NATIONAL TRAINING SURVEY

2025 results

General Medical Council

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National training survey 2025

Foreword

In this year's national training survey, completed by around 71,000 doctors, trainers once again report that they enjoy their role, and trainees rate their training highly. In a system under severe pressure, that is no small thing.

However, profound challenges remain for healthcare systems across the UK. In particular, wellbeing, and its knock-on effects for patient care, remains a real concern.

While down on its 2023 peak, the proportion of trainees at high risk of burnout has doubled since 2019, now standing at a fifth of that cohort. Half find their work emotionally exhausting to a high or very high degree, while a third said their work frustrated them to a high or very high degree.

While there are challenges across the board, certain specialties have more concerning results than others. Emergency medicine had the largest proportion of trainees at high risk of burnout at 30%, compared to 20% overall. 70% of emergency medicine trainees also described their workload as heavy or very heavy, as did 63% of obstetrics and gynaecology trainees and 48% of surgery trainees, compared to 42% overall.

A greater proportion of trainees in these specialties also reported feeling apprehensive or hesitant about escalating a patient to the supervising clinician. 26% of trainees in emergency medicine, 27% in obstetrics and gynaecology and 29% in surgery reported feeling this way, compared to 21% of trainees overall.

That large numbers of trainees feel uncomfortable raising concerns with their senior colleagues is deeply troubling, and points to an environment where patient safety continues to fall victim to unhealthy culture. If ambitions to make the health system work better for patients are to be realised, more attention must be given to fostering working environments that support the provision of good, safe care. Employers' efforts in this area should be properly measured, to help form a view of overall provider performance.

Our data also show that certain groups are more at risk of unacceptable behaviours than others. 39% of gay and 45% of bisexual trainees reported hearing discriminatory comments, compared to 24% of heterosexual trainees. 17% of female trainees reported being ignored or excluded, compared to 13% of male trainees. And 34% of UK graduates from an ethnic minority background report experiencing behaviours like micro-aggressions from colleagues, compared to 25% of their white colleagues.

That this offensive behaviour remains a reality for many doctors is a stain on modern medicine. It is also particularly concerning that, despite the system-wide focus on tackling discrimination in recent years, these data don't seem to have shifted significantly.

As the workforce continues to diversify and evolve, culture and working practices must evolve with it. That is a question of individual attitudes and behaviour, but also the structural framework that dictates doctors' working lives.

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In 2025, 30% of female and 15% of male trainees reported working less than full time, with childcare responsibilities and work/life balance commonly cited as motivations. Meanwhile, most doctors take time off from training after their Foundation Year 2 (F2), with around 65% doing so in 2023.[*]

If the medical training system fails to adapt to these trends, it risks losing doctors from the workforce altogether. That's why we're working closely with workforce planners, employers and education leaders across the UK to develop a new education framework that delivers flexible, fair and innovative learning that supports better patient care.

Ensuring medicine meets modern needs requires sustained, concerted action across the health system. That means tackling disparities across specialties and protected characteristics, aligning medical training with doctors' changing careers and never losing sight of the central importance of culture in determining outcomes. We're committed to playing our part, so doctors have the support they need to give patients the care they deserve.

Charlie Massey

Chief Executive and Registrar

[*] p.45 The state of medical education and practice in the UK Workforce report 2024

Key findings: doctors in training

50,637

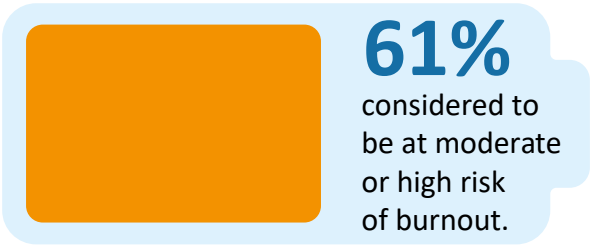
doctors in training completed the survey in 2025.

Supervision

87%

rated the quality of their clinical supervision as good or very good.

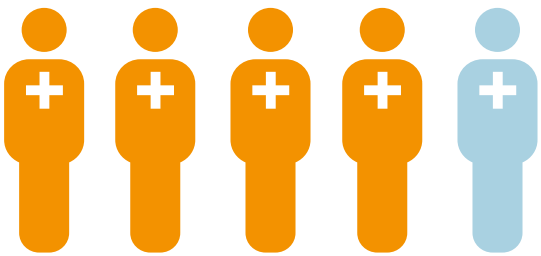
Burnout



61%

considered to be at moderate or high risk of burnout.

Satisfaction



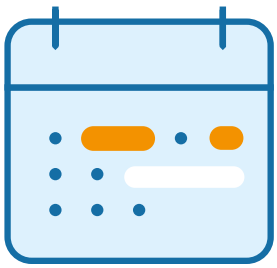
84%

said the quality of their experience was good or very good.

Rota gaps

26%

said training is affected because rota gaps aren't dealt with appropriately.



Leadership skills

63%

said their posts gave them opportunities to develop their leadership skills.

Discriminatory behaviours

28%

experience micro-aggressions, negative comments, or oppressive body language from colleagues.

39%

don't feel confident about reporting discrimination where they work without fear of adverse consequences.

Key findings: trainers

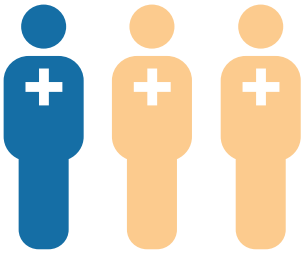
21,289

trainers completed the survey in 2025.

Burnout

47% considered to be at moderate or high risk of burnout.

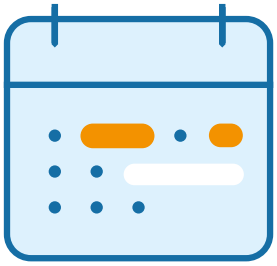
Satisfaction



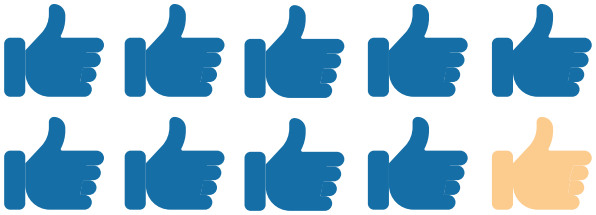
30% said their work frustrates them to a high or very high degree.

Rota gaps

29% of secondary care trainers said their trainees' education and training is adversely affected because rota gaps aren't dealt with appropriately.



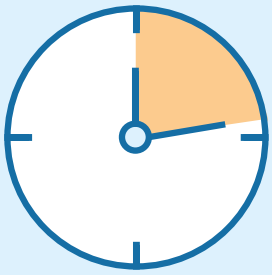
Training and support



90% of trainers enjoy their role.

70% rated support they receive from their employer/local education team as good or very good.

Time to train



29% of secondary care trainers and

18% of GP trainers said they weren't always able to use their allocated training time, specifically for that purpose.

Executive summary

Improvements are encouraging, but challenges persist

This year's findings once again highlight the dedication of both doctors in training and their educators. Trainees continue to report high standards in teaching and clinical supervision, while trainers are clear that they enjoy their role. Encouragingly, there are also some improvements in areas such as the quality of induction, burnout levels, and time allocated for training.

However, against the backdrop of ongoing discussions about the future of our health services and postgraduate medical training, the data also highlight concerns that cannot be ignored.

Escalation hesitancy by doctors in training could put patient safety at risk

New questions in this year's survey show that more than a fifth of trainees (21%) feel apprehensive about escalating a patient to a supervising clinician – an issue that could compromise patient safety. This rises to over a quarter in obstetrics and gynaecology (27%), medicine, emergency medicine (26%), and surgery (29%); specialties that also report higher levels of workload stress, incivility, and bullying.

Rota gaps remain an issue

Over a quarter (26%) of trainees and 29% of trainers said training was adversely affected because rota gaps weren't dealt with appropriately. As the number of medical school places increases, demands on trainers will only grow. It's vital that trusts and boards eliminate any obstacles that undermine effective training delivery, and that employers and education providers use the reports and information in our education data tool to help make the necessary improvements for doctors in training and their trainers.

Discriminatory behaviours persist in some workplaces

Analysis of questions exploring discriminatory behaviours continue to show certain doctors experience disadvantages associated with their personal or protected characteristics including gender, ethnicity, religion, and disability. And while a third (34%) of white trainees said they weren't confident about reporting such behaviours without fear of adverse consequences, this increased to 43% of those from an ethnic minority background.

Fostering inclusive, discrimination-free environments must remain a priority for trusts and boards across the UK. Failing to do so risks losing the valuable skills and experiences essential for sustaining the workforce and delivering safe, high-quality patient care.

Flexible training models are needed for a sustainable workforce and safe patient care

With increasing numbers of trainees working less than full time, often citing a better work life balance as the reason, and a fifth (21%) of year 2 foundation doctors planning to step out of training to obtain a service post, it's clear medical education and training needs to adapt.

