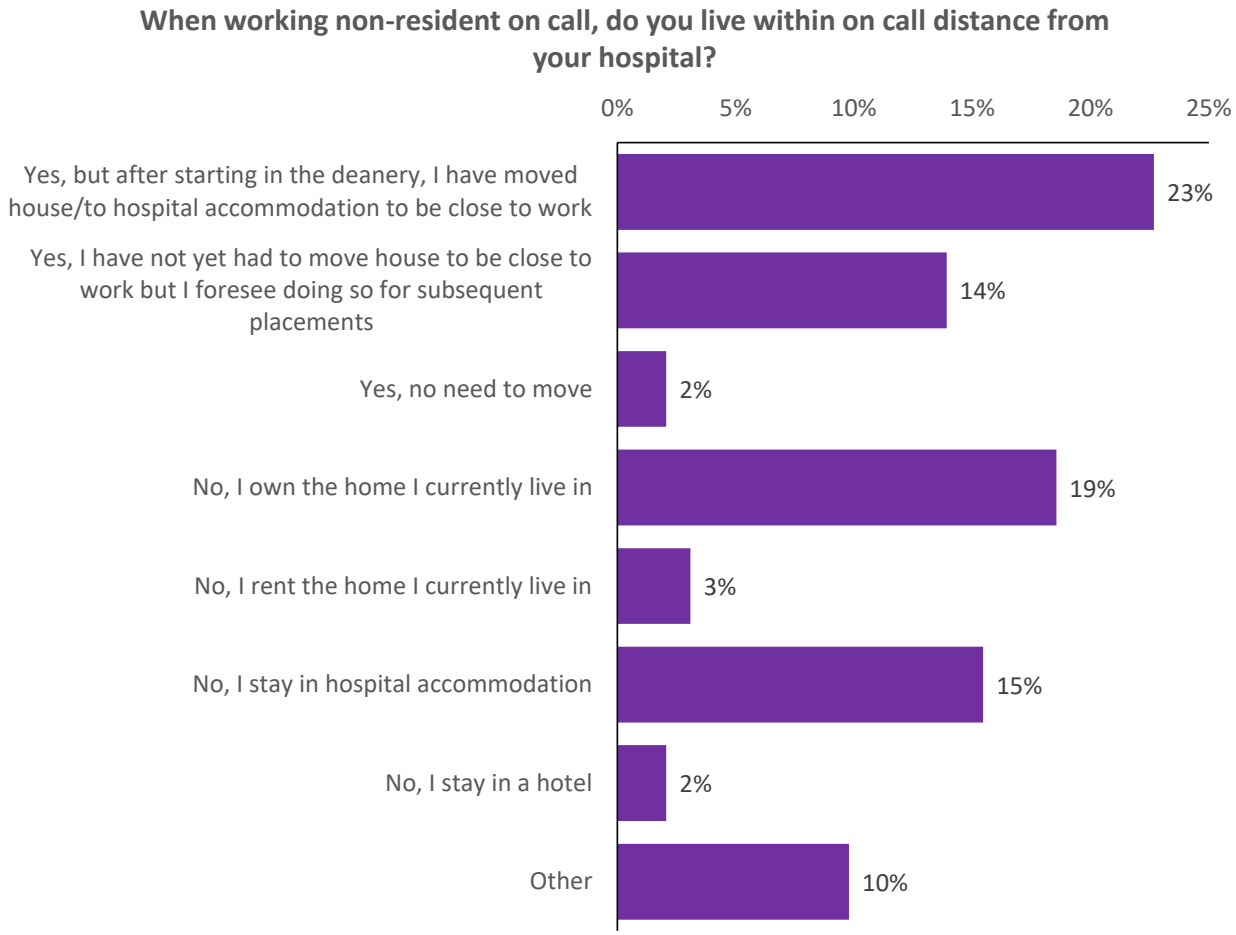


Working on-call

87% of respondents (n=160) work resident on-calls.



39% of respondents (n=75) said that when working non-resident on-call they live within on-call distance from their hospital while 39% (n=76) do not.



The other responses were as follows:

"I live within an on-call distance from my current hospital however have had multiple placements where I have had to stay in an on-call room as U so. Or live close enough, and foresee having to do this in the future also."

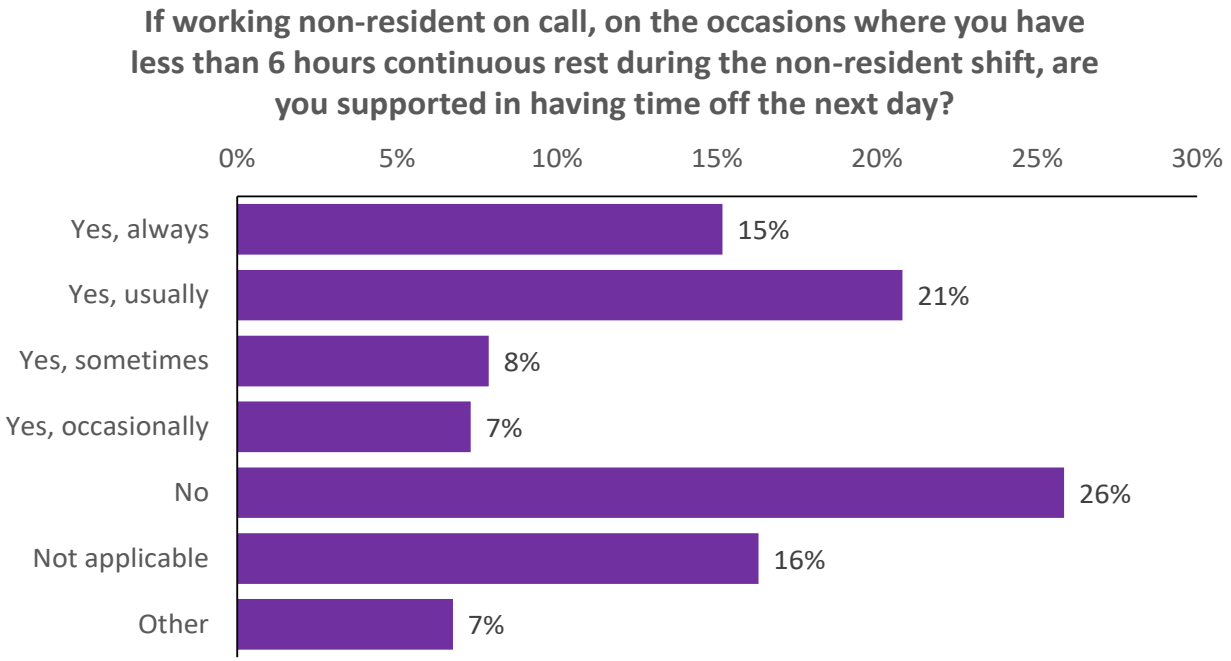
"No, I stay with friends nearby. I will, in future need to stay in a hotel or hospital accommodation as my partner works in London so we cannot move."

"I have a home that's ok for NROC for most but at all. Also the rules of distance are unclear and transport/parking can make the timings more challenging. I have and will again stay in on site accommodation."

"Yes. Have moved regularly to accommodate this throughout training or at times when job changed last minute, I have stayed on site."

"For some placements I've been obliged to stay in hospital accommodation. This really means one isn't non-resident at all….. it also makes arrangements for other things not difficult."

Just over a quarter of respondents (n=46) said that if working non-resident on-call, they are not supported in having time off the next day on the occasions where they have less than 6 hours continuous rest during the non-resident shift. Just 15% of respondents (n=27) said that they are always supported in having time off the next day and 21% (n=37) said they are usually supported to do so.



The other responses were as follows:

"I am, but it would often mean missing precious learning opportunities such as theatre lists, therefore I'll still go into work."

"This depends on the generation of surgeon. Older consultants are disapproving of the time off and I have been questioned as to why I would need time off if I had a busy night on-call."

"The time off is given. But it is quite clear that lots of consultants don't support it."

"Only if I'm in for most of the night and then only if I have no clinic."

"Never requested this."

"I have never requested it but if I did they would give it."

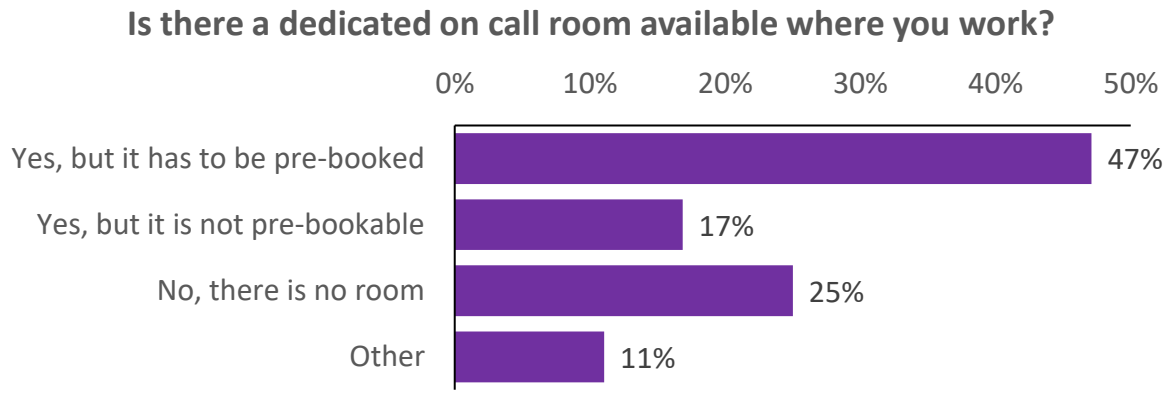
"Yea if I asked for it, but don't."

"Time in lieu another time."

"Half day off next day."

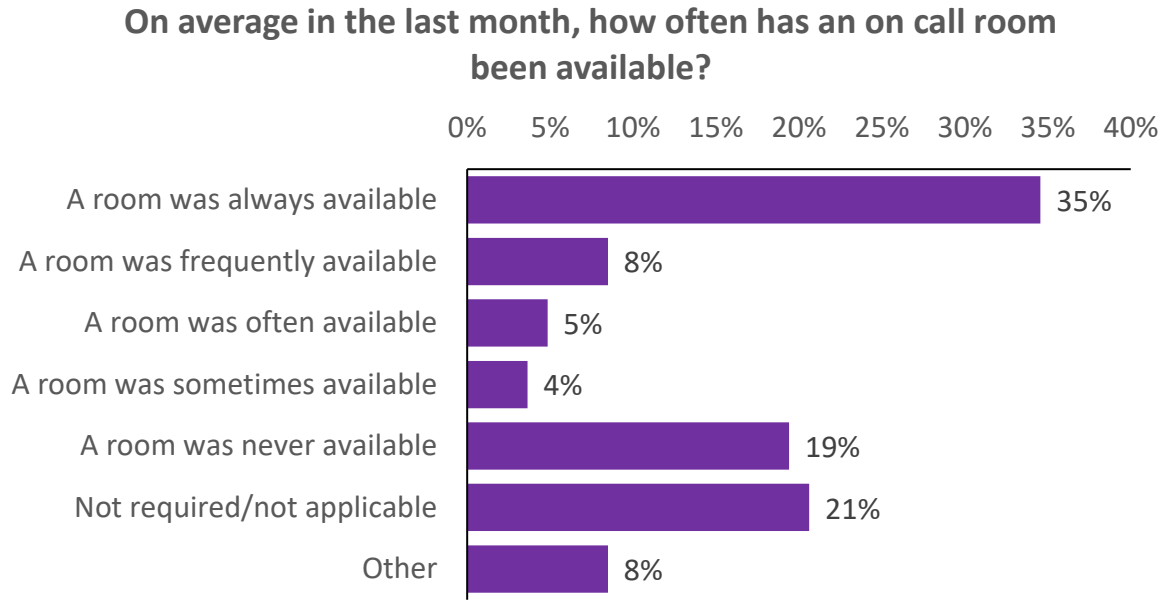
On-call accommodation

64% of respondents (n=110) said that there is a dedicated on-call room available where they work, although it is not pre-bookable for a proportion, but 25% (n=43) said that there is no room.



Just one person who ticked "other" provided a comment, which was that there is no dedicated on-call room but they can pre-book hospital accommodation for free.

Just over a third of respondents (n=57) said that, on average in the last month, an on-call room was always available with another 8% (n=14) saying a room was frequently available. 19% (n=32) said that a room was never available.



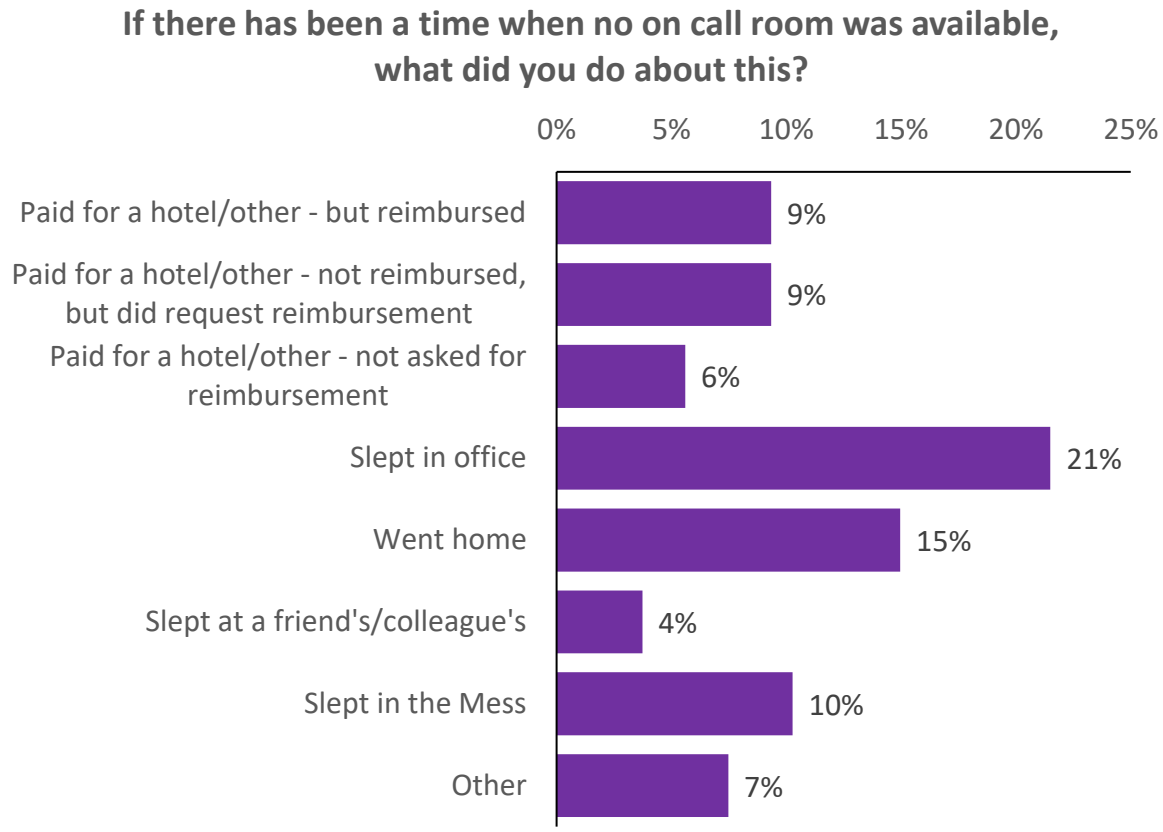
The three people who provided a comment under other said:

"The room has sometimes been dirty, used bedsheets, unclean bathroom etc."

"Some hospitals provide on-call rooms, not all. Some are not on site at the hospital."

"If we get chance to sleep when working overnight it is on a mattress on the floor of our tiny office."

107 respondents replied to the question about what they did when no on-call room was available, with 24% (n=26) saying they paid for a hotel (some of whom were then reimbursed) 24% (n=23) saying they slept in their office and 15% (n=16) that they went home.



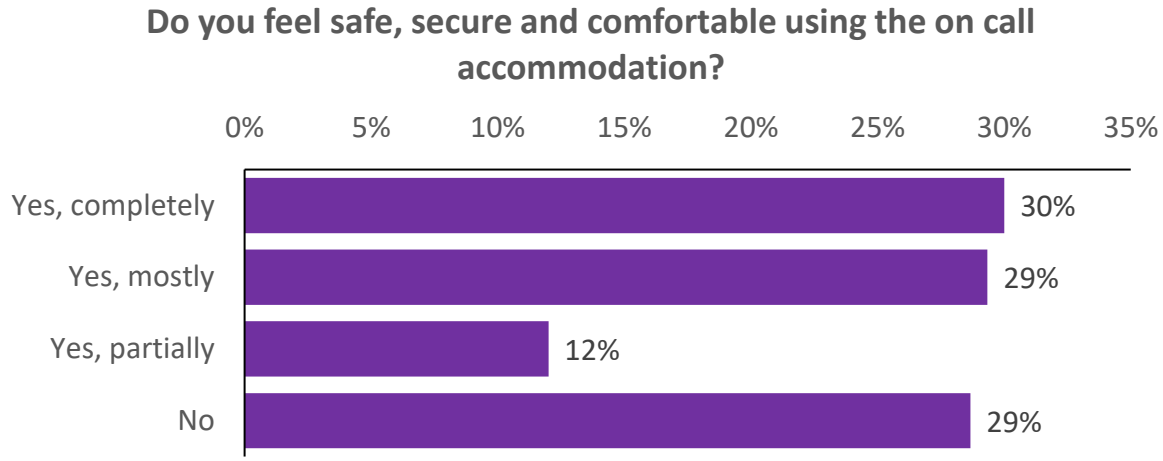
The other comments were as follows.

"Once when no on-call room was available slept in admin office near ward."

"Slept in recovery."

"Slept in patient bed in closed area of hospital."

30% of respondents (n=45) said that they feel completely safe, secure and comfortable using the on-call accommodation and 29% (n=44) said they mostly felt safe. However, 29% (n=43) said that they do not feel safe, secure and comfortable using the accommodation.



When asked what would make respondents feel safer in on-call accommodation, the responses were as follows:

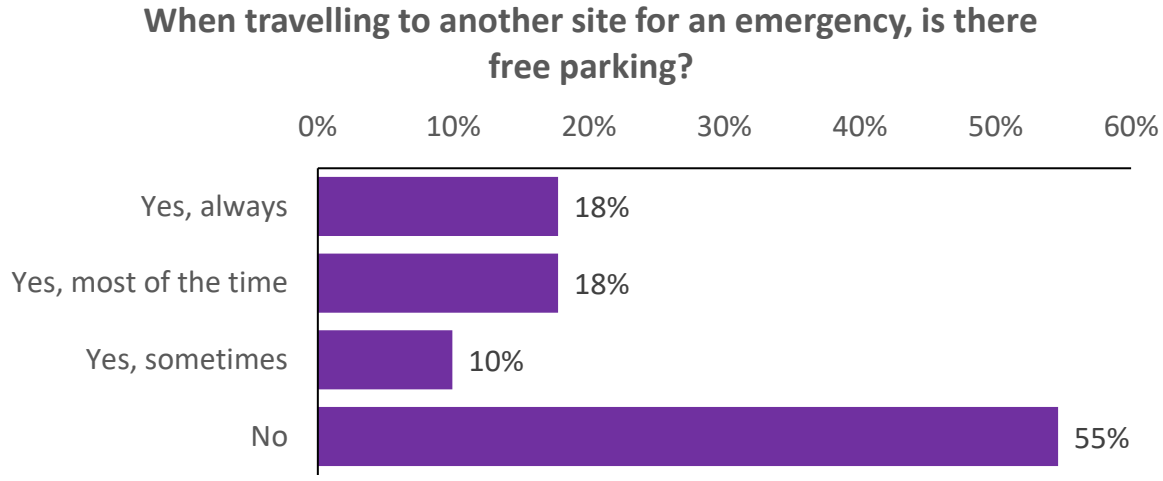
- Locks on the door, or better locks (11 people).
- Better comfort or a more comfortable bed/warm bedding (10 people).
- Ensuite or non-communal bathrooms (8 people).
- Better lighting and/or security support (7 people).
- Clean accommodation or better cleanliness (7 people).
- Accommodation being nearer to the hospital or wards (6 people).
- Accommodation being in a safer place (3 people).
- Parking near to accommodation (2 people).
- Quiet location so ambulances and patients do not disturb sleep (2 people).
- Not having other people access room when respondent is there (2 people).
- Kitchen facilities (1 person).
- Wi-Fi access (1 person).
- Dedicated room for the specialty (1 person).
- ID checks since ID card is never checked so anyone could ask for a key (1 person).

> *"It is however just miserable. Too hot. Poor kitchen facilities. Nowhere to sit comfortably to sit and eat food (there used to be a living room but this was converted into another executive committee room and taken away from doctors)."*

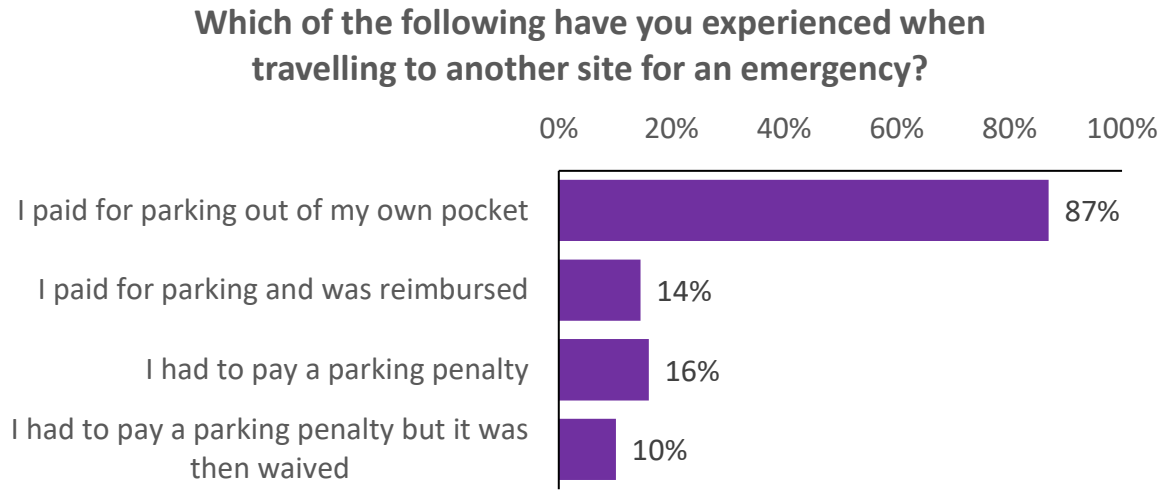
> *"On several occasions, someone has entered the room when I was asleep in there. Estates have now put a chain on the door but I always worry that the code is known by so many people and someone might already be in there when I go in late at night, as has happened before despite me booking the room."*

Parking

55% of respondents (n=77) said that there is no free parking when travelling to another site for an emergency while 17% (n=25) said there is always free parking and 17% (n=25) that there is free parking most of the time.



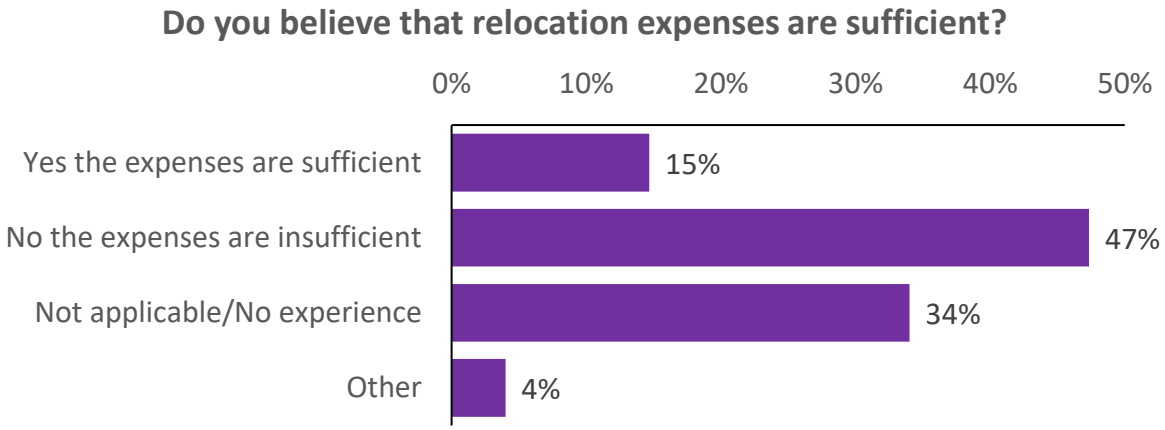
When travelling to another site for an emergency, 87% of respondents (n=60) said that they have paid for parking out of their own pocket.



Three quarters of rspondents reported difficulties with parking at work, with 63% (n=93) saying there is not enough parking for staff, 46% (n=68) that they pay a premium fee for parking, 42% (n=62) that they are not given a parking permit and 26% (n=35) that the places to park are unsafe.

Relocation expenses

Just 15% of respondents (n=22) believed that relocation expenses are sufficient, with 47% (n=71) saying they are insufficient.



The other responses were as follows:

"Variable access to funds depending on trust. Not always been able to get expenses covered."

"Relocation expenses are good but difficult to qualify. Refused in past."

"Relocation expenses not well advertised and never claimed by myself."

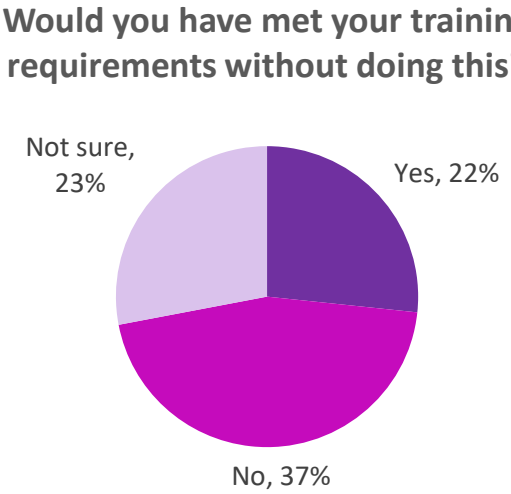
"Yes but the payment is often very delayed."

"Really really difficult. Deanery and Dean personally have no care for trainees' personal circumstances. HEE offered better terms but these are blocked locally (eg putting price caps on relocation, refusing to pay for return-to-work mileage) [name] personally refused this saying rules were rules (even though there are no specific rules for return to work mileage)."

Training opportunities

90% of respondents (n=150) said that they seek training opportunities on their off days to meet training requirements, with 11% (n=19) saying they do this every week, 19% (n=31) once a month, 33% (n=54) a few times a month and 28% (n=46) less often.

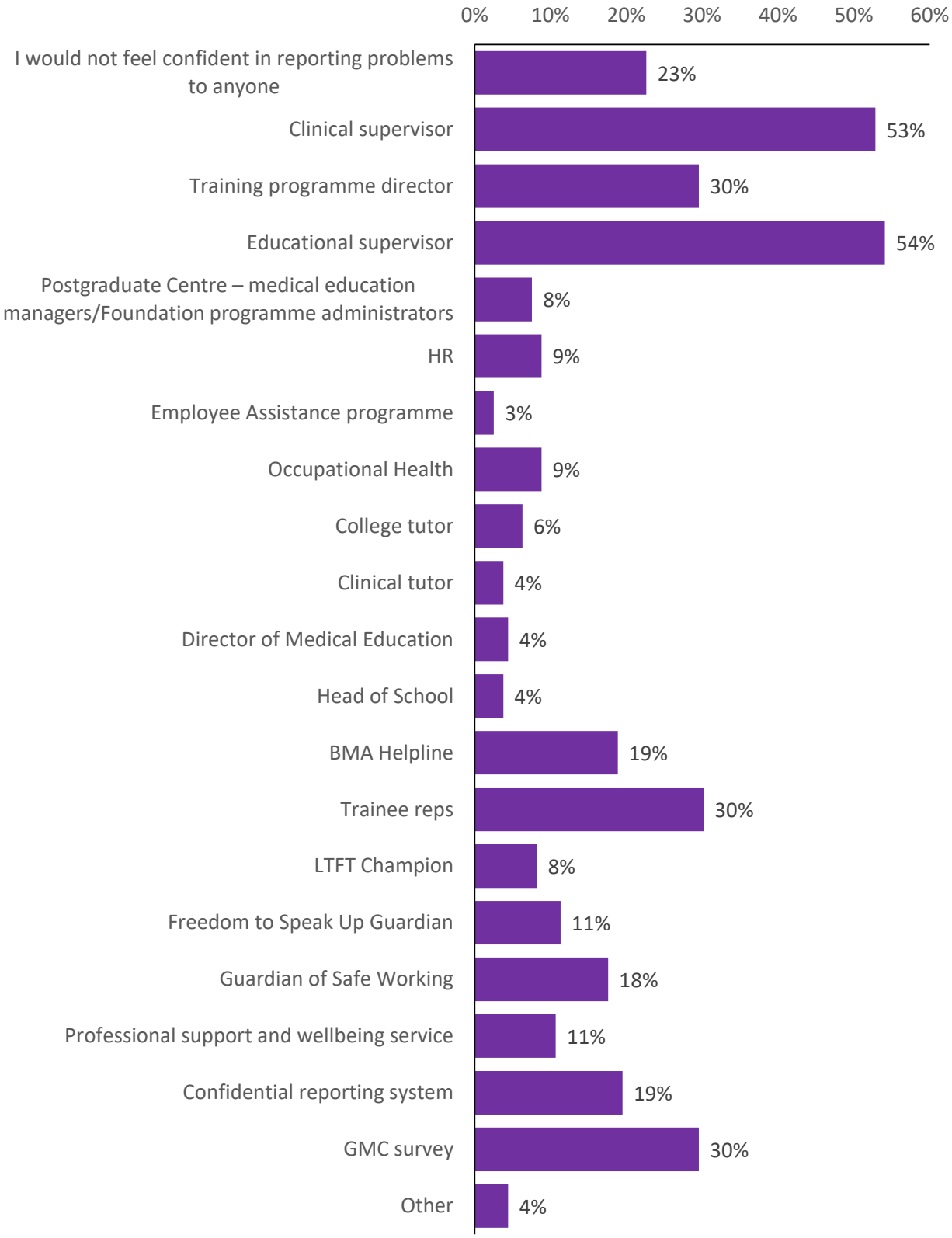
37% (n=40) said that they would not have met their training requirements without doing this.



Reporting problems

Respondents were asked to which of different people/roles they would feel confident in reporting problems with working hours or working conditions. The main replies were their educational or clinical supervisor followed by trainee reps and via the GMC survey. However, 23% (n=36) said that they would not feel confident in reporting problems to anyone.

To which of the following would you feel confident in reporting problems with working hours or working conditions?



The reasons given why respondents would not feel confident about reporting problems with working hours or working conditions were as follows:

- Fear of repercussions or being seen as a difficult trainee/not able to cope - *"if you report you become a black sheep"* (17 people).
- No action taken (9 people).
- No one cares (4 people)
- Just what is expected by senior doctors (4 people)

"Reporting is never anonymous and you will be blamed forever, maybe seniors will even make your life difficult. I may report to BMA but to take action means to ID yourself."

"The culture of bullying and victimisation in our Deanery is frightening. I wouldn't dare report anything or speak out. Even just existing leads to horrific bullying by consultants well known for this behaviour who have never been held accountable."

"Back fired from previous experience. I learnt to be comfortable with being bullied on regular basis."

"Nobody cares about doctors working hours or working conditions including senior doctors. Seen as difficult or lazy if you report problems about this. Senior figures turn a blind eye."

"It's expected for doctors to work extra hours without getting compensated and without being able to open their mouths to talk about it. We're expected to work extra hours like slaves with no compensation."

Many of the comments made about reporting problems echo those above:

- No action taken (9 people).
- Just what is expected as part of the job (8 people).
- Fear of repercussions or being seen as a difficult trainee/not able to cope (7 people).
- No trust in HR department to take action (4 people).
- No trust in TPD to be supportive (3 people).
- Problems have been taken seriously and acted upon (3 people).
- No one cares (2 people).
- Reporting via the GMC survey is not anonymous or no trust in GMC (2 people)
- Lack of awareness raising during induction of reporting mechanisms (1 person).
- Should be a confidential, centralised reporting system which allows someone to report something without the person being accused of inappropriate behaviour being told who it was. If more than 2 people complain or an offence is very serious then that person has to be investigated (1 person).

"In one of my previous placements I did have concerns about one of the consultants, but actually it turned out lots of people did about that consultant. Yet it was so difficult for anything to get done about them. They'd even been investigated by the GMC before. This makes me even less likely to say anything in future."

"From surgeons in clinical roles in same specialty in current region (ie rather than a 'Champion') limited understanding due to working long hours themselves as juniors (without recognition of increase in volume/ patient expectations/ documentation/ litigation that applies since they trained/lack of junior staff meaning SpR covers SHO

work too). Most of them work long hours now although different pace and vastly different remuneration. Haven't tried discussing with younger or non-male consultants as don't work with any at present. Management have absolutely no understanding in my current department, which is notoriously understaffed, but this isn't true of all departments."

"Whenever I have reported problems to a clinical or educational supervisor, I have been met with apathy at best. My last educational supervisor was actively against exception reporting and I was dressed down for doing them. My AES tried to reject all of my reports and this had to be overturned by the Guardian of Safe Working. I was actually bullied by this AES and the Clinical Director of the department and even though I did report this too, to the GSW and DME and my TPD, nothing was done. I have also always had problems being paid following the reports."

"I feel it would work against me as it would impact on the consultant's opinion of me which is important when it comes to along for references and applying for jobs."

"If I was consistently working an hour longer than when my shift was supposed to finish (as an example) I would probably feel uncomfortable reporting this to anyone for a number of reasons. Firstly, it seems to be expected as part of the job and I feel as though it would also reflect badly on me as a person. If I were to finish on time and not complete jobs it may put patients at risk, which leaves trainees in a difficult position. Most of us would never leave a patient or job that needed doing and therefore inevitably we end up working more and not getting paid, and if we speak up about it we look bad."

"Usually as ENT is a small specialty- what does around does come back around and it's best to try and come up with your own solutions. It's sad but it's the way it's is - no one wants extra paperwork and no one cares much about improving trainee experience in keeping with current work culture values - which are very different from what it's was previously."

Wellbeing

Measuring burnout

The Copenhagen Burnout Inventory (CBI) was developed with a framework that characterizes the core of burnout as fatigue and exhaustion, which are attributed to specific domains in a person's life (personal, work-related, and client-related). It is a 19-item survey with positively and negatively framed items that covers 3 areas: personal (degree of physical and psychological fatigue and exhaustion), work (degree of physical and psychological fatigue and exhaustion related to work), and client-related (or a similar term such as patient, student, etc.) burnout (Kristensen et al., 2007). Mean scores for the three domains are classified as: none/low (less than 50); moderate (50–74); high (75–99); and severe (100) (Creedy et al., 2017).

An online survey of neurosurgical trainees in the UK and Ireland, with 75 respondents, had a median CBI score of 38.85. Participants showed a higher degree of personal and workplace burnout (median CBIs of 47.02 and 49.14 respectively) compared with patient-related burnout (median CBI 18.67) (Salloum et al. 2021). A survey of staff working in an acute paediatric hospital setting in Ireland during the Covid 19 pandemic, with 133 respondents, reported a mean score in the three domains of 56.9 for personal burnout, 55.6 for work-related burnout and 28.1 for patient-related burnout. (Murray et al., 2022) A survey of nurses, midwives and AHPs in summer 2020, with 1,410 respondents, reported a mean score of 58.82 for personal burnout, 54.67 for work-related burnout and 25.02 for patient-related burnout. (Gillen et al., 2022)

Mean scores in this survey were 54.88 for personal burnout, 51.14 for work-related burnout and 25.58 for patient-related burnout. These are all higher than the scores (47.02, 49.14 and 18.67) measured for neurosurgical trainees in 2021 but are lower than the scores in summer 2020 for nurses, midwives and AHPs (58.82, 54.67 and 25.02).