Doctors must receive high quality training in environments that prioritise wellbeing, are supportive, fair, and enable them to raise concerns. Trainers, in turn, need sufficient time, resources, and development opportunities to fulfil their roles effectively.

It's in everyone's interest that doctors are deeply motivated, and confident about their future within our health services. Without meaningful reform and greater flexibility in medical training we risk losing talented professionals from the workforce altogether.

Meeting the evolving and increasingly complex needs of patients requires a clear focus on supporting trainees and those responsible for their development.

How we're driving change at a local level

We use the national training survey to drive local change. Our quality assurance team reviews the data, identifying good practices and concerns. They also read every free-text comment and ask postgraduate deans and employers for a full response on how they intend to address issues raised.

In some cases, we visit sites to speak directly with trainees and trainers. Where serious issues persist, we apply enhanced monitoring and set out clear actions for the postgraduate dean and employer about the improvements we expect to see. If these aren't fully addressed we place conditions on our approval of a training programme. These make sure standards can be met on a sustainable basis, and that patient safety and trainee wellbeing are maintained.

Ultimately, if conditions aren't met, doctors in training can be removed from the site, and they won't be able to return until we're satisfied that they are safe and supported in their roles. High-quality, inclusive training is essential, and where this isn't happening, we act. The survey is a key tool for driving that change.

Introduction

The national training survey is the largest annual survey of doctors across the UK. It gathers the views of doctors in training on the quality of their postgraduate medical education and work environments. It also seeks feedback from trainers about their experiences as clinical or educational supervisors. The survey questions assess compliance with our standards for medical education and training, organised around the following themes:

- learning environment and culture
- educational governance and leadership
- supporting learners
- supporting educators
- developing and implementing curricula and assessments.

This summary report presents high-level findings from the survey to help organisations improve the quality of training and their training environments. It focuses on UK-wide trends in postgraduate medical education, with country specific data where there are notable differences or changes. The report spotlights:

- the quality of training and support for trainers
- doctors' wellbeing at work and workload
- the supportive nature of working environments, including workplace discrimination.

For the second consecutive year we've included analysis of some national training survey data by demographic characteristics. This furthers our efforts, along with those of education providers, to address inequalities in medical education and foster supportive, inclusive, and fair environments for all doctors.

Changes to the survey in 2025

This year we added two new questions to our survey for doctors in training on clinical supervision and out-of-hours supervision. These new questions ask how often they feel hesitant to escalate a patient to their supervisor or senior support. They were informed by a 2023 study, which links perceived low-quality supervision, especially out of hours, to higher excess mortality rates.

We've also reintroduced a question asking trainers how many trainees they currently supervise, while retaining the question about how many trainees they supervised during the last 12 months. This will help us monitor trainee-to-trainer ratios, an important measure of trainer workload.

How we use the findings

The survey data support our quality assurance of postgraduate medical education. *Promoting excellence* outlines the standards we expect organisations responsible for educating and training medical students and doctors in the UK to meet. We use the survey responses to assess how these standards are being implemented in every site and specialty, to make sure that training

across the UK is provided in safe, effective, and supportive environments.

If we identify risks, we collaborate with those responsible for delivering and providing training to address them. In some cases, we may activate our enhanced monitoring processes to protect trainees and ensure patient safety. For example, we recently placed conditions on the medicine and surgery department at Norfolk University Hospitals Foundation Trust, after doctors in training highlighted inappropriate behaviours and cultures within the department.

Doctors in training can also use the survey to report unresolved concerns related to patient safety, bullying, or undermining. We share this information with the relevant postgraduate dean, who must inform us of the actions taken to address the issue.

By analysing the findings, we spot trends in postgraduate education and specialties, showcasing excellence and innovation. Sharing these insights highlights current issues affecting doctors in training and practice. Partnering with healthcare stakeholders, we drive crucial improvements to retain the essential skills and experience needed for the future workforce.

The education data tool

The education data tool enables users to explore responses to individual survey questions and detailed analysis of national, regional, local, and specialty breakdowns for all indicators. The data tool also provides additional reports based on national training survey data, including those on trainee and trainer risk of burnout and an aggregation report that combines national training survey data across years or reporting groups. A help video is available which explains how to use the tool.

What we expect from others

Patient safety is linked to a positive learning culture that supports both learners and educators. Our approval of postgraduate training relies on organisations delivering opportunities for trainees to meet their curricular requirements and fulfil our standards in *Promoting excellence: standards for medical education and training*. Listening to feedback from doctors in training and their trainers through the survey is a crucial part of this process.

We expect postgraduate deans, training providers, medical royal colleges, and employers to make use of the rich insights available in our education data tool. By analysing feedback across countries, regions, specialties, and individual sites, they can identify and address concerns, celebrate and share good practice, and actively support the career development of doctors in training.

Policymakers also have a vital role to play. They should use the survey findings to shape working environments that are inclusive, supportive, and fair. This is essential for retaining and sustaining both trainees and trainers, and for securing the future of the medical workforce.

This is a period of great change in the health system across the UK, during which the national training survey remains a cornerstone of quality assurance and improvement in medical education and training. Our UK-wide case studies show how survey data has already driven meaningful change and will continue to do so.

Responses to the survey

This year, over 71,000 doctors in training and trainers completed the survey. Although the response rate for trainees (70% ↓6 percentage points) and trainers (33% ↓5pp) was lower than 2024, we have a robust dataset. This allows us to effectively monitor the quality of training environments across all four UK countries.

Table 1: 2025 completion rates by country (change vs 2024)

	England	NI	Scotland	Wales	UK
Trainees	69% (↓6pp)	68% (↓8pp)	71% (↓7pp)	82% (↓4pp)	**70% (↓6pp)**
(No. of doctors)	42,289	1,355	4,421	2,572	**50,637**
Trainers	33% (↓4pp)	36% (↓4pp)	25% (↓6pp)	48% (↓9pp)	**33% (↓5pp)**
(No. of doctors)	17,628	704	1,576	1,381	**21,289**

High level findings

The quality of training

The majority of doctors in training continue to be positive about the quality of their teaching, with over three quarters (76% ↑2pp) rating it as good or very good (see Table 2). A larger proportion of trainees (87% ↑1pp) gave positive ratings for their clinical supervision. As in previous years, there were some differences in responses between specialties. For example, more than one out of ten trainees in surgery (16% ↓2pp), obstetrics and gynaecology (14% as 2024) and medicine (13% ↓1pp) felt the quality of teaching to be poor or very poor, compared to just 3% (↓1pp) of general practice (GP) trainees.

A good induction is crucial for welcoming doctors in training. It helps them maximise learning opportunities and ensures a smooth transition into a complex work environment. It's encouraging that 76% (↑1pp) of trainees rated their induction as very good or good, continuing the steady improvement in positive responses since the Covid-19 pandemic (Table 2).

Research indicates that mentorship can help address achievement disparities. However, as in 2024 over half (56%) of all trainees reported lacking support from a mentor (Table 3). Responses varied across specialties, consistent with 2024. 21% (↑1pp) of GP trainees receive mentoring through a formal scheme run by their employer, while the same percentage (21% as 2024) of trainees in secondary care posts have informal mentoring from another clinician. Given that studies show formal mentorship programmes are fairer than informal ones, we've collaborated with stakeholders to create a toolkit to help organisations establish effective mentorship schemes for trainees.

Table 2: Trainees – Proportion rating the quality of teaching/clinical supervision/induction as very good or good 2019–2025[*]

Question	2019	2021	2022	2023	2024	2025
Please rate the quality of teaching in this post.	74%	76%	74%	74%	74%	**76%**
Please rate the quality of clinical supervision in this post.	88%	88%	87%	86%	86%	**87%**
Please rate the quality of the induction you received for this post.	73%	71%	72%	74%	75%	**76%**

Table 3: Trainees – Do you have support from a mentor (excluding the meetings you have with your education or clinical supervisor) who supports and guides you with your career and/or personal development? (tick all that apply)

No support from a mentor	56% (as 2024)
Yes – informal mentoring from another clinician	20% (as 2024)
Yes – formal mentoring scheme through my employer (eg trust or site of work)	14% (↑1pp)
Yes – formal mentoring scheme through my deanery/NHSE[†] regional team	10% (as 2024)
Yes – informal other	9% (↑1pp)
Yes – formal scheme through my royal college or faculty	2% (as 2024)
Yes – formal scheme through another organisation	1% (as 2024)

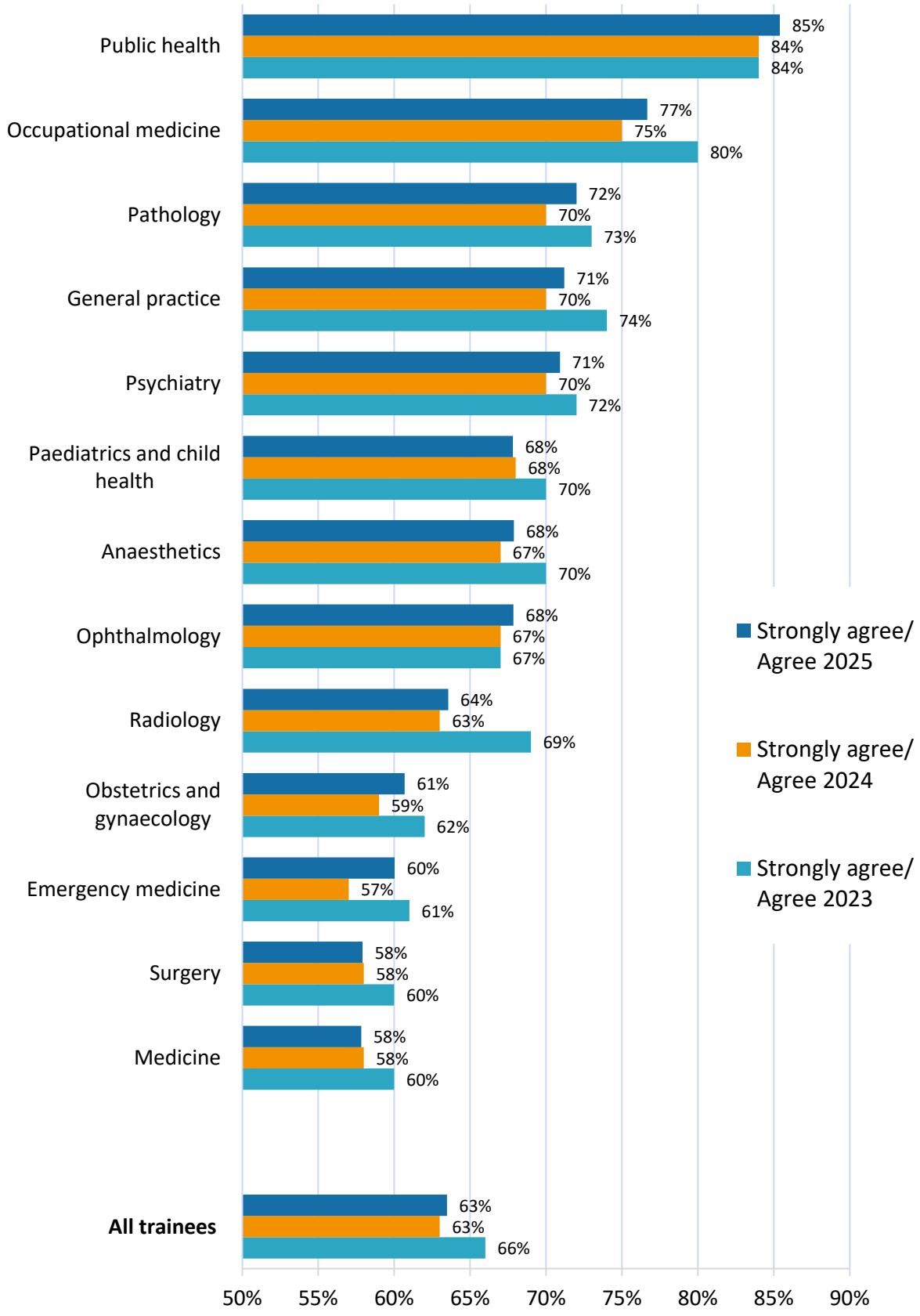
Enabling doctors in training to develop leadership skills, relevant to their role is essential for the future of health services and patient care.

In 2023 and 2024, we reported a worrying decline in the proportion of trainees who felt they had opportunities to develop their leadership skills. It's promising to see that this decline has not continued in 2025 (see Figure 1), with the majority of specialties seeing a slight increase in the proportion of positive responses to this question.

Good leadership is inescapably linked to the delivery of good patient care, so it’s essential this aspect of training isn’t overlooked.

[*] The 2020 national training survey was revised to focus on the impact of the Covid-19 pandemic on training.
[†] National Health Service England

Figure 1: Trainees – In this post I am given opportunities to develop my leadership skills relevant for my stage of training. By post specialty 2023–2025



Clinical supervision – new questions

The two new questions in Table 4 explore how frequently doctors in training feel apprehensive or hesitant about escalating a patient to their supervising clinician or senior support.

Table 4: Trainees – New questions about clinical supervision

In your current post how often, if ever:	Daily / Weekly	Monthly	Less than once a month	Never
do you feel apprehensive or hesitant about escalating a patient to the supervising clinician? This may be your named clinical supervisor, or it may be another doctor.	4%	5%	12%	79%
In this post, OUT OF HOURS, how often (if ever) do you feel apprehensive or hesitant about escalating a patient to the supervising clinician? This may be your named clinical supervisor, or it may be another doctor.	4%	6%	14%	77%

21% of trainees said they'd felt apprehensive about escalating a patient to the supervising clinician. The largest proportion of such responses came from trainees in surgery (29%), obstetrics and gynaecology (27%), medicine and emergency medicine (both 26%). A slightly larger proportion of those working out of hours (23%) reported being hesitant. Given a 2023 study found a correlation between perceived low-quality clinical supervision, and higher rates of excess mortality, especially out of hours, we will continue to monitor results. These questions will contribute to the clinical supervision indicator from 2026.

Trainers – training time, development, and support

The vast majority of trainers are positive about being educators, with 90% (as 2024) enjoying the role. For the first time over half (52% ↑4pp) of all trainers said they were able to use their allocated training time specifically for training purposes (Table 5). However, 27% (↓2pp) disagreed with the statement, increasing to over a third in medicine (36% ↓3pp), pathology (36% ↓1pp), and radiology (34% ↓6pp).

This year a slightly larger proportion of trainers (70% ↑2pp) rated the support from their employer or local education team as good or very good. The improvement can be seen across all four countries of the UK in Table 6. As in 2024, GP trainers (87% ↑3pp) and public health trainers (76% ↓6pp) were the most positive, while only 57% (↑1pp) of surgery trainers shared this sentiment.

Table 5: Trainers – I am always able to use the time allocated to me in my role as a trainer specifically for that purpose

	2019	2021	2022	2023	2024	2025
Positive	46%	47%	45%	46%	48%	**52%**
Negative	30%	29%	31%	31%	29%	**27%**

Table 6: Trainers – Please rate the support you receive from your employer/local education team in your role as a trainer

Country	Very good/Good	Poor/Very poor
England	70% (↑1pp)	8% (as 2024)
NI	72% (↑5pp)	6% (↓2pp)
Scotland	66% (↑2pp)	8% (↓1pp)
Wales	69% (↑2pp)	7% (as 2024)
UK	70% (↑2pp)	8% (as 2024)

GP trainers were also slightly more positive when asked about support and access to resources, (see Table 7).

Table 7: Trainers – Support and development questions

Question	Secondary care trainers		GP trainers	
	Positive	Negative	Positive	Negative
I am able to access learning and development opportunities for my role as a trainer when I need them.	80% (↑1pp)	6% (as 2024)	86% (↑2pp)	4% (↓2pp)
I have access to the training and support I need to provide effective feedback on my trainees' performance.	85% (↑1pp)	3% (as 2024)	93% (↑2pp)	1% (↓1pp)
The resources I need to perform my role as a trainer are available to me in my workplace.	73% (↑1pp)	11% (↓1pp)	89% (↑4pp)	5% (↓3pp)
I have access to the resources I need to confidently support trainees of all backgrounds, beliefs, and identities.	74% (↑1pp)	5% (as 2024)	87% (↑4pp)	2% (↓2pp)

Rota design

Both doctors in training and their trainers continue to express concerns about rota design, the coverage of rota gaps, and the effect on training.

As in 2024, over a quarter (26%) of trainees in secondary care posts reported that their training was adversely affected as rota gaps were not dealt with appropriately. Responses varied across specialties, with 40% (↓2pp) of obstetrics and gynaecology trainees stating this was the case, compared to 11% (as 2024) of anaesthetics trainees.

Similarly, three out of ten secondary care trainers (29% ↓2pp) reported that their trainees' education and training are adversely affected because rota gaps aren't always dealt with appropriately. Over two fifths of obstetrics and gynaecology trainers (41%↓5pp), and over a third of surgery (37% ↓4pp) and medicine (34% ↓4pp) trainers gave negative responses.

Trainer to trainee numbers

Our report, *The state of medical education and practice in the UK: workforce report 2024* highlighted concerns of an increase in workload for doctors with trainee supervision responsibilities. To support the monitoring of this, we reintroduced a question, to ask trainers how many trainees they currently supervise (Table 8).

Table 8: Trainers – How many trainees are you currently a named supervisor for? (clinical and/or educational) 2025 and 2022

	0 / NA	1	2	3	4	5	>5
2025	9%	26%	27%	16%	10%	5%	7%
2022	6%	23%	27%	18%	11%	5%	9%

The highest proportions of trainers supervising four or more doctors in training were in emergency medicine (44%), medicine (31%), and surgery (29%).