Respondents saying they have a specific learning disability had a higher score than those who said they did not for personal burnout (66.21 compared to 52.88) (p=.025) and work-related burnout (62.66 compared to 49.29) (p=.015). Respondents aged 30-39 had higher scores for patient-related burnout than those aged 20-29 (27.32 compared to 21.25) (p=.027).

Table 1: Scores for personal burnout by specific learning disability

Specific learning disability	Mean	N	Std. Deviation	Std. Error of Mean
Yes	66.21	11	23.0	6.9
Have but never assessed	64.58	8	26.7	9.4
No	52.88	130	19.5	1.7
Prefer not to say	83.33	2	0.0	0.0
Total	54.88	151	20.6	1.7

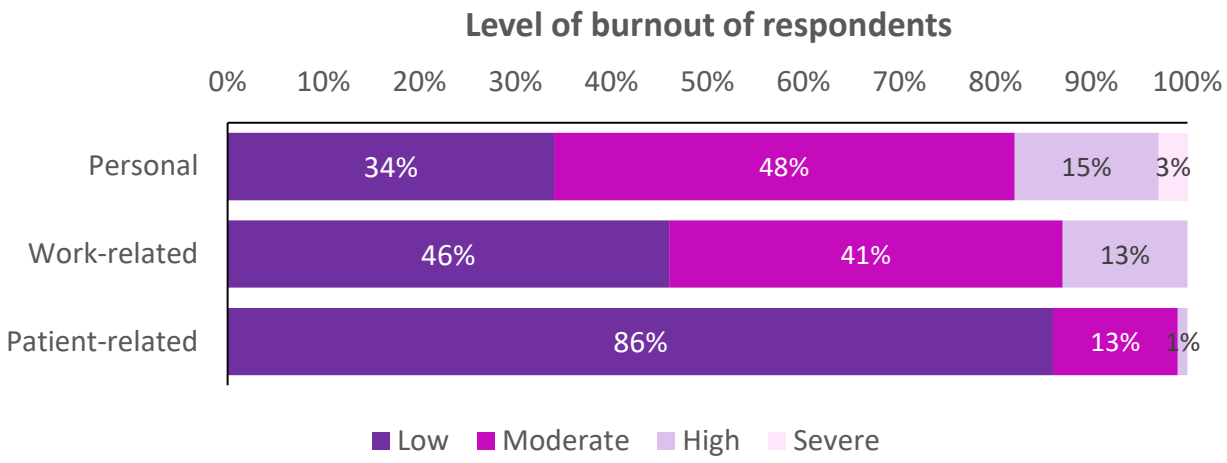
Table 2: Scores for work-related burnout by specific learning disability

Specific learning disability	Mean	N	Std. Deviation	Std. Error of Mean
Yes	62.66	11	15.8	4.8
Have but never assessed	60.27	8	30.4	10.7
No	49.29	130	16.8	1.5
Prefer not to say	71.43	2	5.1	3.6
Total	51.14	151	18.0	1.5

Table 3: Scores for patient-related burnout by age

Age	Mean	n	Std. Deviation	Std. Error of Mean
20-29	21.25	20	17.8	4.0
30-39	27.32	124	19.8	1.8
40-49	8.33	6	3.7	1.5
50-59	0.00	1		
Total	25.58	151	19.6	1.6

While the majority of respondents had low or moderate levels of burnout on all three domains, 15% (n=32) of respondents had a high level of personal burnout - with 3% (n=4) having a severe level of burnout - and 13% (n=20) had a high level of work-related burnout. Just 1% (n=1) had a high level of patient-related burnout.



Measuring wellbeing

The Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS) was developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. The short version uses seven of the WEMWBS's 14 statements about thoughts and feelings, which relate more to functioning than feelings and so offer a slightly different perspective on mental wellbeing. Scores range from 7 to 35 and higher scores indicate higher positive mental wellbeing (Tennant et al., 2007).

Using the Health Survey for England 2010-2013 (n = 27,169 adults aged 16+, nationally representative of the population), norms were estimated and the mean score was 23.5 (23.7

for men and 23.2 for women) (Ng Fat et al., 2017). A survey of Nurse, Midwives and Allied Health Professionals (AHPs) in May/July 2020, with 1,410 respondents, showed wellbeing scores of 21.31 (Gillen et al. 2022).

The mean wellbeing score for respondents to this survey was 22.8, which is lower than the mean score of the whole population (23.5) but higher than the mean scores for health professionals in summer 2020. There were no statistically significant differences in the scores by category of respondent.

Scores can be divided into high, average and low mental wellbeing using cut off points at plus or minus one standard deviation. This approach puts approximately 15% of the participants into high wellbeing and 15% into low wellbeing categories. Using this approach, UK population samples put the top 15% of scores ranging from 27.5 to 35.0 and the bottom 15% from 7.0 to 19.5.

While 15% of the scores for respondents to this survey were in the range of 27.5 to 35.0 (in line with the population norm), 18% were in the range of 7.0 to 19.5, which is three percentage points higher than the population norm.

Measuring resilience

The Brief Resilience Scale (BRS) was created to assess the perceived ability to bounce back or recover from stress. The scale was developed to assess a unitary construct of resilience, including both positively and negatively worded items. The possible score range on the BRS is from 1 (low resilience) to 5 (high resilience) (Smith et al., 2008). In a study with 844 participants, a mix of healthy people and people suffering from diseases, Smith and colleagues found a mean score of 3.70 (Smith et al., 2013). A study of PICU/NICU staff, with 58 respondents (32 nurses, 22 doctors, 4 other HCPs) found a mean score of 3.58 (Dalia et al., 2013).

The mean score on resilience for respondents to this survey was 3.41, which is lower than the 3.58 mean from the Dalia al. study.

Female respondents had lower mean resilience scores than male respondents (3.13 compared to 3.69) (*p*=002.) while respondents saying they have a specific learning disability had lower resilience scores than those who said they did not (2.85 compared to 3.51) (*p*=.002).

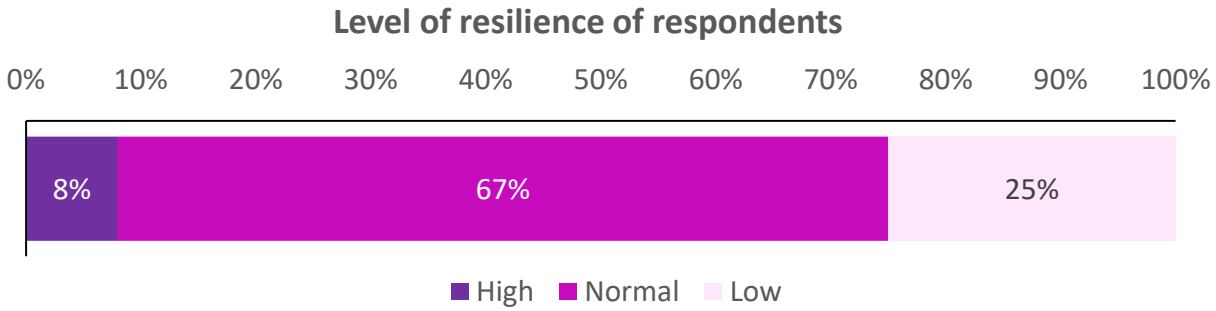
Table 4: Scores for resilience burnout by gender

Sexual identity	Mean	N	Std. Deviation	Std. Error of Mean
Female	3.13	65	0.9	0.1
Male	3.69	69	0.6	0.1
Non-binary	4.00	1		
Prefer not to say	2.75	4	1.3	0.6
Blank	3.62	7	0.7	0.3
Total	3.41	146	0.8	0.1

Table 5: Scores for resilience burnout by learning disability

Specific learning disability	Mean	N	Std. Deviation	Std. Error of Mean
Yes	2.85	11	0.6	0.2
Have but never assessed	2.98	8	0.8	0.3
No	3.51	125	0.8	0.1
Prefer not to say	2.00	2	1.4	1.0
Total	3.41	146	0.8	0.1

8% of respondents (n=12) were measured as having a high level of resilience and 67% (n=98) with a moderate level of resilience. However, 25% of respondents (n=36) had a low level of resilience.



Respondents were asked whether they feel their mental wellbeing has been affected by factors related to their work environment and conditions in the last six months. 39% (n=59) said that it has been slightly affected in a negative way while another 26% (n=40) said it has been significantly affected in a negative way. 21% (n=32) said it has not been affected while just 6% (n=8) said it has been affected positively.

The other replies were as follows:

> *"Both significantly positively and significantly negatively on different occasions although mostly positive."*

"Both positively and negatively affected."

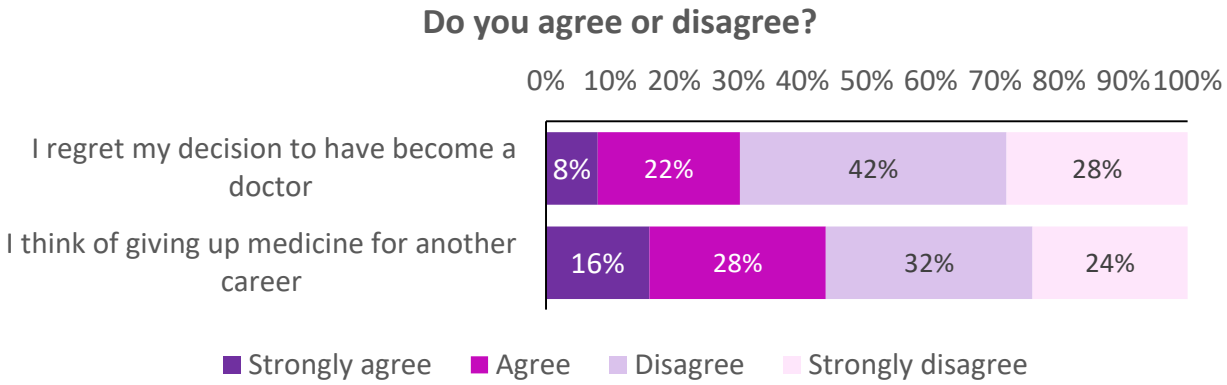
"Supportive colleagues have a positive effect, workload can cause tiredness and mental fatigue."

"What do you mean by mental well-being? It's not defined. There are ups and downs in surgical training."

"Makes me want to quit training and stop working In the NHS."

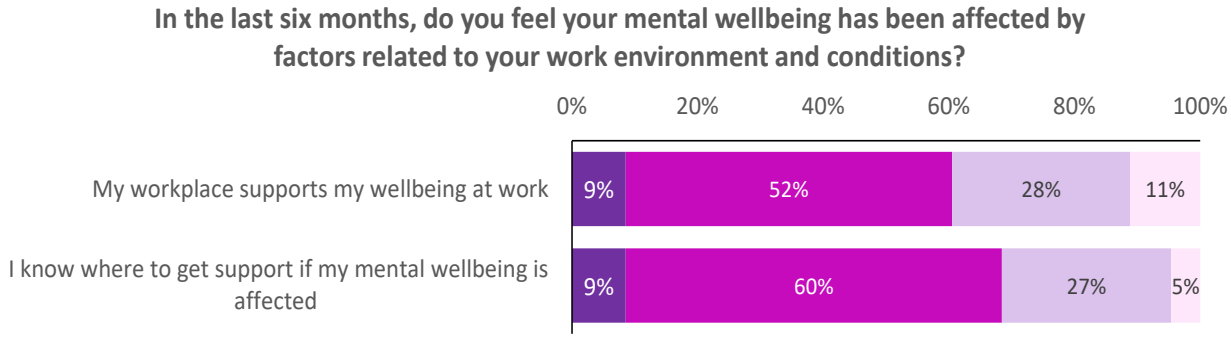
"The commute has negatively affected me in terms of tiredness, stress and feeling overwhelmed and not being able to stay closer to hospital due to having a baby at home."

30% of respondents (n=45) agreed that they regret their decision to become a doctor, with 8% (n=12) agreeing strongly with this statement. 44% (n=65) said that they think about giving up medicine for another career, with 16% (n=24) agreeing strongly.



Support for wellbeing

61% of respondents (n=92) agreed that their workplace supports their wellbeing at work and 68% (n=104) agreed that they know where to get support if their mental wellbeing is affected. However, 11% (n=17) and 4% (n=7) respectively strongly disagreed with these two statements.



Impact on patient safety

When asked how (if their wellbeing has been affected by their work environment and conditions) this has impacted on patient safety, 34 respondents said that it has not. Another 4 respondents said that it had only affected their own personal or family wellbeing and not patient safety.

> *"I have prioritised patient safety persistently, which means my own well-being has been neglected much of the time."*
>
> *"I have found myself being more intolerant, and my concentration has been affected."*

The 43 respondents saying that it has affected patient safety made the following comments:

- Not having enough sleep/feeling tired has an impact (11 people).
- Making simple/careless errors (6 people).
- Reduced efficiency and clarity of thought (5 people).
- Gaps in the rota means having to cover extra shifts without adequate rest (4 people).
- Greater stress and anxiety at work, or tiredness, means that making a mistake or failing to make the right decision quickly is more likely (4 people).
- Less patience/more intolerance with patients (3 people).
- Negative impact on concentration has had an impact (3 people).
- High/unmanageable workload has an impact (3 people).
- The factors affecting wellbeing are related to patient safety issues and service issues at the Trust (2 people).
- Feeling demoralised has an impact (1 people).
- Less time spent in clinic to listen to patients and review their cases (1 person).
- Distraction due to sorting out rota issues or changes to operating lists so full attention may not be on the clinical issue (1 person).
- Less likely to stay beyond rostered hours to help with emergencies (1 person).

> *"It affected my functioning at work such that I made simplistic errors I would otherwise not have, which would have potentially resulted in actual patient harm if I had not corrected them. I also had to take time off work, which affected clinical staffing in our department and hence potentially patient safety."*
>
> *"Less enthusiasm at work, poor sleep which impacts on concentration and decision making."*
>
> *"Workload is unmanageable, therefore work may not be as thorough as should be."*

Improving wellbeing

There were 56 suggestions about something that would help to improve respondents' wellbeing:

25 suggestions made were to do with staffing levels and/or working conditions:

- Not having to cover rota gaps at the expense of my training.
- No rota gaps in the junior rota. Rota timetabled properly so that scheduled teaching is not on at the same time as other commitments.
- Better staffed SHO rota.
- Fully staffing rotas.
- Proper staffing levels. Educational supervisors with an actual interest in training. Not being made to do the job of 2-3 SHOs plus on-call plus elective SpR overbooked clinics.
- Smoother admin/management with less staff turnover and colleagues who are familiar with their roles and who I can trust to have done things I would expect of them, rather than encountering lots of issues that could have been avoided with better organisation/support.
- Clear policies on working hours and rest requirements that ALL employers and ALL educational/clinical supervisors are aware of. Review of work schedule AND actual rota of individual trusts as often these either do not match up or there are clearly non-compliant work schedules/rotas that the department maintains has always been the case and running without problems.
- A system for cover in event of absence that does not ask more hours of colleagues.
- Better help support from admin and seniors and genuine mentorship and reformation of the clinical working team.
- Working hours being reflective of my work schedule. Being given paid time in my timetable for clinical admin. Encouragement to devise a LTFT timetable that is sustainable for me. No pressure from consultants to fill empty rota slots as locums. Less travelling - currently working at 3 different sites - this is draining, a lot more commuting, more expensive and new people/systems to get familiar with all for a 6 month rotation.
- Working less than 48+ hours per week, not being rotated to hospitals & gt;1 hour away, spending & gt;1 year in the same hospital, flexibility in designing work schedule e.g. planned off days, ability to work from home for admin/research time or phone clinics, availability of tea and coffee at work, nice accessible coffee rooms or mess areas for breaks with colleagues away from patient areas.
- Changing the culture so that exception reporting is acceptable for registrar trainees to claim additional working hours in the early morning (coming in to consent patients) and after work in the evening. (Staying overtime).
- Recognition that our deanery size is too large to allow non-resident on-call and then pay accordingly. Lack of centralised organisation for the rotation so I end up doing e-learning modules every 6 months every time I rotate. Constantly receiving emails out of work. Expectation that I will complete all the other parts of the curriculum in my own time
- More autonomy over our hours and annual leave and study leave and work places.
- More autonomy (e.g. about my timetable and rotations).
- Empowering doctors, reducing number of managers and hence micromanaging, increased transparency and accountability of managers, healthy mutual respect

between doctors and management and better communication between the two groups.

- More input into our timetable at work. I'd like to be treated like an adult more at work and allowed to manage my time. We have so many different demands placed upon us for training and the department doesn't always appreciate this and it is the managers who end up telling us we have to cover an additional clinic etc for service provision without asking if we can spare the time out of our admin.
- More staff and especially competent staff in the working places, able to get lunch breaks.
- 20% smaller clinic sizes. Staff around me that are good at what they do and motivated.
- Management of the department is what is the most frustrating, not the actual work. Having a well run dept that isn't constantly asking us to do more without pay would help with overall wellbeing as all good will is rapidly evaporating
- Less pressure from management to continuously go above and beyond to fill in gaps. The constant comments that we don't work hard enough. That they would prefer we were replaced with other harder working full time trainees.
- Make the theatre nurses motivated by sending them home when the team finishes early due to high productivity. Never overbook a clinic. Discuss languishing below-average staff and anyone with a persistently negative attitude.
- Remove all paper forms from hospitals across the entire NHS. Have one unified national induction, an electronic notes system with integrated PACS and computers which are checked proactively to be working quickly.
- Everything has gone electronic. Doctors need an office, a decent computer and admin time to catch up with all the changed. So many wards share 1 working computer or 1 I-pad and doctors have nowhere to sit as space is given to non-clinical staff.

16 suggestions related to being valued as an employee (or not being valued) and/or better understanding or support from consultant and managers.