Fostering excellence in training

As in previous years, trainee satisfaction with teaching remains high, thanks largely to the dedication of trainers.

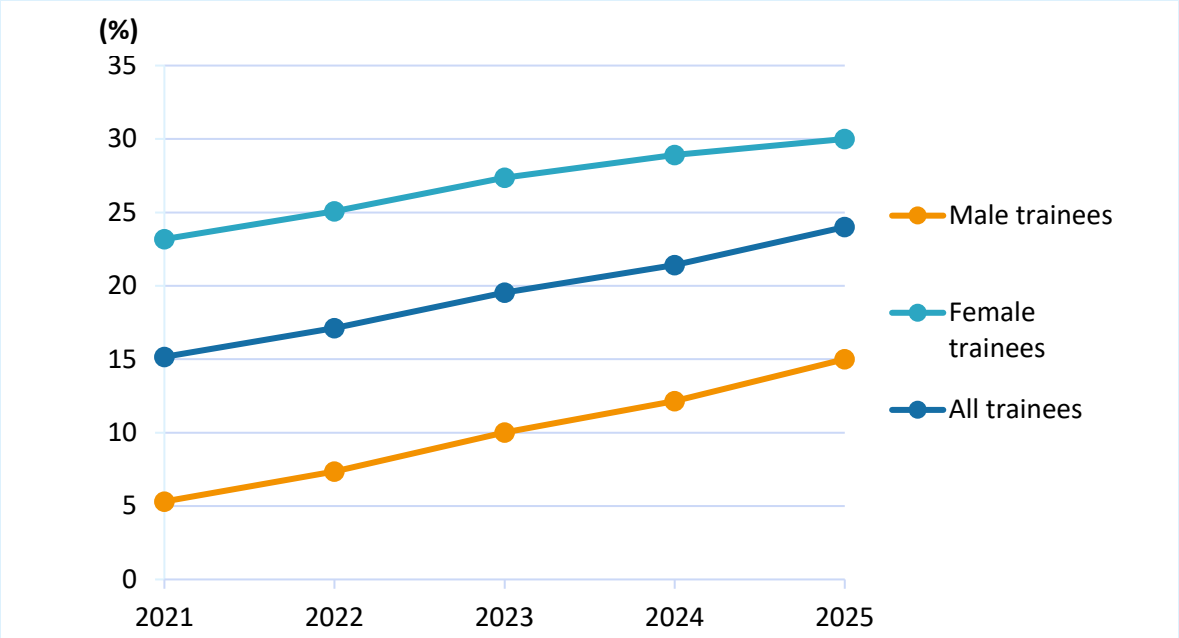
It's encouraging to see a larger proportion of positive responses from trainers to our question about training time. While being cautiously optimistic this can be sustained, we recognise the challenges ahead. As demands on trainers grow with the expansion of medical school places, it's crucial to commit to protecting training time and addressing the issues associated with rota design.

Trainers play a vital role in developing the workforce pipeline, and need adequate support, resources, and development opportunities, so we welcome the improvement in the responses to the associated questions. The future of our healthcare system depends on the unwavering support and development of our trainers. We need firm commitments to enable the necessary growth of training opportunities and develop capacity across the system, including increasing the

educator workforce.

Doctors training less than full time

Figure 2: % of trainees training less than full time 2021–2025



Over recent years, there has been a steady increase in the proportion of trainees working less than full time (LTFT), see Figure 2.

In 2025, 30% of female and 15% of male trainees reported working LTFT, with most (66%) approved to work 80% of their full-time hours. Among those working LTFT, or those who had applied or considered it, 44% cited childcare responsibilities, and 66% sought a better work-life balance as reasons for choosing LTFT arrangements. There's also a notable variation between the different specialties, with 46% of paediatrics and child health trainees training less than full time, compared to just 8% of those in surgery posts. 4% of Foundation trainees choose LTFT arrangements, increasing to 42% of all those in year 5 specialty training (ST5) and above.

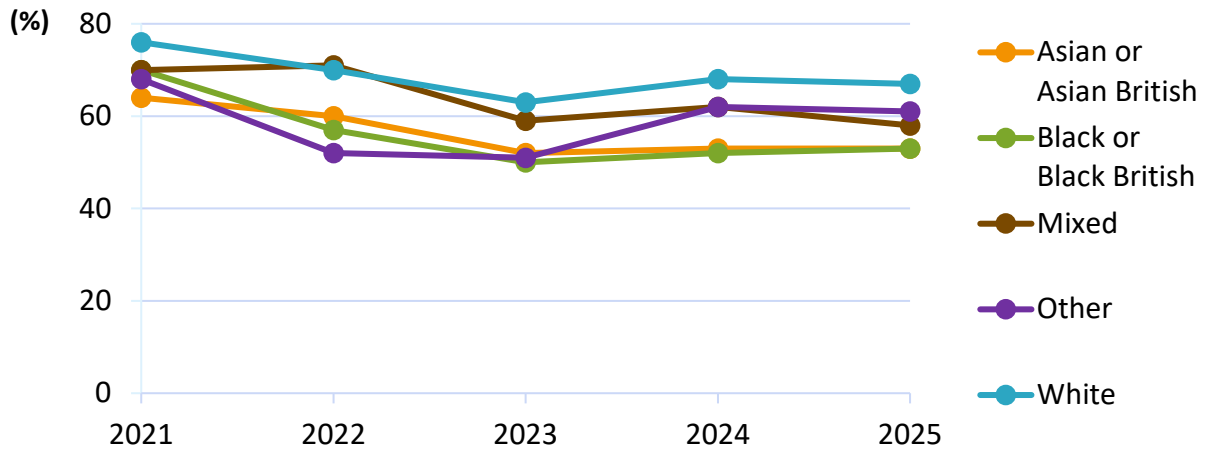
Trainees are clearly adopting a more flexible approach to their training. The majority of doctors are taking time off from training after their Foundation Year 2 (F2) and increasing numbers are choosing to train LTFT, partly to manage their own wellbeing. Notably, a third (32%) of those trainees who considered working reduced hours measured to be at high risk of burnout.

Of those trainees who are on a LTFT arrangement, a similar proportion measured to be at high risk of burnout (18%) as those who work full time (19%), suggesting that reducing working hours possibly brings its own pressures.

Foundation programme preparedness

59% (↓1pp) of trainees completing year one of their foundation programme (F1) said they were adequately prepared for their first foundation post. Unsurprisingly, a smaller proportion (39%) of trainees who graduated outside the UK felt this way. Figure 3 shows there's also a disparity in preparedness among graduates with a UK primary medical qualification (UK PMQ) from an ethnic minority background.

Figure 3: UK PMQ year one foundation programme trainees – I was adequately prepared for my first foundation post, % agreeing/strongly agreeing 2021–2025, by ethnicity



Those who disagreed with the statement were asked what contributed to them feeling less prepared. The most commonly selected options and the variation between the responses for the different ethnic groups for trainees with a UK PMQ can be seen in Table 9.

Table 9: UK PMQ F1 trainees – Which factors do you think contributed to you feeling less prepared? (Tick all that apply) Five most commonly selected options, by ethnicity

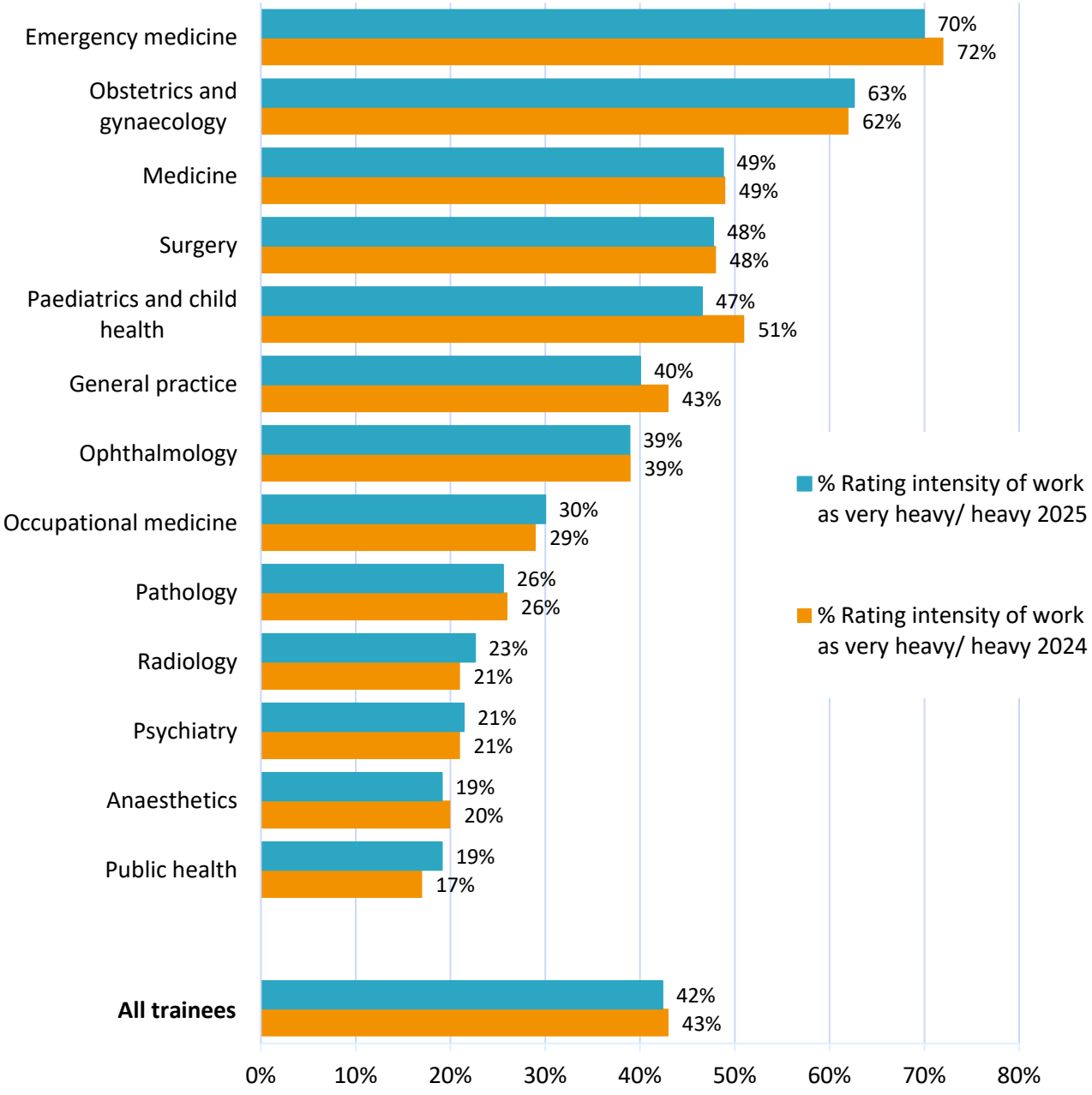
	All UK PMQ	Asian	Black	Mixed	Other	White
Limited knowledge of the day-to-day reality of working as a foundation doctor.	78%	80%	73%	81%	80%	77%
Lack of knowledge and guidance on the paperwork and documentation required for a foundation post.	51%	55%	48%	55%	58%	47%
Inadequate training in how to use the IT hardware / software in my hospital.	50%	52%	51%	60%	46%	48%
Working in a different type of hospital or health system, compared to previous experience.	44%	45%	47%	51%	54%	39%
Geographical re-location.	40%	43%	31%	49%	44%	38%

Workload

There was a small decrease in the proportion of doctors in training who rated the intensity of their daytime work as heavy or very heavy (42% ↓1pp). Figure 4 highlights the variation between specialties and the high proportion of negative responses from emergency medicine (70% ↓2pp), emphasising the highly pressured nature of this work. Over two-fifths (42% ↓1pp) of doctors training in this specialty and 45% (↓3pp) of their trainers, reported that their working pattern leaves them feeling short of sleep on a daily or weekly basis, compared to 24% (as 2024) of all trainees and 27% (↓2pp) of all trainers.

Figure 4: Trainees – % rating intensity of workload as very heavy/heavy 2025 vs 2024

By post specialty



Tackling burnout

To assess burnout and better understand trainee and trainer wellbeing in the workplace, we include seven voluntary work-related questions from the Copenhagen Burnout Inventory in our survey. This year, over 43,000 doctors (57% of trainees and 68% of trainers) completed these questions.

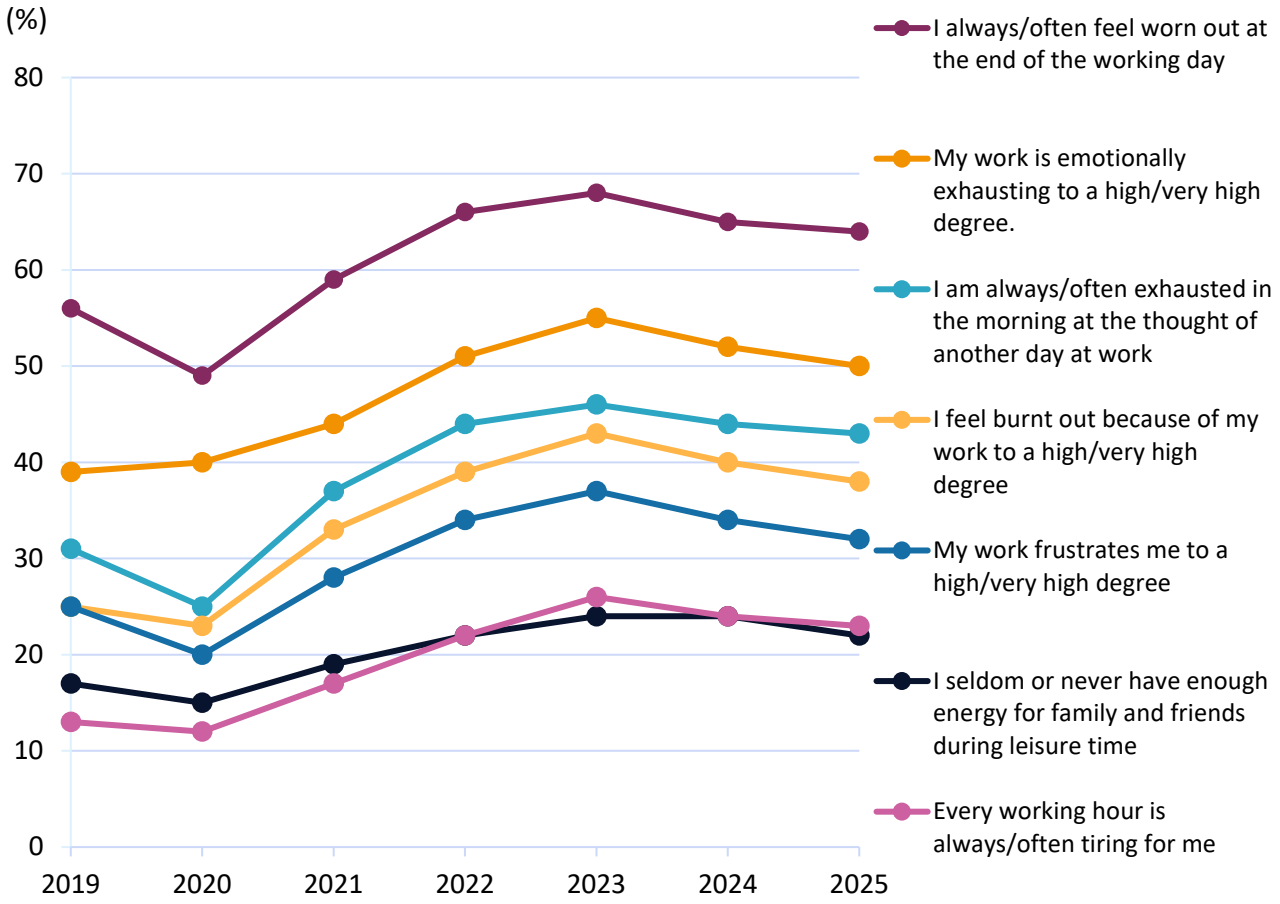
Trainees – responses to questions about burnout

For the second consecutive year there's been a decrease in the proportion of negative responses from trainees to the burnout questions (see Figure 5). While this is certainly a positive trend, levels have not yet returned to pre-COVID-19 pandemic levels.

Half of all trainees (50% ↓2pp) said their work was emotionally exhausting to a high or very high degree and over two fifths (43% ↓1pp) told us they're exhausted in the morning at the thought of another day at work. A third (32% ↓2pp) said their work frustrated them to a high or very high degree.

While all specialties saw a small decrease in the proportion of negative responses to most of the seven questions, there's a marked variation between them. Half (51% ↓2pp) of emergency medicine trainees said they felt burnt out because of their work to a high or very high degree compared to 26% (↓1pp) of those in psychiatry posts. And while a quarter (26% ↓1pp) of obstetrics and gynaecology trainees felt that every working hour is always or often tiring for them, a smaller proportion (15% ↓2pp) of anaesthetics trainees responded this way. Once again, the most negative set of responses came from emergency medicine.

Figure 5: Trainees – Negative responses to individual burnout questions, 2019–2025



Trainers – responses to questions about burnout

There was also a decrease in the proportion of negative answers to the seven burnout questions from trainers. Figure 6 shows that these are now similar to results from 2019, before the Covid-19 pandemic.

This decrease is more pronounced in the results for trainers working in general practice (see Figures 7 and 8). Three fifths (60%) of these trainers said they were always or often worn out at the end of the working day – a reduction of eight percentage points from 2024. This compares to 47% (↓2pp) of those working in secondary care.