> *"A complete overhaul of NHS management so trainees were not treated like inanimate resources to fulfil numerical service provision."*
>
> *"Trainers who care about you as an individual and who care about your training. The effort one puts in as a trainee is not reflected in the training one receives."*
>
> *"Being treated like a human by admin staff (local and regional). The way that some admin staff treat junior doctors is horrific (rude, unhelpful, misogynistic) and there is no accountability. The way the Dean is allowed to reject mileage and there is no accountability for the possibility it may be an unfair decision. There has to be better systems in place if you are being mistreated."*

15 comments related to pay and finances, including their administration and the reimbursement of travel and relocation costs.

> *"Despite being a senior registrar, earning significantly less than my friend who is a train driver, who works less hours than me."*
>
> *"Higher pay that recognises my skills, qualifications and output. Having management that doesn't mess up simple things like our salary & pay. Being treated better as a doctor, shorter commute, better relocation expenses."*

“Proper pay. Not having to fight with HR every time I have a change of hospital or my circumstances. It's like the system is trying to underpay and overtax me and see if I notice it.”

10 respondents wanted more or better support for training.

"Have study leave and compulsory exam leave approved without having to beg and rearrange the whole departments rota."

Six suggestions related to work life balance and having time for hobbies or family life while 3 respondents wanted a shorter commute.

“The main thing that negatively impacts my wellbeing is long commutes due to centres in the deanery being very spread out. It is impractical to move house every year. Long commutes in the car make the working day long and tiring. It means I can’t spend time with family and I don’t have energy to work on projects (QIPs, papers etc) at the end of the working day.”

Five suggestions made were to improve the working environment, including better food in staff canteens.

"A dedicated room for registrars to work that is quiet, clean and not messy. Even just the addition of a plant would help… An on-call room which is pleasant and not freezing in the winter!"

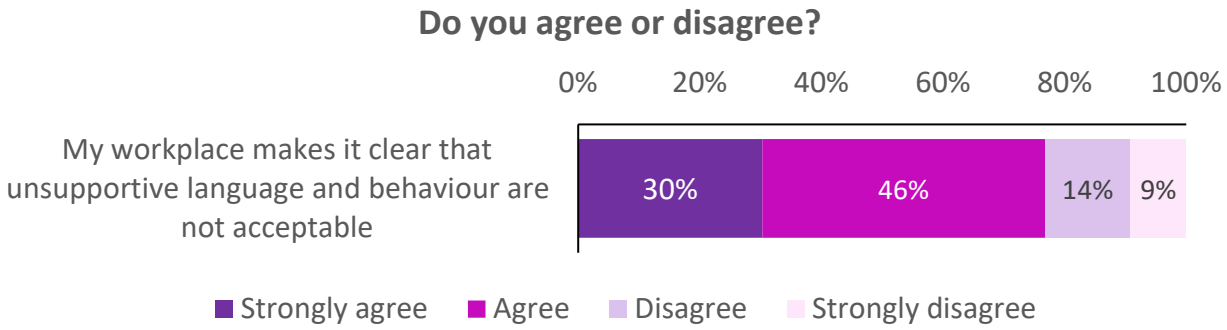
The other suggestions (made by 18 respondents) were as follows:

- Kindness from colleagues and seniors. Treat mistakes with support and dignity. Make it ok to get things wrong or for a junior to be abrupt once in a while without it being escalated. Learn to deal with things locally with privacy and dignity.
- It is not the work that’s the problem, it is the behaviour of consultants whose bullying behaviours have been unchecked for years. Trainee after trainee takes time out because of bullying. Consultants have resigned because of bullying. But the bullies are allowed to carry on bullying, destroying lives and destroying careers. Sure, well-being could be better. But please, please, please do something about the toxic, destructive bullying culture in ENT. It cannot be allowed to continue.
- Effective and confidential mechanisms to report and address unprofessional behaviour by non-medical staff e.g. rota coordinators which results in mistreatment of junior doctors.
- Consultants normalising mistakes and sharing theirs.
- Ability to take mental health days and not be judged through a change in culture.
- More awareness of mental health issues amongst supervisors.
- Being able to train in hospitals closer to home.
- The deanery being so large and the impending need to move house and impact that will have on my young family is constantly on my mind to the point where I’m considering leaving medicine.
- There is an enormous difficulty when it comes to couples where one person works in a different region to one another. The hardest thing about training is that I am unable to live with my wife if I am to move throughout the deanery as they cannot leave the region that they work in (NB/ They are non-medical).

- Easy affordable housing and parking. Easy to reclaim mileage to work if choose to live with partner and children in own home.
- Better access for parking. The parking is a particular problem as I currently work across 3 trusts and seem somehow expected to pay for 3 separate parking permits none of which are offered at discount rate given I am only there 1/3rd of the time. Ridiculously long commutes.
- Living close to work. Adequate childcare facilities. Adequate parking facilities.
- Make parking plentiful and easy.
- Have annual leave approved when 6 weeks notice and on standard days with issue as per contract.
- More TRIM (trauma) and resilience training for doctors and particularly surgeons in training.
- Completely restructure the NHS so it's not managed by incompetent managers.
- Easier access to paternity leave.
- Improving my sleep hygiene and routine.
- Free sporting activities for NHS.
- Having fewer children…they can be draining.

Bullying and harassment

77% of respondents (n=109) agreed that their workplace makes it clear that unsupportive language and behaviour are not acceptable (e.g. condescending or intimidating language, ridicule, overly familiar behaviour, jokes/banter that stereotype people or focus on their appearance or characteristics). However, 13% (n=20) disagreed and 9% (n=13) disagreed strongly with this statement.



Experience of bullying and harassment behaviours

Respondents were asked whether they had experienced or witnessed a number of bullying or harassment behaviours in the last six months. 33% of respondents (n=51) said that they had experienced unrealistic expectations about workload, responsibilities or level of competence, while another 22% (n= 33) said they had witnessed this. 25% (n=39) said they had experienced inadequate or absent supervision while another 16% (n=24) had witnessed this. 25% (n=38) said they had experienced undervaluing someone's contribution (in their presence or otherwise) while another 18% (n=28) had witnessed this.

However, very few respondents (under 5% for all statements) said that they had reported any of these behaviours.

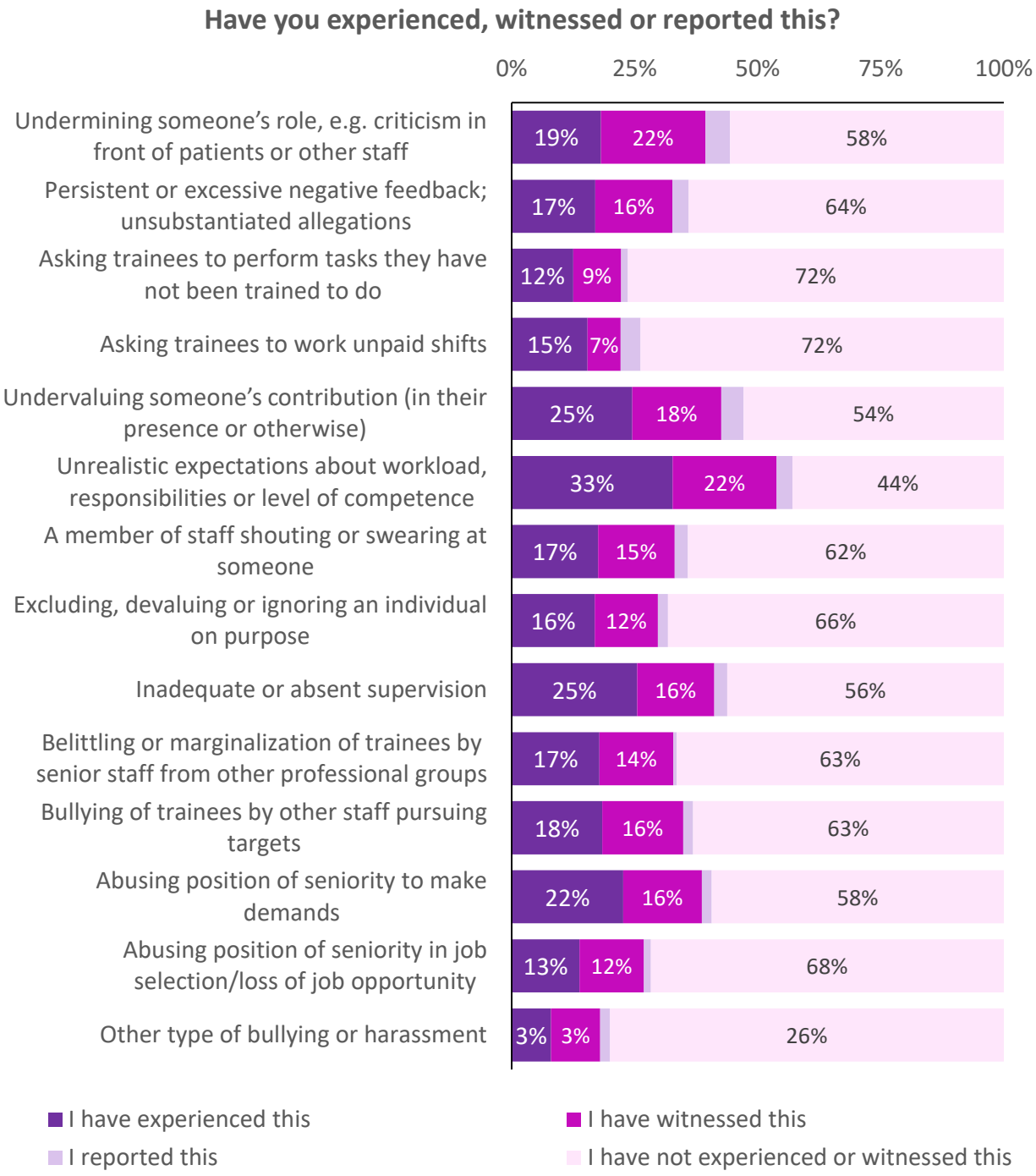

Have you experienced, witnessed or reported this?
0%
25%
50%
75%
100%
Undermining someone's role, e.g. criticism in front of patients or other staff
19%
22%
58%
Persistent or excessive negative feedback; unsubstantiated allegations
17%
16%
64%
Asking trainees to perform tasks they have not been trained to do
12%
9%
72%
Asking trainees to work unpaid shifts
15%
7%
72%
Undervaluing someone's contribution (in their presence or otherwise)
25%
18%
54%
Unrealistic expectations about workload, responsibilities or level of competence
33%
22%
44%
A member of staff shouting or swearing at someone
17%
15%
62%
Excluding, devaluing or ignoring an individual on purpose
16%
12%
66%
Inadequate or absent supervision
25%
16%
56%
Belittling or marginalization of trainees by senior staff from other professional groups
17%
14%
63%
Bullying of trainees by other staff pursuing targets
18%
16%
63%
Abusing position of seniority to make demands
22%
16%
58%
Abusing position of seniority in job selection/loss of job opportunity
13%
12%
68%
Other type of bullying or harassment
3%
3%
26%
I have experienced this
I have witnessed this
I reported this
I have not experienced or witnessed this

Table 6: Experiences of bullying and harassment behaviours

	I have experienced this		I have witnessed this		I reported this		I have not experienced or witnessed this	
	%	No	%	No	%	No	%	No
Undermining someone's role, e.g. criticism in front of patients or other staff	19%	29	22%	34	5%	8	58%	89
Persistent or excessive negative feedback; unsubstantiated allegations	17%	26	16%	24	3%	5	64%	98
Asking trainees to perform tasks they have not been trained to do	12%	18	9%	14	1%	2	72%	110
Asking trainees to work unpaid shifts	15%	23	7%	10	4%	6	72%	110
Undervaluing someone's contribution (in their presence or otherwise)	25%	38	18%	28	5%	7	54%	82
Unrealistic expectations about workload, responsibilities or level of competence	33%	51	22%	33	3%	5	44%	67
A member of staff shouting or swearing at someone	17%	26	15%	23	3%	4	62%	95
Excluding, devaluing or ignoring an individual on purpose	16%	25	12%	19	2%	3	66%	101
Inadequate or absent supervision	25%	39	16%	24	3%	4	56%	86
Belittling or marginalization of trainees by senior staff from other professional groups	17%	26	14%	22	1%	1	63%	97
Bullying of trainees by other staff pursuing targets	18%	28	16%	25	2%	3	63%	96
Abusing position of seniority to make demands	22%	34	16%	24	2%	3	58%	89
Abusing position of seniority in job selection/loss of job opportunity	13%	20	12%	19	1%	2	68%	104
Other type of bullying or harassment	3%	4	3%	5	1%	1	26%	40
Total number of respondents	**153**							

The other types of bullying or harassment were stated to be the following.

"Persistently asking trainees to cover rota gaps that management have been aware of and not covered with no rate escalation."

*"Pressure to incorrectly report on monitoring forms to save the department money with the threat that if not we would lose SHO support *this was not in an ENT role, this was as a CT elsewhere."*

"Admin staff not doing work and saying junior doctors should be doing it. Usually admin and hr - to all of these answers."

“Sexual harassment, sexual assault, malicious referrals to Occupational Health to try to have trainees branded as mentally ill. Malicious accusations and fake reports of incompetence. Throwing instruments in theatre, tipping theatre trays onto the floor in anger. Using foul language. Threatening my career if I fill out feedback or complete the GMC survey. Fake minutes of meetings where I was threatened and silenced. I could carry on but perhaps you get the message?”

“Numerous episodes of bullying and unrealistic expectations of the TPD towards almost every trainee in the region. Despite this being raised to the Deanery level, this has not been unequivocally dealt with.”

“Requesting trainees undertake more service provision (clinics, supporting SHOs when lacking a person to cover SHO on-call bleep) instead of seeking ways to recoup training time and opportunities eg additional lists when lists are cancelled.”

“I have witnessed someone report a bully and then have the whole department collectively call them a bad trainee.”

Analysis of respondents' experiences of bullying and harassment by gender show two statistically significant differences between female (n=82) and male respondents (n=88). Females were 2.6 times more likely than males (*p*=.0102) to say that they had experienced unrealistic expectations about workload and 2.8 times more likely (*p*=.0146) to say they had experienced inadequate or absent supervision.

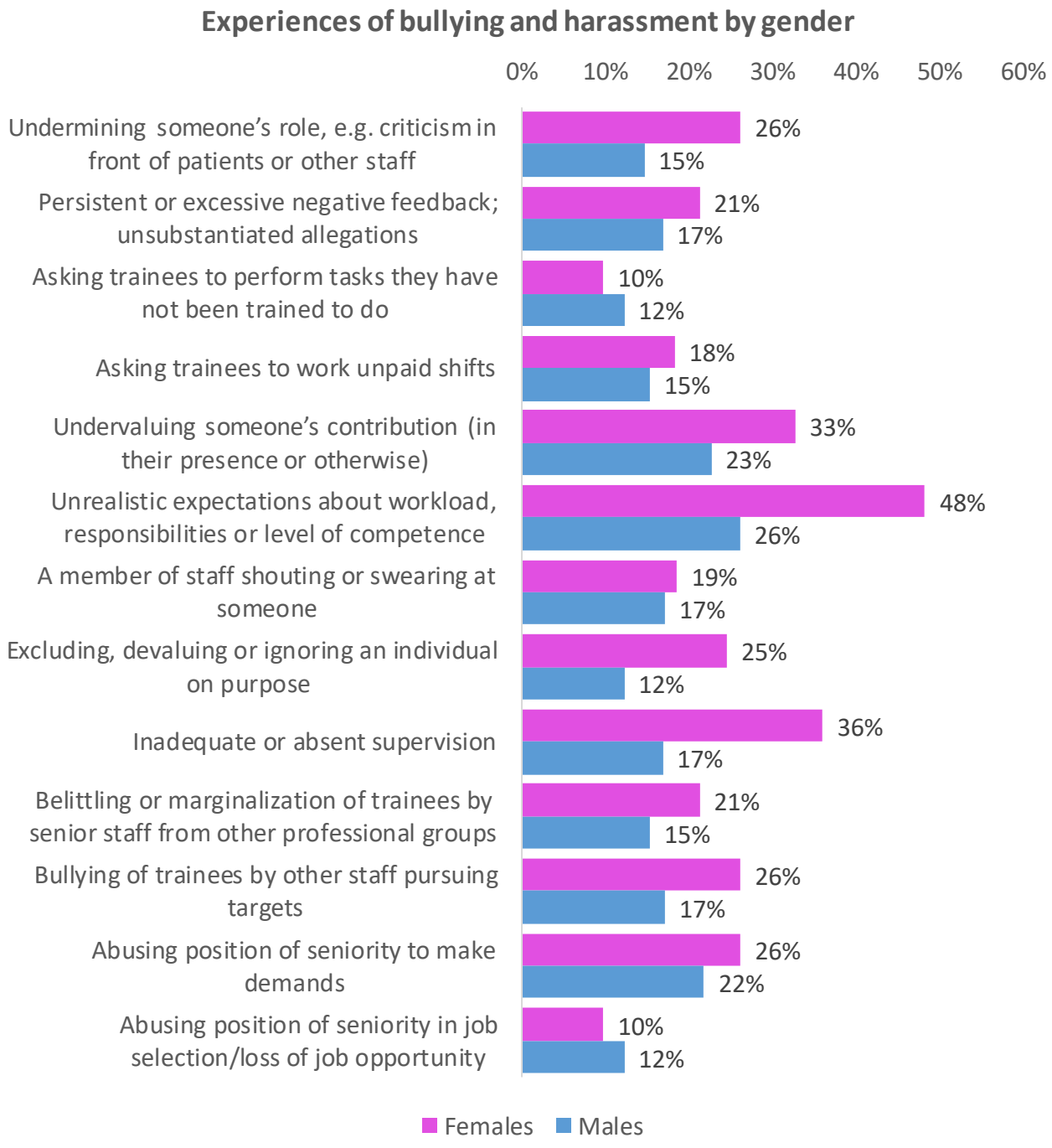


Table 7: Experiences of bullying and harassment behaviours by gender

	Females		Males	
	Number	%	Number	%
Undermining someone's role, e.g. criticism in front of patients or other staff	16	26%	10	15%
Persistent or excessive negative feedback; unsubstantiated allegations	13	21%	11	17%
Asking trainees to perform tasks they have not been trained to do	6	10%	8	12%
Asking trainees to work unpaid shifts	11	18%	10	15%
Undervaluing someone's contribution (in their presence or otherwise)	20	33%	15	23%
Unrealistic expectations about workload, responsibilities or level of competence	29	48%	17	26%
A member of staff shouting or swearing at someone	11	19%	11	17%
Excluding, devaluing or ignoring an individual on purpose	15	25%	8	12%
Inadequate or absent supervision	22	36%	11	17%
Belittling or marginalization of trainees by senior staff from other professional groups	13	21%	10	15%
Bullying of trainees by other staff pursuing targets	16	26%	11	17%
Abusing position of seniority to make demands	16	26%	14	22%
Abusing position of seniority in job selection/loss of job opportunity	6	10%	8	12%
Total	**82**		**88**	

(These are statistically significant differences)

Reporting incidences of bullying and harassment

Three people said that nothing had been done after they had reported an incident. The other replies to the question about the outcome of reporting the incident(s) were as follows.

"Fit to work note and moving to a different placement, took many months and included me having to do a vetted MSF due to the backlash of raising concerns. Fortunately my feedback was very good."

"Agreements about supervision which were not always adhered to, sometimes acknowledgement but not always."

"Asked to keep a record of it and told they would keep a record of it in case it was a repeated problem."

"An informal investigation was conducted about our TPD as a result of almost unanimous, anonymous witnesses accounts from registrars about our TPD. Nobody was brave enough to submit a formal complaint as this would mean the individual complainant would have to identify themselves. The result of the investigation is that the TPD remains in post and has reportedly been asked to stay on longer than the original term."

"Meeting was arranged, reported doctor was told to change their behaviour."

“It was recommended that I keep quiet about the incident and move on.”

“Informal discussion with member of staff in question.”

“A written apology.”

“A proposed change in clinic working patterns to provide more support.”

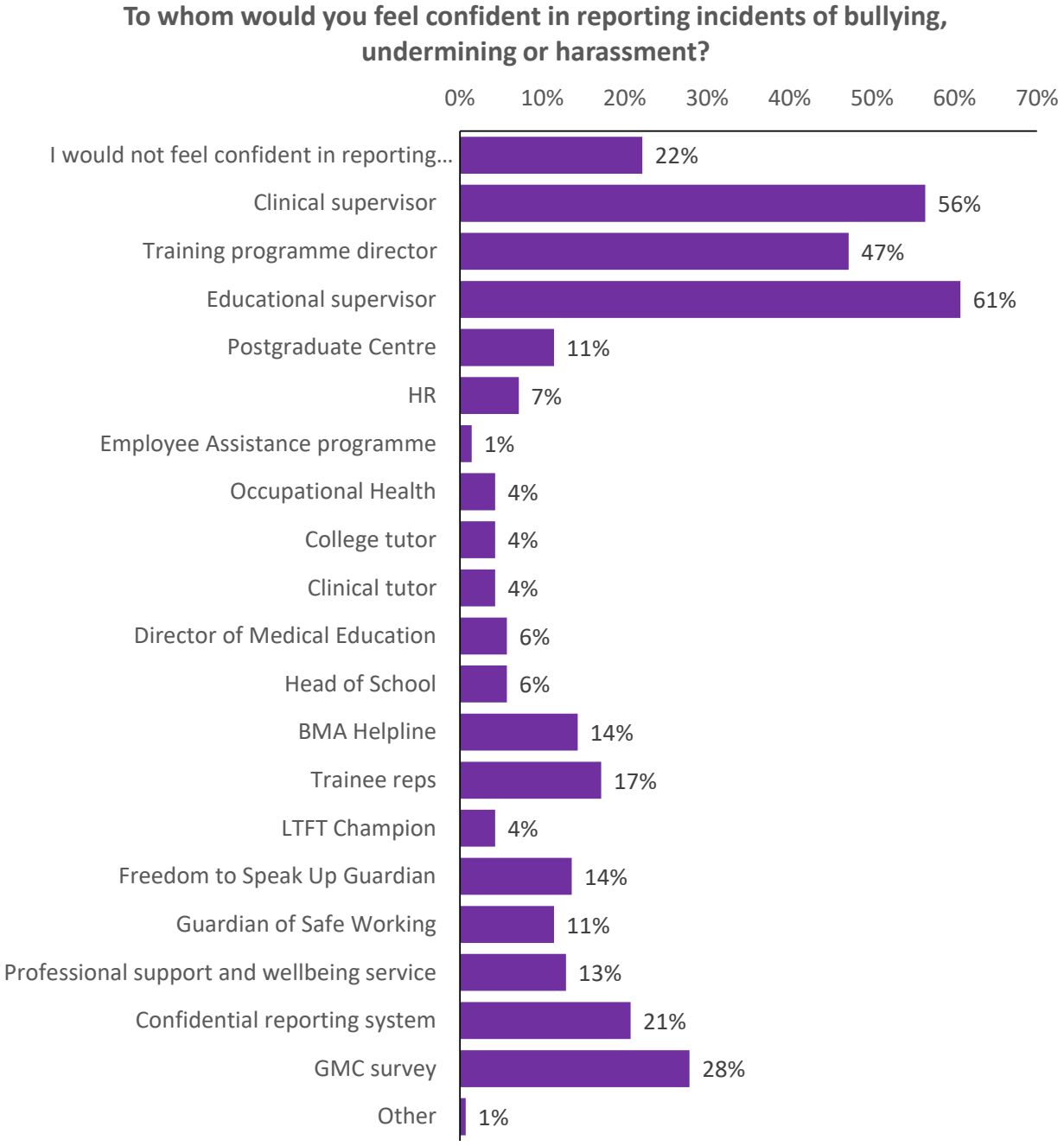
“Some issues were taken seriously. Others were ignored.”

"I was branded a trainee in difficulty. I was hounded, harassed and bullied much worse when people found out I’d reported the bullying. I was accused of being mentally ill and not able to cope with training (this wasn’t true, I was an outstanding trainee). I was accused of being incapable of accepting feedback - this is untrue, I’ve always actively sought feedback. I was accused of being incapable clinically and having zero leadership skills - this was untrue, I’d been leading a daily ward round and managing specialist nurses and junior trainees because the consultants didn’t bother turning up. I was accused of being a greasy pole climber and sleeping my way to the top when I won a number of prizes. I cannot begin to tell you how filthy and toxic the culture can be for a successful female who dares to stand up for themself. It is utterly disgusting. The current culture protects bullies. It needs to change."

“He apologised in an email after he insulted me in front of the theatre staff.”

“The feedback I received was the issue was my fault.”

Respondents were asked to which of different people/roles they would feel confident in reporting problems of bullying and harassment. The main replies were their educational or clinical supervisor or training programme director. 22% (n=31) said that they would not feel confident in reporting problems to anyone.



The reasons given why respondents would not feel confident about reporting bullying, undermining or harassment that it is unlikely that any action will be taken or no action has been taken in the past (14 people) and due to the fear of repercussions or being seen as a difficult trainee, including doubts about the confidentiality of the process (12 people).

> *"I have previously reported mistreatment. The feedback was that it was my fault and it reflected badly on me as a trainee."*

"No action was taken to look into the problem and the NCHD who reported problems got into troubles."

"In my experience, the person who raises concerns is usually the person who gets disadvantaged the most. In terms of job opportunities, etc in the future."

"No secure way to report bullying and having witnessed a trainee be collectively attacked after reported (valid) bullying and undermining behaviour, I know Consultants and managers will always stick together."

Many of the other comments made about reporting bullying and harassment incidents reflect the themes above: 7 people said that there was no action taken and 4 people said that there is a culture of not investigating, while 4 people cited fear of the consequences.

"Consultants/supervisors know about it, witness it, trainees report it and nothing is done about it."

"There is a culture of not escalating or investigating bullying and harassment concerns, even when they are reported. I have been told that formally reporting these concerns would adversely affect my career."

"I discussed the most serious incident of bullying with the TPD who although sympathetic, did not give a confidence inspiring response, suggesting I apologise that the perpetrator had felt compelled to swear and shout at me and offer to move on professionally for the sake of patients, citing the likelihood that a formal complaint would more likely impact future employers' perception of me than result in any action against the consultant responsible for the bullying."

The other comments made were as follows.

"The chief executive of my current Trust seems particularly proactive and I would have no hesitation to raise a bullying concern directly to them if required."

"Usually comes from managers wanting to achieve pointless targets and not valuing doctors."

"Micro aggressions are common. Undermining comments from one particular senior anaesthetist (out of earshot of one's consultant). One consultant is a very difficult personality to deal with and one is always on edge when working with him. It is difficult to predict when he will "fly off the handle". Can be aggressive in surgery if he is getting frustrated eg by repositioning the retractor one is holding in an aggressive manner."

"What do you do if senior people are the bullies? Very difficult. Still never seen a reporting format protects you. If you provide appropriate detail then you are identified. We can have total unsubstantiated accusations either but I don't know what middle ground is. Unless we employ a consultant who has just retired to literally only deal with welfare and bullying and be seen as a higher rank even than tpd for example?"

"The 'anti bullying champion' in [place] is a renowned bully who has boys tormenting and humiliating women. HR collude with bullying to protect bullies and blame trainees (eg making false minutes of meetings)."

Experience of sexual harassment behaviours

18% of respondents (n=29) said that they had experienced or witnessed sexual harassment behaviours at work in the last six months in the form of comments on physical appearance while 16% (n=26) said they had experienced or witnessed intrusive comments about personal life and 13% (n=22) had experienced or witnessed lewd comments. As a serious concern, 2 respondents said they had experienced sexual assault or rape and 1 had experienced physical assault. Just 1% said that they had reported ogling/staring or lewd comments but none reported they had reported any of the other sexual harassment behaviours.

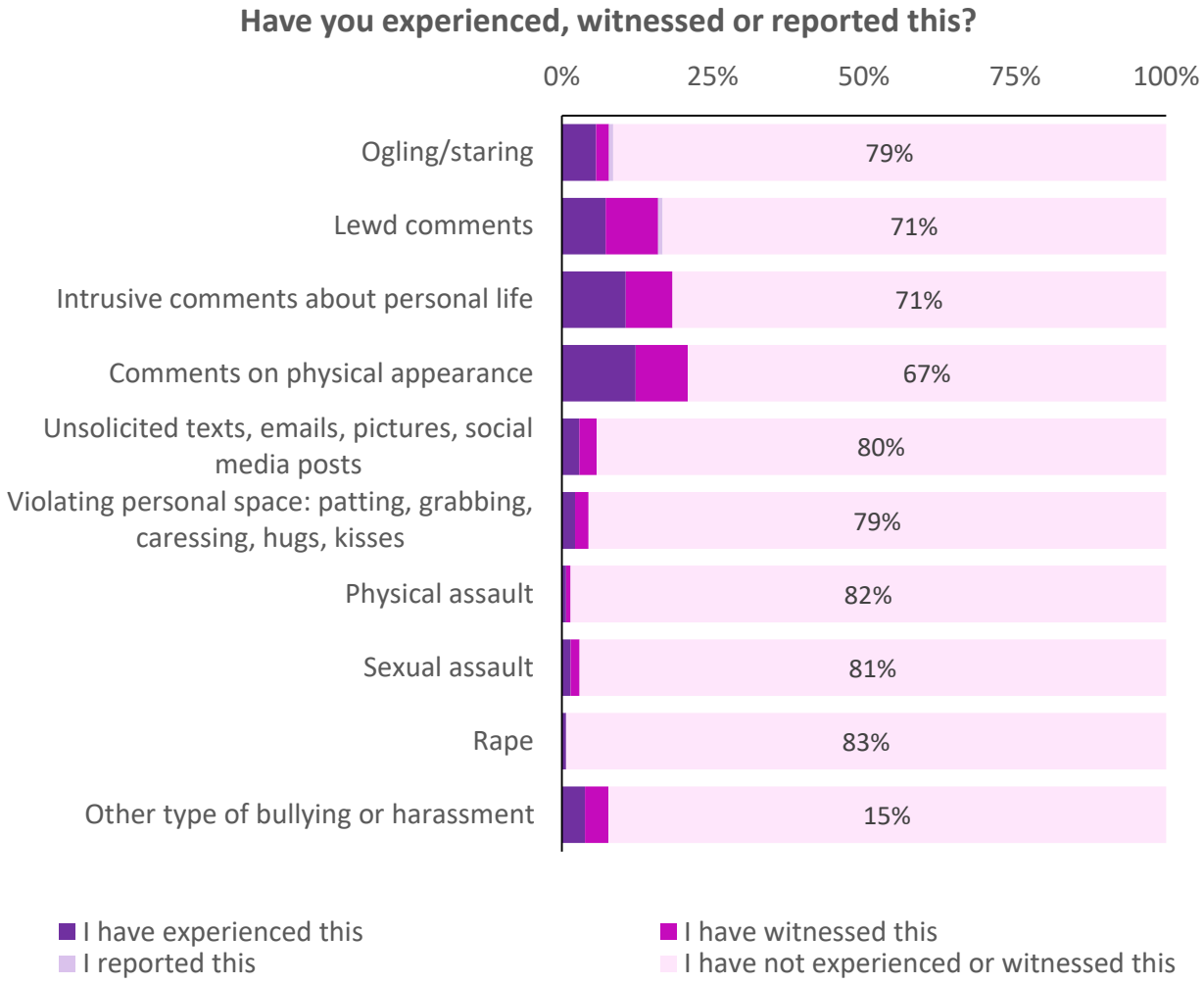


Table 8: Experiences of sexual harassment behaviours

	I have experienced this		I have witnessed this		I reported this		I have not experienced or witnessed this	
	%	No	%	No	%	No	%	No
Ogling/staring	5%	8	2%	3	1%	1	79%	129
Lewd comments	6%	10	7%	12	1%	1	71%	115
Intrusive comments about personal life	9%	15	7%	11	0%	0	71%	116
Comments on physical appearance	10%	17	7%	12	0%	0	67%	110
Unsolicited texts, emails, pictures, social media posts	2%	4	2%	4	0%	0	80%	131
Violating personal space: patting, grabbing, caressing, hugs, kisses	2%	3	2%	3	0%	0	79%	129
Physical assault	1%	1	1%	1	0%	0	82%	134
Sexual assault	1%	2	1%	2	0%	0	81%	132
Rape	1%	1	0%	0	0%	0	83%	135
Other	1%	1	1%	1	0%	0	15%	24
Total number of respondents	**163**							

The other comments were as follows.

"NB often from patients not just colleagues."

"Inappropriate comments about trainees having children making consultants lives more difficult to arrange placements."

"Comments about bad timing of a bad pregnancy."

Analysis of the experiences of sexual harassment by gender showed that female respondents (n=82) were significantly more likely than males (n=88) to say they had experienced intrusive comments about their personal life (*p*=.0005) or comments on their physical appearance (*p*=.0423). All of the other behaviours (apart from unsolicited texts/emails/pictures/social media posts) were only experienced by female respondents, not by male respondents.