Emergency medicine trainers continue to report the most negative responses, with a quarter 25% (↓3pp) finding every working hour tiring and 57% (↓2pp) highly frustrated by their work.

Figure 6: All trainers – Negative responses to individual burnout questions, 2019–2025

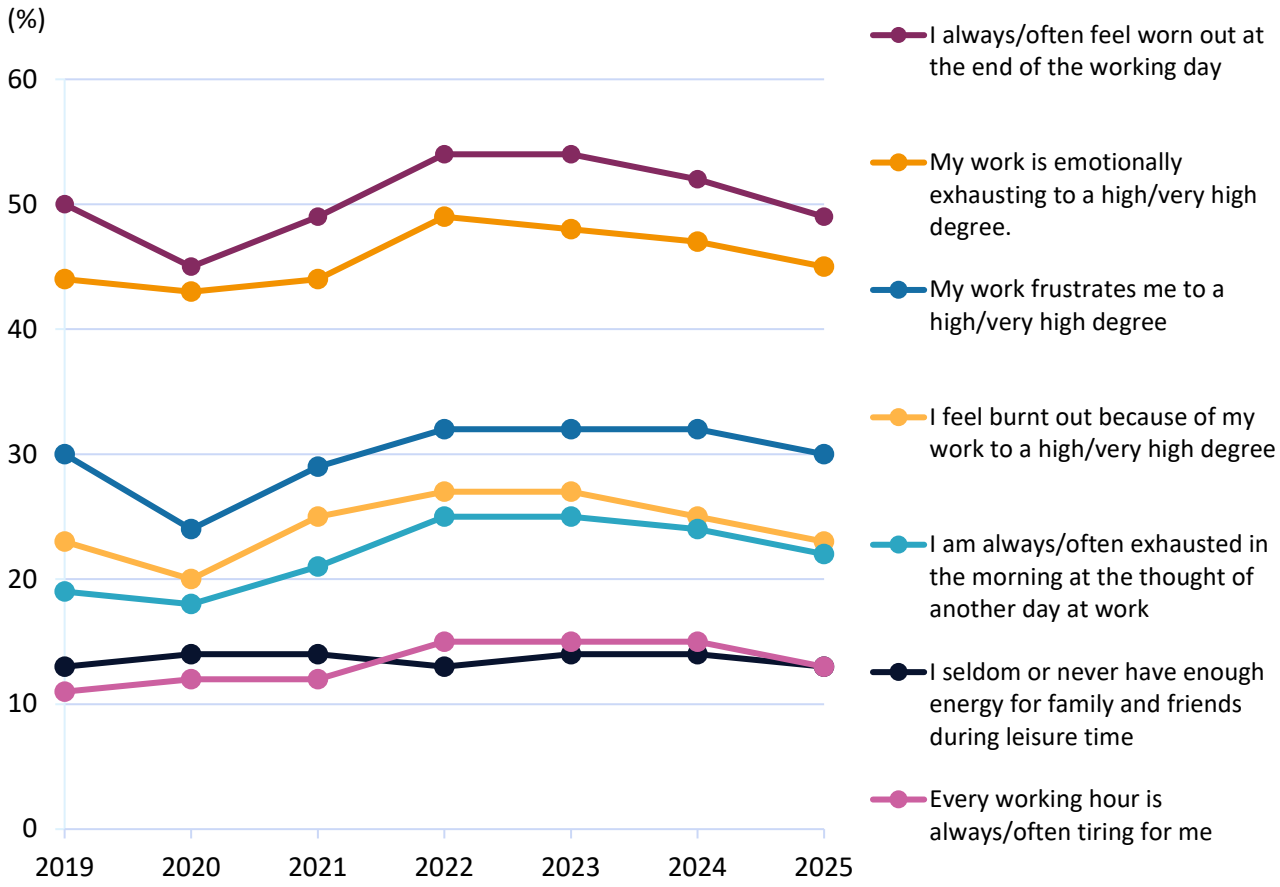
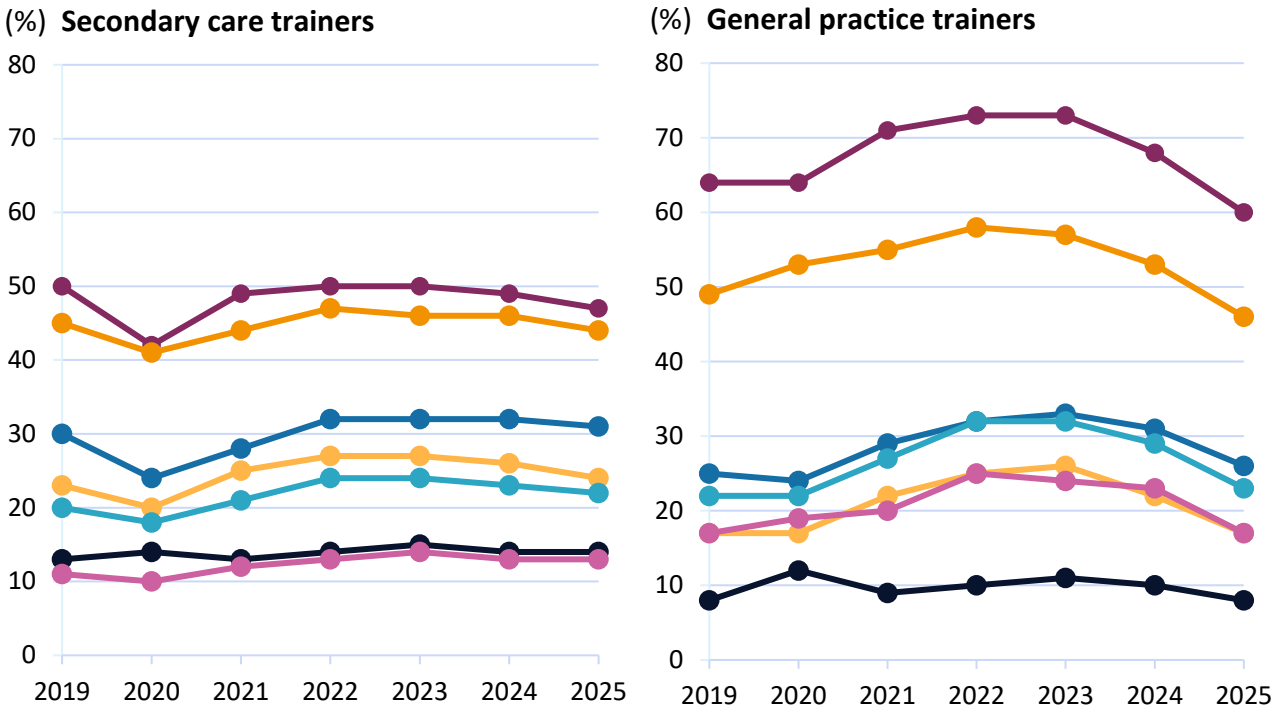


Figure 7 and 8: Negative responses to individual burnout questions, 2019–2025

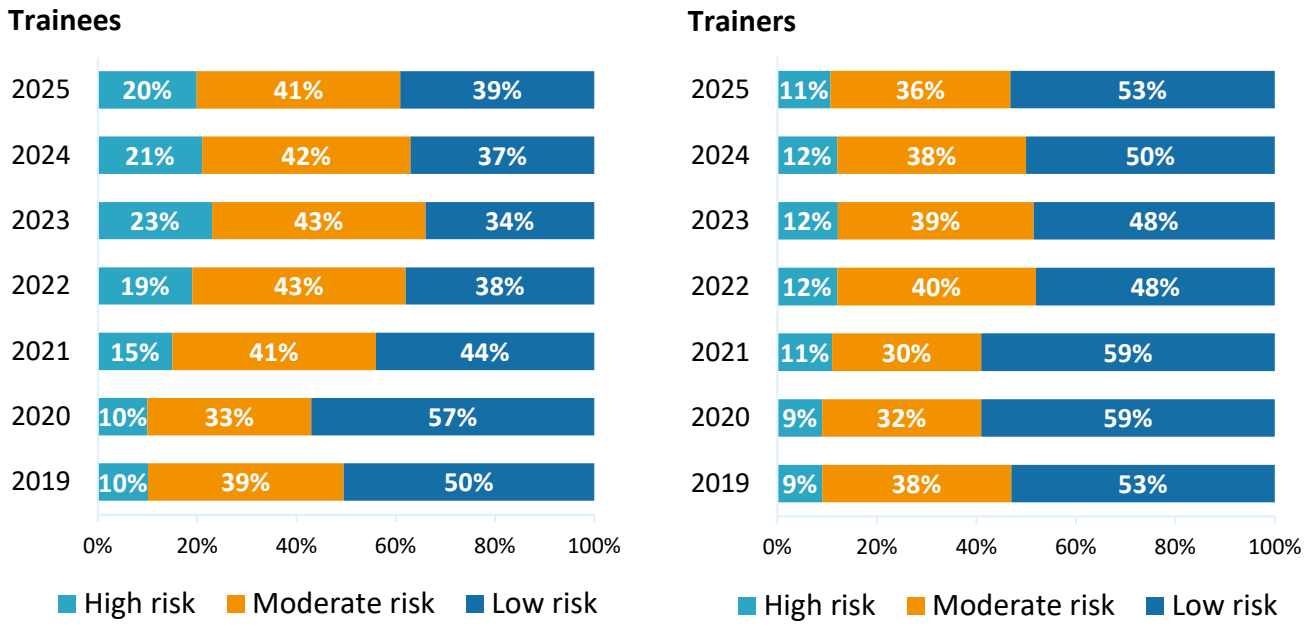


Risk of burnout

We used responses to the seven individual burnout questions to assess overall risk of burnout.