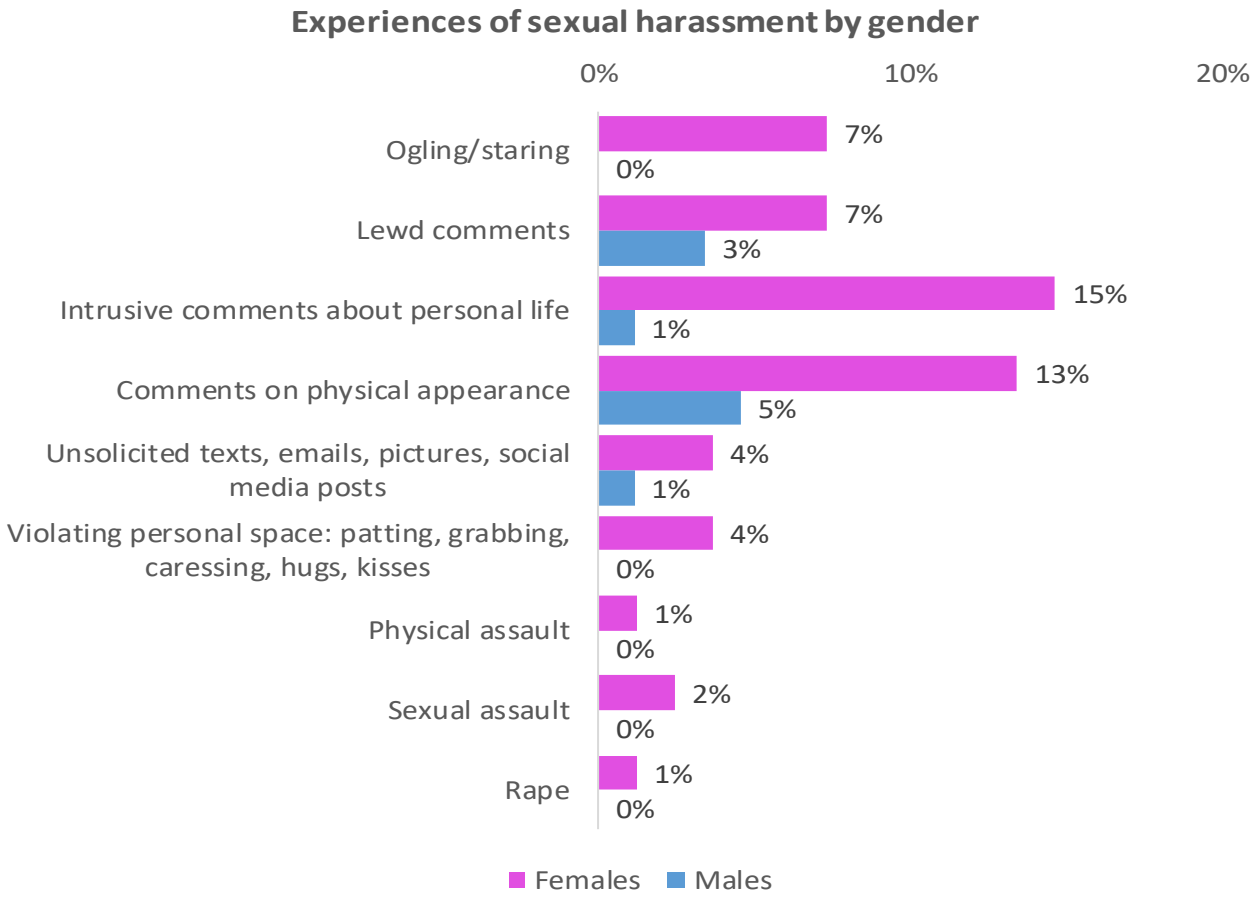


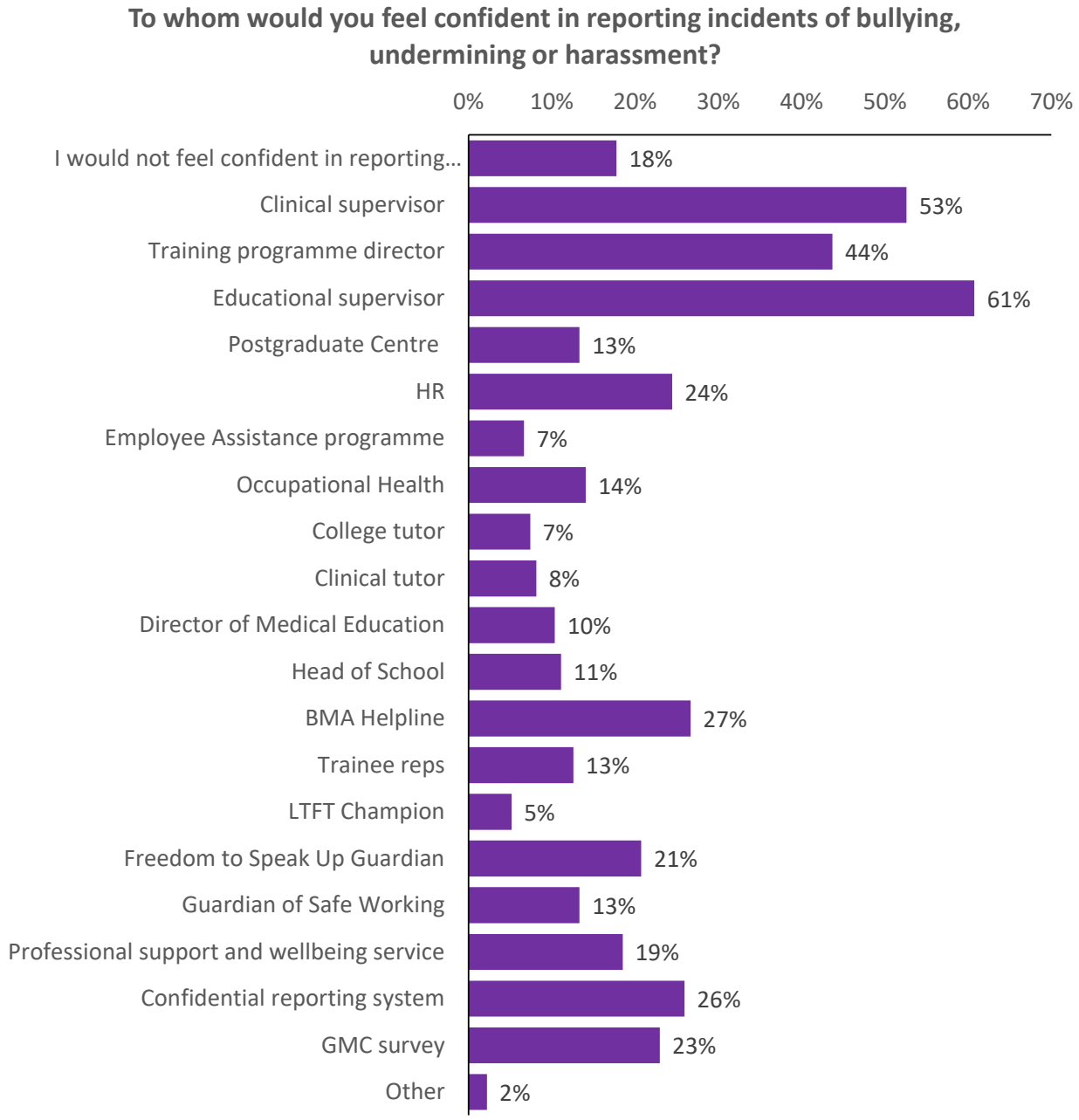
Table 9: Experiences of sexual harassment behaviours by gender

	Females		Males	
	Number	%	Number	%
Ogling/staring	6	10%	0	0%
Lewd comments	5	8%	3	5%
Intrusive comments about personal life	13	21%	1	2%
Comments on physical appearance	11	18%	4	6%
Unsolicited texts, emails, pictures, social media posts	3	5%	1	2%
Violating personal space: patting, grabbing, caressing, hugs, kisses	3	5%	0	0%
Physical assault	1	2%	0	0%
Sexual assault	2	3%	0	0%
Rape	1	2%	0	0%
Total	**82**		**88**	**1**

(▭ These are statistically significant differences, although please note that exact confidence levels are not possible with zero count cells.)

Reporting incidents of sexual harassment

Respondents were asked to which of different people/roles they would feel confident in reporting problems of sexual harassment. The main replies were their educational or clinical supervisor or training programme director. However, 18% (n= 24) said that they would not feel confident in reporting problems to anyone.



The reasons why respondents would not feel confident about reporting incidents of sexual harassment were similar to the reasons under bullying and harassment generally: 4 people said it would not be acted upon and 1 people said that their reputation and/or job prospects would be impacted. The other comments are reported verbatim below.

"My specialty is small. Remaining anonymous is near impossible."

"There is a misogynistic culture that is rampant in NHS and hidden in plain sight - the changes have to come from within and a wider debate in society is needed to address these issues."

"Huge ramifications for all the people identified. Would only support or engage in this reporting if the individual survivor involved wanted it."

"Most organisations however professional are still people who like to gossip at the end or the day. People are selfish."

"NHS trusts and training bodies act to cover up sexual abuse and blame the trainee eg accuse them of lying or not being able to cope with training."

"As a sociable female trainee, I will always be blamed."

The comments made about reporting sexual harassment incidents were as follows.

"I would get legal advice (outside of health service). Don't trust anyone in NHS."

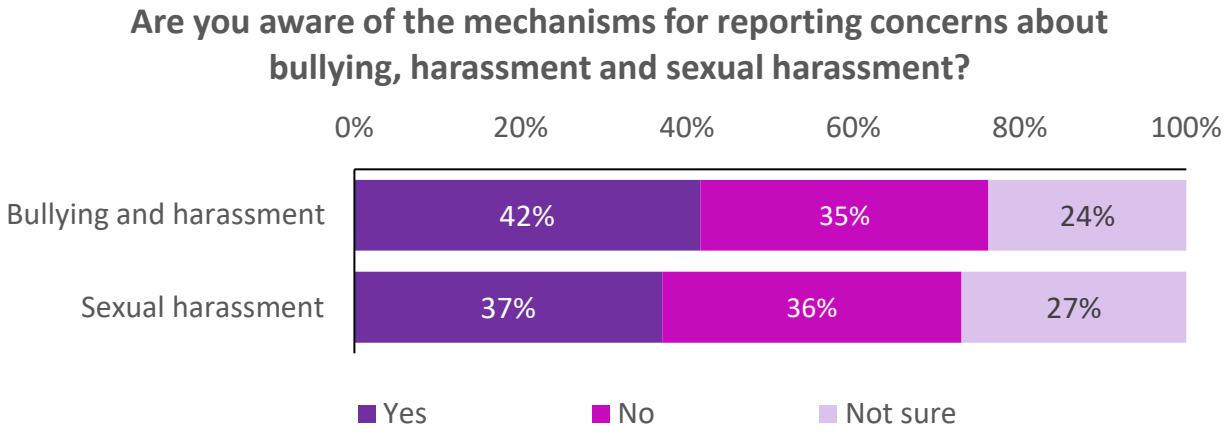
"Would be harder to report as we all know each other and it is more shameful than bullying, for both perpetrator and victim. I would call out bullying to someone's face but I would wonder if I was misinterpreting harassment and not want to give someone a weird reputation if it was genuinely a misunderstanding or accident."

"From personal experience there is a culture of victim shaming."

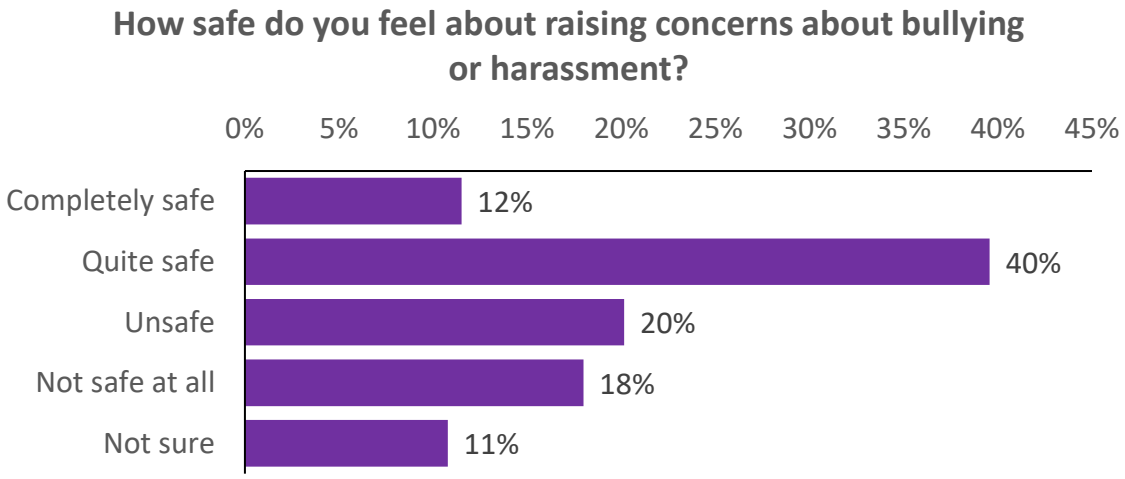
"If I experienced mild sexual harassment I would be worried that if I told some of my bosses this would be looked on negatively as if I was too sensitive. I would therefore not mention it."

Reporting mechanisms

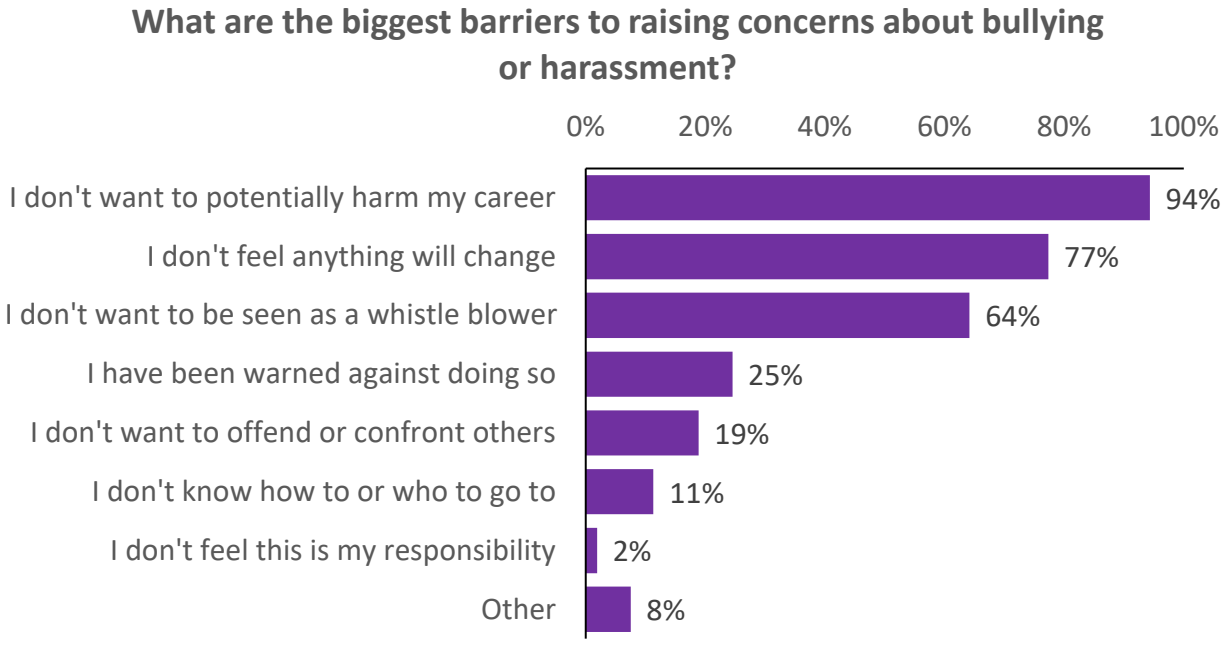
Around two fifths of respondents said that they were aware of the mechanisms for reporting concerns about bullying, harassment and sexual harassment but just over a third were not and around a quarter were unsure.



While 52% of respondents (n=71) said that they feel safe about raising concerns about bullying or harassment, 38% (n=53) did not feel safe.



For the 53 respondents who did not feel safe raising concerns, the biggest barriers to reporting any inappropriate behaviour that respondents have witnessed or experienced are not wanting to potentially harm their career (94%, n=50), feeling that nothing will change (77%, n=41) and not wanting to be seen as a whistle blower (64%, n=34). A quarter (25%, n=13) reported that they have been warned against doing so.



The other barriers are reported verbatim below.

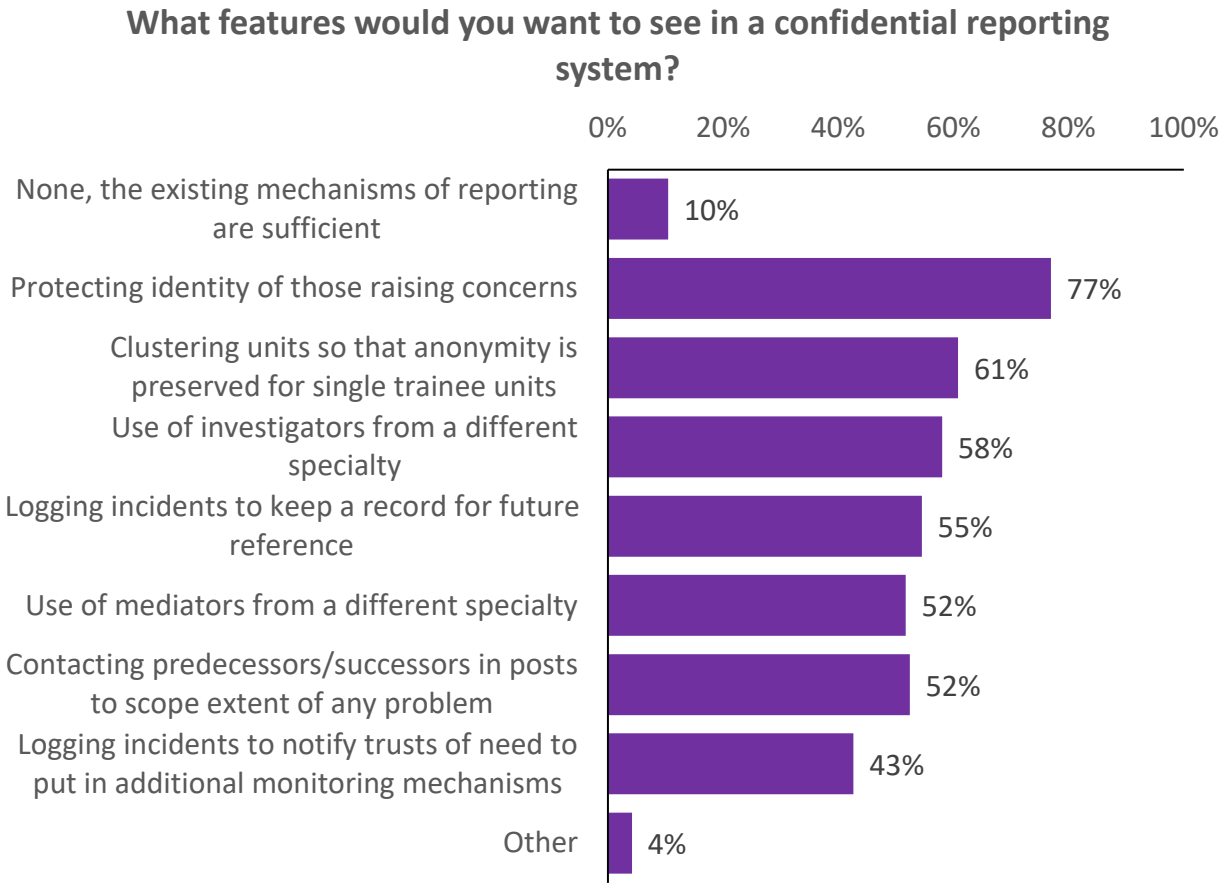
"Staff shortages mean if someone was suspended this could potentially harm patients."

"Everyone knows each other and consultants are more likely to be friends with fellow colleagues and subconsciously take their side than that of the trainee. It would have to be really flagrant/intolerable for me to report harassment."

"Some bosses would think that I was being too sensitive and it would negatively impact their impression of me."

"No safe confidential reporting system like in Australia."

Just 10% of respondents (n=15) said that the existing mechanisms of reporting are sufficient. The most popular features that respondents would like to see in a confidential reporting system were protecting the identity of those raising concerns, clustering units so that anonymity is preserved for single trainee units and the use of investigators from a different specialty, followed by logging incidents to keep a record for future reference.



The other features of a confidential reporting system suggested are shown below.

"Use of investigators from outside the unit."

"Clustering units even if many trainees as often easy to work out who is raising the concern."

"If there was one both need to be protected. Trainee and supervisor. Obviously it needs to be looked into thoroughly but there could be potential for malicious claims against supervisors if it's completely confidential."

"No GMC involvement until clear evidence. The GMC does not support doctors."

"Many of these need to be instilled."

Suggestions made about how barriers to raising concerns could be addressed are as follows:

- Confidential or anonymous reporting (5 people).
- Using external staff from a different speciality or a non-surgical body with no conflict of interest (4 people).
- Abolishing the culture in medicine of 'just getting on with it' (4 people).
- Very hard in such a small specialty as everyone knows everyone and even when concerns are raised nothing seems to happen (2 people).
- Awareness raising of where to go about concerns and knowledge of how any potential concerns would be responded to.
- Through a separate organisation and not via the GMC - *"They have demonstrated they are not trustworthy after bawa gaba."*
- Sticking to whistleblowing policy and not jeopardising that person's career.
- Continuing a super working environment and strong policy that it will not be tolerated.
- Transparency, more women in senior leadership roles, admission that there is that elephant in the room.
- Very difficult since while anonymity gives security it is difficult to follow up/explore the truth.

> *"Only way is an anonymous validated reporting system. Otherwise people start posting anon posts on websites targeting 1 Consultant. This is also wrong. The accused should also be protected and if valid, given training and counselling. Keep blame out (unless a criminal offence like sexual assault) and allow people to change.. the may be bullying because they are in mental health crisis themselves."*

> *"Reporting has to be normalised by consultants and encouraged. Consultants' language and attitudes need to change so that this empowers juniors to bring up concerns. Consultants talking calling out inappropriate behaviour and acting as role models. Only when trainees know it will be taken seriously will they feel confident reporting won't impact negatively on their career. There is a lot of "in my day" we had to work in terrible conditions, therefore juniors shouldn't complain."*

> *"By creating a system where person who raise concerns feel safe, anonymous, protected and absolutely certain that it cannot be traced back to the individual and affect future placements or career prospects."*

Other comments about trainee wellbeing

Respondents were asked whether there was anything they would like to say about trainee wellbeing that was not covered by the previous questions. The comments made are reported verbatim below.

> *"Erosion of pay, increasing training debt, and increasing demands of modern clinical practice, poorly understood by senior generation who believe they had it worse and the new generation are "snowflakes"."*

> *"I could have not come in on my zero days or done the extra work and I probably would have gotten enough numbers to progress through ARCP, but the expectation is that we do better than that, and the only way to achieve this is to put in extra time and effort, which is unpaid. This is cultural and puts a burden on trainees, particularly those who have eg family commitments. I should be able to achieve the standards of an excellent trainee without having to put in extra hours, and this could be achieved through dedicated training theatre and clinic lists, where there is enough time for me to*

learn, rather than service provision lists where we need to rush to finish the overbooked list or just get through the huge clinic backlog without slowing things down too much with questions."

"The situation needs to drastically change. I've unfortunately had too many negative experiences and plan to CCT and leave. I hope it changes for the future generation."

"How remuneration , on-call logging, overtime submission, relocation , pressures for research and publication , cost of all those afore mentioned things affect junior doctors has not been addressed in the survey. Sick leave or forced leave for family matters, and on-call cover."

"The racism has not been addressed and should be included into harassment."

"Wellbeing training would definitely be welcome in the surgical community, in my opinion. I also think LTFT working needs less stigma/bias attached to it."

"Stop annoying WhatsApp groups. Trainees in general need to respect one another's down time for their wellbeing. NHS should really issue us with work phones, especially when we undertake non resident on-call."

"Thank you for doing this study."

"Often coercion makes the trainee party to bullying & harassment."

"I am hopefully going to leave medicine very soon. The training conditions are awful and I do not see a fulfilling life in this career, Medicine, and surgery, in particular, have archaic training processes that are not fit for modern medical practice. There is a complete lack of understanding from senior staff who have not noticed or refuse to acknowledge the intensity of work has increased substantially so the ability to attend theatre or conduct arduous audits or excessive portfolio demands have diminished, which means more personal time is taken up to fulfil requirements. This is unsustainable on the work force. I think the NHS as a whole is unsustainable in its current form."

"Overall we have a very rewarding job with a privileged position to care for patients but the attraction of being a doctor and the financial rewards for it are very much waning. Unfortunately now it pays more to work in a business or technology sector and with better working conditions and less stress. The NHS is being neglected and waiting lists are growing. We face a daily depressing prospect of failing patients and overall this greatly reduces our job satisfaction."

"Care for trainees needs to be more individualised. Consultants with an interest in well being should get to know the trainees and individualise support and sign posting. At the moment educational supervisors and people with interest in education get completely bogged down in paperwork and can't actually look after and get to know the trainees needs."

"GMC treatment of doctors makes us fearful and stressed. We are underpaid and undervalued. I am looking to move to a different country because of this, but continue working as a doctor. I would not advise anyone to become a doctor in the UK."

"Being given unexpected poor outcomes from ARCP on a Teams meeting is impersonal and unsupportive. We wouldn't dream of giving cancer diagnoses to patients like this, but it seems ok to affect people's careers this way."

“Trainee wellbeing is obviously not a priority for anyone within the NHS or HEE. We are seen as transient and expendable. We are always somebody else's problem because we have no longevity anywhere and because there are huge gaps within and between the structures that are supposed to support us i.e. HEE and NHS. HEE are UNREGULATED and when they fall short or actively antagonise there is nothing that can be done.”

“Rotations vary greatly in quality. This current rotation has left me feeling demotivated and deskilled and have not enjoyed working with two of my three trainers who are not invested in training nor should they have any trainees. It has certainly put me off choosing Head and Neck surgery as a career.”

"Current contract for junior doctors is inadequate. Current Deanery is inadequately designed and not appropriate for purpose of training - designed to be convenient for managers not for training. Never in 6 years been able to do an on-call from home, despite being paid to do Non-resident on-call. Awful commutes. Endlessly rotate and each time spend the first 3 months renegotiating with HR to get paid. Endlessly redoing e-learning modules that i already did 6 months previously at another trust. Endless pile of admin / paperwork which i need to do and do at home when "off". Poor quality on-call rooms."

“Having worked in other regions, I feel extremely well supported by peers, training programme and trust supervisors across the region.”

“We just need fully staffed rotas. Does anyone actually have data on how many rotas across the country have unfilled posts??? This would cover at least 80% of all welfare and burn out issues.”

“Some of the questions don’t take into account personal/home situation. For example, I feel tired all the time but I have a baby and poor sleep at home.”

“There is increased pressure since covid to meet the same requirements in effectively a shorter time as the goal posts for getting extensions keeps being moved.”

“Please remove our TPD ASAP.”

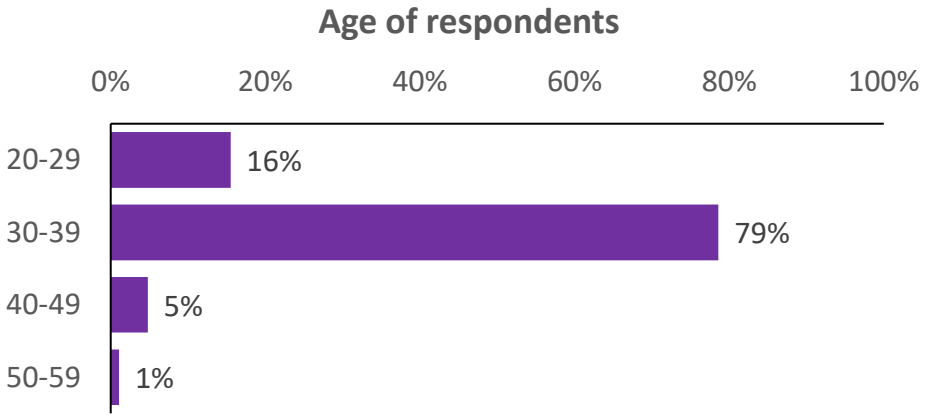
“Wellbeing is not poor because of patients. I love patients, they keep me in the job. But the lack of respect, good for nothing IT systems, rude managers, poor training, extra administrative tasks that are not my job, money spent on travel and hotels and parking and mandatory training is wearing me down. It’s not worth it.”

Profile of respondents

Of the 190 respondents, 81% were Registrars.

	Number	Percentage
Core Trainee (including ST1-ST2)	19	10%
Foundation Doctor (or acting on a foundation doctor rota, e.g. F3)	2	1%
Registrar (ST3-ST8)	152	80%
SAS doctor	2	1%
Senior Fellow/Peri-CCT Fellow	3	2%
Middle grade - Non trainee doctor on registrar rota	5	3%
Junior Fellow	1	1%
SHO - Non-trainee doctor on SHO rota (e.g. junior clinical fellow)	2	1%
Prefer not to say	3	2%
Other	1	1%
Total	**190**	

44% of respondents were male (n=88), 41% were female (n=82) and the remainder preferred not to say/were non-binary. 86% (n=153) were straight/heterosexual, 3% (n=6) were gay or lesbian, 3% (n=5) were bisexual and the remainder preferred not to say. 79% of respondents (n=147) were aged 30-39.



Respondents were asked whether they work less than full time, with two thirds saying that they do not. 17% of females said 'Yes – category 1' (3% of males) and 30% of females said 'No - but would like to' (15% of males).

	Number	Percentage
Yes – category 1 (disability/ill health/caring responsibilities)	19	10%
Yes – category 2 (unique opportunities/ commitment/courses)	1	1%
Yes – category 3 (personal choice)	2	1%
No – but would like to	44	23%
No – and do not intend to	124	65%
Total	**190**	

Respondents were asked which deanery they predominantly worked in.

	Number	%
East Midlands	9	5%
East of England	23	12%
Ireland	10	5%
Kent, Surrey and Sussex	12	6%
London - North Central and East	9	5%
London - North West	8	4%
London - South	12	6%
North East	15	8%
North West East	4	2%
North West West/ Mersey	13	7%
Northern Ireland	10	5%
Scotland - East/ North/ South	5	3%
Scotland - West	3	2%
South West - Penisula	5	3%
South West - Severn	8	4%
Thames Valley	14	7%
Wales	4	2%
Wessex	4	2%
West Midlands	10	5%
Yorkshire and Humber	9	5%
No prominent or fixed deanery	1	1%
Total respondents	**188**	

The ethnicity of respondents is shown in the table below.

	Number	Percentage
Arab	6	3.2%
Asian or Asian British: Bangladeshi	4	2%
Asian or Asian British: Chinese	6	3%
Asian or Asian British: Indian	24	13%
Asian or Asian British: Pakistani	5	3%
Any other Asian or Asian British background	7	4%
Black or Black British: African	4	2%
Mixed or multiple ethnic group: White and Asian	3	2%
Any other mixed or multiple ethnic background	2	1%
White: English, Welsh, Scottish, Northern Irish or British	75	40%
White: Irish	16	9%
Any other White background	16	9%
Any other ethnic group	3	2%
Prefer not to say	16	9%
Total	**187**	

94% of respondents (n=176) said that they did not consider themselves disabled under the Equality Act 2010.

Nearly half of respondents said that they have no religion.

	Number	Percentage
Buddhist	2	1%
Christian	34	18%
Hindu	18	10%
Jewish	6	3%
Muslim	18	10%
Sikh	1	1%
No religion	87	47%
Any other religion or belief	1	1%
Prefer not to say	18	10%
Total	**185**	

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Appendix 2: Statistical tables

CBI mean score - work related

Deanery	Mean	n	Std. Deviation	Std. Error of Mean
East Midlands	56.5	6	14.2	5.8
East of England	51.6	16	15.8	4.0
Ireland	52.8	9	22.1	7.4
Kent, Surrey and Sussex	53.9	11	14.9	4.5
London - North Central and East	54.0	8	17.1	6.1
London - North West	57.1	4	10.5	5.3
London - South	64.3	8	26.5	9.4
North East	49.4	12	12.8	3.7
North West East	52.4	3	5.5	3.1
North West West/ Mersey	48.4	13	19.6	5.4
Northern Ireland	37.9	10	11.3	3.6
Scotland - East/ North/ South	47.3	4	7.9	4.0
South West - Penisula	42.9	4	27.2	13.6
South West - Severn	49.0	7	14.8	5.6
Thames Valley	52.1	12	26.1	7.5
Wales	59.8	4	11.4	5.7
Wessex	40.5	3	9.0	5.2
West Midlands	45.1	8	19.1	6.7
Yorkshire and Humber	57.6	8	21.6	7.6
Total	**51.1**	**151**	**18.0**	**1.5**

Age	Mean	n	Std. Deviation	Std. Error of Mean
20-29	54.8	20	17.7	4.0
30-39	50.8	124	18.5	1.7
40-49	45.2	6	7.7	3.1
50-59	50.0	1		
Total	**51.1**	**151**	**18.0**	**1.5**

Has disability under Equality Act	Mean	N	Std. Deviation	Std. Error of Mean
Yes	63.4	4	12.8	6.4
No	50.6	143	17.7	1.5
Prefer not to say	58.9	4	32.7	16.3
Total	**51.1**	**151**	**18.0**	**1.5**

Specific learning disability	Mean	N	Std. Deviation	Std. Error of Mean
Yes	62.66	11	15.8	4.8
Have but never assessed	60.27	8	30.4	10.7
No	49.29	130	16.8	1.5
Prefer not to say	71.43	2	5.1	3.6
Total	**51.14**	**151**	**18.0**	**1.5**

Ethnicity	Mean	N	Std. Deviation	Std. Error of Mean
Any other Asian or Asian British background	57.9	5	19.8	8.8
Any other ethnic group	64.3	3	30.5	17.6
Any other mixed or multiple ethnic background	51.8	2	27.8	19.6
Any other White background	56.4	14	24.8	6.6
Arab	55.4	4	26.2	13.1
Asian or Asian British: Bangladeshi	46.4	3	21.7	12.5
Asian or Asian British: Chinese	50.9	4	26.5	13.2
Asian or Asian British: Indian	55.5	17	15.0	3.6
Asian or Asian British: Pakistani	67.9	2	15.2	10.7
Black or Black British: African	53.6	3	9.4	5.5
Mixed or multiple ethnic group: White and Asian	39.3	2	5.1	3.6
White: English, Welsh, Scottish, Northern Irish or British	48.3	66	14.7	1.8
White: Irish	43.6	15	15.6	4.0
Prefer not to say	56.5	11	24.3	7.3
Total	**51.1**	**151**	**18.0**	**1.5**

Sexual identity	Mean	N	Std. Deviation	Std. Error of Mean
Female	52.9	68	19.1	2.3
Male	48.7	71	15.9	1.9
Non-binary	39.3	1		
Prefer not to say	65.2	4	20.5	10.2
Missing	52.6	7	25.7	9.7
Total	**51.1**	**151**	**18.0**	**1.5**

Sexual orientation	Mean	N	Std. Deviation	Std. Error of Mean
Bisexual	39.3	3	17.9	10.3
Gay or Lesbian	45.7	5	15.6	7.0
Straight/Heterosexual	51.2	125	17.7	1.6
Other	50.0	1		
Prefer not to say	56.1	10	19.3	6.1
Missing	52.6	7	25.7	9.7
Total	**51.1**	**151**	**18.0**	**1.5**

Religion	Mean	N	Std. Deviation	Std. Error of Mean
Buddhist	75.0	1		
Christian	51.2	29	15.5	2.9
Hindu	54.2	12	16.5	4.8
Jewish	60.0	5	22.5	10.1
Muslim	53.9	11	19.8	6.0
Sikh	42.9	1		
No religion	47.1	77	17.4	2.0
Prefer not to say	63.1	15	19.9	5.1
Total	**51.1**	**151**	**18.0**	**1.5**

CBI mean score - personal

Deanery	Mean	n	Std. Deviation	Std. Error of Mean
East Midlands	60.4	6	23.2	9.5
East of England	59.9	16	17.6	4.4
Ireland	55.1	9	23.4	7.8
Kent, Surrey and Sussex	59.5	11	14.3	4.3
London - North Central and East	52.1	8	24.0	8.5
London - North West	52.1	4	16.8	8.4
London - South	66.7	8	26.7	9.4
North East	51.0	12	16.7	4.8
North West East	47.2	3	15.8	9.1
North West West/ Mersey	47.7	13	25.6	7.1
Northern Ireland	39.2	10	17.0	5.4
Scotland - East/ North/ South	50.0	4	18.9	9.5
South West - Penisula	63.5	4	31.8	15.9
South West - Severn	57.7	7	11.6	4.4
Thames Valley	55.6	12	23.7	6.8
Wales	52.1	4	15.4	7.7
Wessex	56.9	3	10.5	6.1
West Midlands	48.4	8	25.2	8.9
Yorkshire and Humber	68.8	8	14.9	5.3
Total	**54.9**	**151**	**20.6**	**1.7**

Age	Mean	n	Std. Deviation	Std. Error of Mean
20-29	55.6	20	25.6	5.7
30-39	54.7	124	20.3	1.8
40-49	53.5	6	8.1	3.3
50-59	66.7	1		
Total	**54.9**	**151**	**20.6**	**1.7**

Has disability under Equality Act	Mean	N	Std. Deviation	Std. Error of Mean
Yes	72.9	4	22.7	11.3
No	54.0	143	20.3	1.7
Prefer not to say	69.8	4	19.7	9.8
Total	**54.9**	**151**	**20.6**	**1.7**

Specific learning disability	Mean	N	Std. Deviation	Std. Error of Mean
Yes	66.2	11	23.0	6.9
Have but never assessed	64.6	8	26.7	9.4
No	52.9	130	19.5	1.7
Prefer not to say	83.3	2	0.0	0.0
Total	**54.9**	**151**	**20.6**	**1.7**