61% (↓2pp) of trainees measured to be at high or moderate risk of burnout as did 47% (↓3pp) of all trainers (Figure 9). While it's encouraging to see a reduction in these proportions since the high levels reported in 2023, it's worth noting that a fifth (20% ↓1pp) of trainees and a tenth (11% ↓1pp) of their trainers are at high risk of burnout – a substantial part of the medical workforce.

Figure 9: Trainees and trainers – Calculated risk of burnout 2019–2025



Trainees at high risk of burnout

The proportion of trainees at high risk of burnout (20% ↓1pp) has decreased for the second consecutive year, although it is double pre-pandemic levels. This reduction can be seen across all specialties (Figure 10), except for ophthalmology (15% ↑2pp). Consistent with previous years, emergency medicine (30% ↓2pp) had the largest proportion of trainees at high risk of burnout.

While all four countries of the UK saw a small decrease from 2024's results, the proportion of trainees in Northern Ireland at high risk of burnout reduced by six percentage points to 20% (Table 10).

Given the potential impact of burnout, it's important that trainees know who to contact in their trust, board or equivalent to discuss matters relating to wellbeing and occupational health. Over two-thirds (68% ↑2pp) said they did. However, a smaller percentage (55% ↑3pp) of those at high risk of burnout knew who to contact, compared to three-quarters (74% as 2024) of those at low risk.

Figure 10: Trainees – Post specialty variation at high risk of burnout, 2025 vs 2024

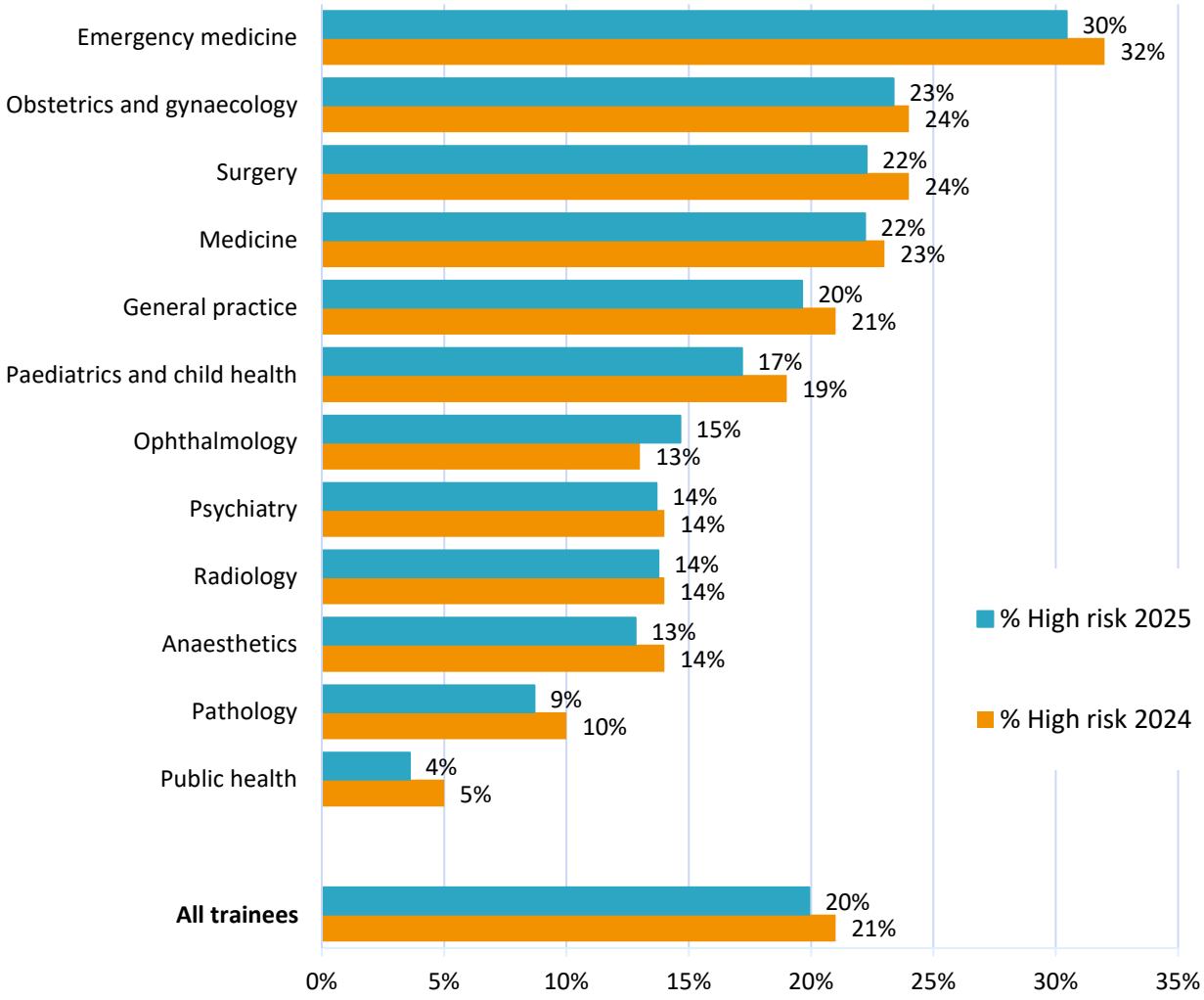


Table 10: Trainees – Calculated risk of burnout by country

Trainee country	High risk	Moderate risk	Low risk
England	20% (↓1pp)	41% (↓1pp)	39% (↑2pp)
NI	20% (↓6pp)	42% (as 2024)	38% (↑7pp)
Scotland	16% (↓2pp)	40% (↓3pp)	43% (↑3pp)
Wales	18% (↓2pp)	41% (↓1pp)	40% (↑2pp)
UK	20% (↓1pp)	41% (↓1pp)	39% (↑2pp)

Trainers at high risk of burnout

The proportion of trainers calculated to be at high risk of burnout decreased across all four countries of the UK and all specialties – except for pathology (11% ↑2pp) and public health (10% ↑1pp). General practice (11% ↓4pp) and ophthalmology (12% ↓4pp) saw the largest decline in the proportion of trainers at high risk of burnout (Figure 11 and Table 11).