Ethnicity	Mean	N	Std. Deviation	Std. Error of Mean
Any other Asian or Asian British background	60.8	5	13.0	5.8
Any other ethnic group	68.1	3	28.4	16.4
Any other mixed or multiple ethnic background	62.5	2	23.6	16.7
Any other White background	61.6	14	27.5	7.3
Arab	61.5	4	18.1	9.1
Asian or Asian British: Bangladeshi	36.1	3	26.8	15.5
Asian or Asian British: Chinese	46.9	4	29.7	14.9
Asian or Asian British: Indian	61.0	17	18.9	4.6
Asian or Asian British: Pakistani	81.3	2	14.7	10.4
Black or Black British: African	68.1	3	8.7	5.0
Mixed or multiple ethnic group: White and Asian	33.3	2	0.0	0.0
White: English, Welsh, Scottish, Northern Irish or British	53.1	66	16.3	2.0
White: Irish	43.3	15	18.4	4.7
Prefer not to say	56.4	11	30.4	9.2
Total	**54.9**	**151**	**20.6**	**1.7**

Sexual identity	Mean	N	Std. Deviation	Std. Error of Mean
Female	58.9	68	20.7	2.5
Male	50.4	71	19.0	2.3
Non-binary	50.0	1		
Prefer not to say	64.6	4	32.0	16.0
Missing	56.5	7	24.5	9.3
Total	**54.9**	**151**	**20.6**	**1.7**

Sexual orientation	Mean	N	Std. Deviation	Std. Error of Mean
Bisexual	44.4	3	9.6	5.6
Gay or Lesbian	47.5	5	20.7	9.3
Straight/Heterosexual	54.9	125	20.5	1.8
Other	37.5	1		
Prefer not to say	62.5	10	22.9	7.2
Missing	56.5	7	24.5	9.3
Total	**54.9**	**151**	**20.6**	**1.7**

Religion	Mean	N	Std. Deviation	Std. Error of Mean
Buddhist	62.5	1		
Christian	58.5	29	15.9	2.9
Hindu	62.5	12	19.8	5.7
Jewish	66.7	5	26.2	11.7
Muslim	53.4	11	24.4	7.3
Sikh	41.7	1		
No religion	49.7	77	20.0	2.3
Prefer not to say	66.1	15	22.7	5.8
Total	**54.9**	**151**	**20.6**	**1.7**

CBI mean score - patient related

Deanery	Mean	n	Std. Deviation	Std. Error of Mean
East Midlands	20.8	6.0	19.9	8.1
East of England	24.7	16.0	15.3	3.8
Ireland	27.8	9.0	23.2	7.7
Kent, Surrey and Sussex	40.2	11.0	20.3	6.1
London - North Central and East	28.1	8.0	18.2	6.4
London - North West	19.8	4.0	19.1	9.5
London - South	41.7	8.0	21.8	7.7
North East	27.1	12.0	21.3	6.1
North West East	26.4	3.0	9.6	5.6
North West West/ Mersey	19.2	13.0	12.9	3.6
Northern Ireland	26.3	10.0	14.6	4.6
Scotland - East/ North/ South	19.8	4.0	16.8	8.4
South West - Penisula	15.6	4.0	18.8	9.4
South West - Severn	19.6	7.0	25.8	9.7
Thames Valley	19.1	12.0	23.5	6.8
Wales	29.2	4.0	17.3	8.7
Wessex	18.1	3.0	16.8	9.7
West Midlands	22.9	8.0	24.3	8.6
Yorkshire and Humber	22.4	8.0	19.4	6.9
Total	**25.6**	**151.0**	**19.6**	**1.6**

Age	Mean	n	Std. Deviation	Std. Error of Mean
20-29	21.3	20	17.8	4.0
30-39	27.3	124	19.8	1.8
40-49	8.3	6	3.7	1.5
50-59	0.0	1		
Total	**25.6**	**151**	**19.6**	**1.6**

Has disability under Equality Act	Mean	N	Std. Deviation	Std. Error of Mean
Yes	9.4	4.0	12.0	6.0
No	25.6	143.0	19.5	1.6
Prefer not to say	40.6	4.0	21.9	10.9
Total	**25.6**	**151.0**	**19.6**	**1.6**

Specific learning disability	Mean	N	Std. Deviation	Std. Error of Mean
Yes	26.5	11	24.7	7.4
Have but never assessed	33.9	8	20.8	7.4
No	24.6	130	18.9	1.7
Prefer not to say	54.2	2	0.0	0.0
Total	**25.6**	**151**	**19.6**	**1.6**

Ethnicity	Mean	N	Std. Deviation	Std. Error of Mean
Any other Asian or Asian British background	33.3	5.0	14.7	6.6
Any other ethnic group	38.9	3.0	26.8	15.5
Any other mixed or multiple ethnic background	37.5	2.0	0.0	0.0
Any other White background	27.7	14.0	24.3	6.5
Arab	30.2	4.0	22.9	11.5
Asian or Asian British: Bangladeshi	12.5	3.0	4.2	2.4
Asian or Asian British: Chinese	40.6	4.0	24.1	12.1
Asian or Asian British: Indian	29.4	17.0	20.5	5.0
Asian or Asian British: Pakistani	0.0	2.0	0.0	0.0
Black or Black British: African	19.4	3.0	12.7	7.3
Mixed or multiple ethnic group: White and Asian	8.3	2.0	0.0	0.0
White: English, Welsh, Scottish, Northern Irish or British	23.0	66.0	18.2	2.2
White: Irish	21.9	15.0	14.5	3.7
Prefer not to say	34.1	11.0	25.3	7.6
Total	**25.6**	**151.0**	**19.6**	**1.6**

Sexual identity	Mean	N	Std. Deviation	Std. Error of Mean
Female	22.1	68	19.2	2.3
Male	27.4	71	19.4	2.3
Non-binary	25.0	1		
Prefer not to say	36.5	4	22.7	11.3
Missing	34.5	7	22.8	8.6
Total	**25.6**	**151**	**19.6**	**1.6**

Sexual orientation	Mean	N	Std. Deviation	Std. Error of Mean
Bisexual	8.3	3.0	14.4	8.3
Gay or Lesbian	25.0	5.0	15.6	7.0
Straight/Heterosexual	25.5	125.0	19.9	1.8
Other	25.0	1.0		
Prefer not to say	26.3	10.0	17.0	5.4
Missing	34.5	7.0	22.8	8.6
Total	**25.6**	**151.0**	**19.6**	**1.6**

Religion	Mean	N	Std. Deviation	Std. Error of Mean
Buddhist	66.7	1		
Christian	20.8	29	17.6	3.3
Hindu	35.8	12	19.7	5.7
Jewish	22.5	5	25.3	11.3
Muslim	16.7	11	17.6	5.3
Sikh	25.0	1		
No religion	24.1	77	18.3	2.1
Prefer not to say	38.9	15	21.2	5.5
Total	**25.6**	**151**	**19.6**	**1.6**

Short Warwick–Edinburgh Mental Wellbeing Scale score

Deanery	Mean	n	Std. Deviation	Std. Error of Mean
East Midlands	21.8	16	4.0	1.0
East of England	24.1	8	6.4	2.3
Ireland	23.4	11	3.9	1.2
Kent, Surrey and Sussex	23.8	8	4.5	1.6
London - North Central and East	24.0	4	2.6	1.3
London - North West	20.8	8	5.8	2.0
London - South	0.0	1		
North East	21.9	11	2.8	0.9
North West East	26.5	2	0.7	0.5
North West West/ Mersey	23.9	13	4.2	1.2
Northern Ireland	25.0	10	3.2	1.0
Scotland - East/ North/ South	23.8	4	2.1	1.0
South West - Penisula	23.3	4	6.2	3.1
South West - Severn	24.6	7	4.1	1.6
Thames Valley	22.3	12	6.0	1.7
Wales	22.5	4	3.5	1.8
Wessex	22.7	3	1.5	0.9
West Midlands	24.1	8	4.0	1.4
Yorkshire and Humber	19.9	7	4.5	1.7
Total	**22.8**	**147**	**4.7**	**0.4**

Age	Mean	n	Std. Deviation	Std. Error of Mean
20-29	21.8	19	5.5	1.3
30-39	23.0	121	4.5	0.4
40-49	22.3	6	6.5	2.7
50-59	29.0	1		
Total	**22.8**	**147**	**4.7**	**0.4**

Has disability under Equality Act	Mean	N	Std. Deviation	Std. Error of Mean
Yes	21.5	4	3.1	1.6
No	23.0	139	4.7	0.4
Prefer not to say	18.5	4	3.8	1.9
Total	**22.8**	**147**	**4.7**	**0.4**

Specific learning disability	Mean	N	Std. Deviation	Std. Error of Mean
Yes	20.9	11	3.8	1.1
Have but never assessed	20.0	8	4.8	1.7
No	23.3	126	4.7	0.4
Prefer not to say	16.0	2	4.2	3.0
Total	**22.8**	**147**	**4.7**	**0.4**

Ethnicity	Mean	N	Std. Deviation	Std. Error of Mean
Any other Asian or Asian British background	17.2	6	9.1	3.7
Any other ethnic group	20.7	3	5.9	3.4
Any other mixed or multiple ethnic background	23.0	2	1.4	1.0
Any other White background	20.7	14	3.5	0.9
Arab	21.0	4	5.4	2.7
Asian or Asian British: Bangladeshi	23.7	3	1.2	0.7
Asian or Asian British: Chinese	26.0	4	3.4	1.7
Asian or Asian British: Indian	22.2	16	4.8	1.2
Asian or Asian British: Pakistani	21.0	1		
Black or Black British: African	23.0	3	2.6	1.5
Mixed or multiple ethnic group: White and Asian	27.5	2	0.7	0.5
White: English, Welsh, Scottish, Northern Irish or British	23.1	64	4.3	0.5
White: Irish	26.0	14	4.1	1.1
Prefer not to say	23.1	11	4.6	1.4
Total	**22.8**	**147**	**4.7**	**0.4**

Sexual identity	Mean	N	Std. Deviation	Std. Error of Mean
Female	21.9	66	4.8	0.6
Male	24.0	69	4.4	0.5
Non-binary	22.0	1		
Prefer not to say	19.8	4	3.8	1.9
Missing	21.7	7	5.8	2.2
Total	**22.8**	**147**	**4.7**	**0.4**

Sexual orientation	Mean	N	Std. Deviation	Std. Error of Mean
Bisexual	25.3	3	3.2	1.9
Gay or Lesbian	24.0	4	2.8	1.4
Other	20.0	1		
Prefer not to say	21.5	10	3.0	0.9
Straight/Heterosexual	22.9	122	4.9	0.4
Missing	21.7	7	5.8	2.2
Total	**22.8**	**147**	**4.7**	**0.4**

Religion	Mean	N	Std. Deviation	Std. Error of Mean
Buddhist	28.0	1		
Christian	22.1	29	4.1	0.8
Hindu	21.2	12	5.3	1.5
Jewish	19.8	5	5.0	2.2
Muslim	23.1	9	4.3	1.4
Sikh	25.0	1		
No religion	24.1	74	4.2	0.5
Prefer not to say	19.8	16	6.0	1.5
Total	**22.8**	**147**	**4.7**	**0.4**

Brief Resilience Scale scores

Deanery	Mean	n	Std. Deviation	Std. Error of Mean
East Midlands	3.5	6	1.4	0.6
East of England	3.0	16	0.8	0.2
Ireland	3.8	8	1.1	0.4
Kent, Surrey and Sussex	3.3	11	0.8	0.2
London - North Central and East	3.5	8	0.7	0.3
London - North West	4.2	4	0.3	0.1
London - South	3.2	8	0.7	0.2
North East	3.4	11	0.6	0.2
North West East	3.9	2	0.1	0.1
North West West/ Mersey	3.6	13	0.7	0.2
Northern Ireland	3.8	10	0.6	0.2
Scotland - East/ North/ South	3.9	4	0.5	0.3
South West - Penisula	3.1	4	0.9	0.5
South West - Severn	3.3	7	0.7	0.3
Thames Valley	2.9	12	1.0	0.3
Wales	3.0	4	0.8	0.4
Wessex	3.7	3	0.5	0.3
West Midlands	3.7	8	0.8	0.3
Yorkshire and Humber	3.5	7	0.8	0.3
Total	**3.4**	**146**	**0.8**	**0.1**

Age	Mean	n	Std. Deviation	Std. Error of Mean
20-29	3.4	19	0.8	0.2
30-39	3.4	120	0.8	0.1
40-49	3.3	6	0.8	0.3
50-59	3.2	1		
Total	**3.4**	**146**	**0.8**	**0.1**

Has disability under Equality Act	Mean	N	Std. Deviation	Std. Error of Mean
Yes	3.0	4	0.7	0.4
No	3.4	138	0.8	0.1
Prefer not to say	2.8	4	1.3	0.6
Total	**3.4**	**146**	**0.8**	**0.1**

Specific learning disability	Mean	N	Std. Deviation	Std. Error of Mean
Yes	2.8	11	0.6	0.2
Have but never assessed	3.0	8	0.8	0.3
No	3.5	125	0.8	0.1
Prefer not to say	2.0	2	1.4	1.0
Total	**3.4**	**146**	**0.8**	**0.1**

Ethnicity	Mean	N	Std. Deviation	Std. Error of Mean
Any other Asian or Asian British background	3.2	5	1.1	0.5
Any other ethnic group	3.0	3	1.0	0.6
Any other mixed or multiple ethnic background	3.3	2	0.1	0.1
Any other White background	3.3	14	0.8	0.2
Arab	3.1	4	0.8	0.4
Asian or Asian British: Bangladeshi	3.4	3	1.2	0.7
Asian or Asian British: Chinese	3.6	4	0.5	0.3
Asian or Asian British: Indian	3.3	16	0.7	0.2
Asian or Asian British: Pakistani	4.0	1		
Black or Black British: African	2.5	3	0.5	0.3
Mixed or multiple ethnic group: White and Asian	4.1	2	0.1	0.1
White: English, Welsh, Scottish, Northern Irish or British	3.5	64	0.8	0.1
White: Irish	3.9	14	0.7	0.2
Prefer not to say	3.2	11	1.0	0.3
Total	**3.4**	**146**	**0.8**	**0.1**

Sexual identity	Mean	N	Std. Deviation	Std. Error of Mean
Female	3.1	65	0.9	0.1
Male	3.7	69	0.6	0.1
Non-binary	4.0	1		
Prefer not to say	2.8	4	1.3	0.6
Missing	3.6	7	0.7	0.3
Total	**3.4**	**146**	**0.8**	**0.1**

Sexual orientation	Mean	N	Std. Deviation	Std. Error of Mean
Bisexual	3.8	3	0.3	0.2
Gay or Lesbian	2.6	4	0.9	0.4
Straight/Heterosexual	3.4	121	0.8	0.1
Other (please specify)	2.2	1		
Prefer not to say	3.4	10	1.2	0.4
Missing	3.6	7	0.7	0.3
Total	**3.4**	**146**	**0.8**	**0.1**

Religion	Mean	N	Std. Deviation	Std. Error of Mean
Buddhist	3.8	1		
Christian	3.5	29	0.8	0.1
Hindu	3.2	12	0.8	0.2
Jewish	3.3	5	0.9	0.4
Muslim	3.6	9	0.7	0.2
Sikh	3.7	1		
No religion	3.5	74	0.8	0.1
Prefer not to say	3.0	15	1.1	0.3
Total	**3.4**	**146**	**0.8**	**0.1**

Experiences of bullying and harassment by gender

I have experienced this	Total responses	Female		Male		*p*	Odds ratio	95% Confidence Interval
		Number	%	Number	%			
Undermining someone's role, e.g. criticism in front of patients or other staff	129	16	26%	10	15%	0.2295	1.713131	.6652312 4.51796
Persistent or excessive negative feedback; unsubstantiated allegations	126	13	21%	11	17%	0.5307	1.329545	.495653 3.609141
Asking trainees to perform tasks they have not been trained to do	126	6	10%	8	12%	0.6591	.7772727	.2082325 2.750367
Asking trainees to work unpaid shifts	125	11	18%	10	15%	0.6595	1.234694	.4330847 3.548461
Undervaluing someone's contribution (in their presence or otherwise)	127	20	33%	15	23%	0.2049	1.658537	.7044648 3.939048
Unrealistic expectations about workload, responsibilities or level of competence	125	29	48%	17	26%	0.0102	2.641366	1.171623 6.010202
A member of staff shouting or swearing at someone	123	11	19%	11	17%	0.8332	1.104167	.3937311 3.092536
Excluding, devaluing or ignoring an individual on purpose	126	15	25%	8	12%	0.0745	2.32337	.8317093 6.873833
Inadequate or absent supervision	126	22	36%	11	17%	0.0146	2.769231	1.122784 7.055709
Belittling or marginalization of trainees by senior staff from other professional groups	126	13	21%	10	15%	0.3894	1.489583	.5449353 4.159364
Bullying of trainees by other staff pursuing targets	125	16	26%	11	17%	0.2195	1.713131	.6652312 4.51796
Abusing position of seniority to make demands	125	16	26%	14	22%	0.5688	1.269841	.5148776 3.15317
Abusing position of seniority in job selection/loss of job opportunity	126	6	10%	8	12%	0.6591	.7772727	.2082325 2.750367

Experiences of sexual harassment by gender

I have experienced this	Total responses	Females		Males		*p*	Odds ratio	95% Confidence Interval
		Number	%	Number	%			
Ogling/staring	124	6	10%	0	0%	0.0107	-	1.735548
Lewd comments	124	5	8%	3	5%	0.4364	1.785714	.3283692 11.97479
Intrusive comments about personal life	125	13	21%	1	2%	0.0005	17.0625	2.365843 736.2101
Comments on physical appearance	123	11	18%	4	6%	0.0423	3.311224	.8991622 15.02324
Unsolicited texts, emails, pictures, social media posts	124	3	5%	1	2%	0.2940	3.206897	.247292 170.9952
Violating personal space: patting, grabbing, caressing, hugs, kisses	123	3	5%	0	0%	0.0724	-	.8366437
Physical assault	124	1	2%	0	0%	0.3075	-	-
Sexual assault	124	2	3%	0	0%	0.1474	-	.5407476
Rape	124	1	2%	0	0%	0.3075	-	-

(Please note: exact confidence levels are not possible with zero count cells.)