Figure 11: Trainers – Specialty variation at high risk of burnout, 2025 vs 2024

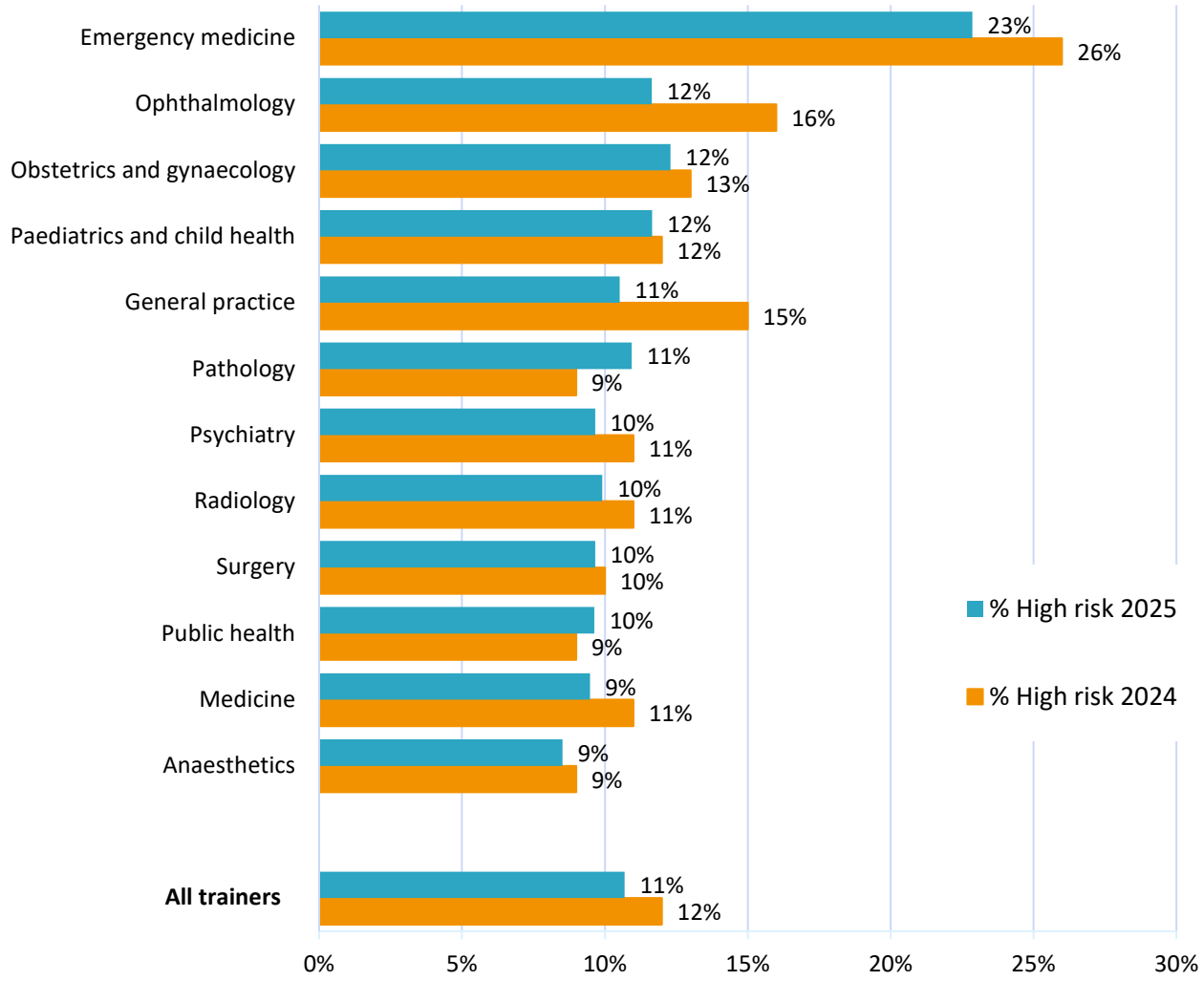


Table 11: Trainers – Calculated risk of burnout by country

Trainer country	High risk	Moderate risk	Low risk
England	11% (↓1pp)	36% (↓1pp)	54% (↑3pp)
NI	16% (↓2pp)	43% (↑2pp)	41% (as 2024)
Scotland	11% (↓1pp)	35% (↓5pp)	54% (↑6pp)
Wales	10% (↓3pp)	39% (↑2pp)	51% (↑1pp)
UK	11% (↓1pp)	36% (↓2pp)	53% (↑3pp)

Addressing burnout

The improvements in the burnout data are encouraging, but significant challenges persist. Figure 10 illustrates the intense pressures experienced in certain specialties. Notably, burnout levels in emergency medicine have remained alarmingly high, with over two out of ten trainers and three out of ten trainees consistently at high risk over the past four years.

Burnout not only severely affects individuals but also poses significant risks to patient care and safety. Addressing doctors' wellbeing requires coordinated efforts across the UK healthcare system to foster and sustain healthy workplace cultures. Enhancing working conditions and ensuring fair, inclusive environments will help retain staff, alleviate pressure, and safeguard both patients and healthcare workers.

While there may be a glimmer of cautious optimism, it's crucial to acknowledge that the proportion of trainees at high risk of burnout has doubled since 2019 – a time of relative stability before the pandemic. The data once again underscores the challenges faced by doctors and should galvanize efforts to tackle both the immediate and long-term issues confronting the profession and the healthcare system.

Supportive environments

Good medical practice emphasises that everyone deserves to work and train in fair, discrimination-free environments where they are respected and valued as individuals. Inclusive and supportive workplaces thrive on shared values and behaviours focused on patient care.

Tables 12 and 13 show that most doctors in training and their trainers feel they work in such environments. However, there's variation between specialties, consistent with previous years. For example, when asked whether incidents of rudeness and incivility amongst doctors or healthcare staff negatively affected their experience in their role, 43% (↓1pp) of trainers and 20% (↓1pp) of trainees in emergency medicine agreed, compared to 10% (↓1pp) and 7% (↑1pp) in general practice respectively. Doctors training in surgery posts were generally more negative. For example, a fifth (21% as 2024) said that staff aren't always treated fairly.

Table 12: Trainees – Supportive environment questions

Question		2021	2022	2023	2024	2025
The working environment is a fully supportive one.	Positive	81%	79%	80%	80%	**81%**
	Negative	6%	7%	7%	7%	**7%**
Staff, including doctors in training, are always treated fairly.	Positive	70%	67%	68%	68%	**69%**
	Negative	12%	15%	15%	14%	**14%**
Staff, including doctors in training, always treat each other with respect.	Positive	79%	76%	77%	77%	**77%**
	Negative	8%	10%	10%	10%	**10%**
My department/unit/practice provides a supportive environment for everyone regardless of background, beliefs, or identity.	Positive	89%	88%	88%	88%	**89%**
	Negative	3%	3%	4%	3%	**3%**

Table 13: Trainers – Supportive environment questions

SC = secondary care trainers, GP = general practice trainers

Question		2021	2022	2023	2024	2025
Staff are always treated fairly by my employer/in my practice.	Positive	72% SC 68% GP 97%	67% SC 62% GP 97%	67% SC 61% GP 97%	67% SC 61% GP 97%	**68%** **SC 63%** **GP 97%**
	Negative	10% SC 12% GP 1%	11% SC 13% GP 1%	11% SC 12% GP 1%	10% SC 12% GP 1%	**10%** **SC 12%** **GP 1%**
My employer/practice provides a supportive environment for everyone regardless of background, beliefs, or identity.	Positive	80% SC 77% GP 99%	82% SC 79% GP 98%	81% SC 78% GP 98%	82% SC 79% GP 98%	**83%** **SC 80%** **GP 98%**
	Negative	6% SC 7% GP 1%	5% SC 6% GP 0%	5% SC 6% GP 0%	5% SC 6% GP 0%	**4%** **SC 5%** **GP 0%**

Discriminatory behaviours

This year over 27,000 (55%) of doctors in training who completed the survey answered our optional questions about discrimination from colleagues and healthcare professionals. The responses were broadly similar to those in 2024 (see Table 14).

Table 14: Trainees – Discriminatory behaviours questions

In your current post how often, if at all:	Daily / Weekly	Monthly	Less than once a month	Never
do you hear insults, stereotyping or jokes in your presence on the grounds of a person's protected characteristics?*	4% (as 2024)	6% (as 2024)	16% (as 2024)	74% (as 2024)
do you experience micro-aggressions, negative comments, or oppressive body language from colleagues?	6% (↓1pp)	7% (as 2024)	15% (↓1pp)	72% (↑1pp)
are you not given the same training opportunities as your peers at the same stage of training?	7% (as 2024)	4% (as 2024)	7% (↓1pp)	82% (↑1pp)
are you ignored or excluded from conversations, groups, or meetings?	3% (as 2024)	3% (as 2024)	10% (as 2024)	84% (as 2024)
are you intentionally humiliated in front of others?	1% (as 2024)	2% (as 2024)	10% (↑1pp)	87% (↓1pp)
do you experience unwelcome sexual comments or advances causing you embarrassment, distress, or offence?	0% (↓1pp)	1% (as 2024)	5% (as 2024)	93% (as 2024)

Conducting an intersectional analysis of this set of questions and sharing the data allows us and postgraduate training organisations to gain deeper insights into trainees' unique experiences. This approach helps identify barriers to progress and address bias and discrimination. Data visibility is crucial; we can't solve problems we can't see.

* The question in full: In your current post how often, if at all do you hear insults, stereotyping or jokes in your presence on the grounds of age, race (colour, nationality, ethnic or national origin), sex, gender reassignment, disability, sexual orientation, religion or belief, marital status, or pregnancy/maternity?
There are nine 'protected characteristics' under the Equality Act 2010. They are sex, age, disability, race, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment, and marriage and civil partnership. Section 75 of the Northern Ireland Act 1998 does not refer to 'protected characteristics' but instead includes a statutory obligation on public authorities to promote equality of opportunity between: people of different religious belief, political opinion, racial group, age, marital status, or sexual orientation.

Responses to the discriminatory behaviours questions are explored in more detail below. Percentages show the total of all negative responses (daily, weekly, monthly, less than once a month) unless otherwise stated.

In your current post how often, if at all, do you hear insults, stereotyping or jokes in your presence on the grounds of age, race (colour, nationality, ethnic or national origin), sex, gender reassignment, disability, sexual orientation, religion or belief, marital status, or pregnancy/maternity?

Specialty and gender

- 28% (↓1pp) of female trainees reported hearing such comments, compared to 22% (as 2024) of male trainees.
- 41% (as 2024) of female surgery trainees and 40% (↑1pp) of female anaesthetics trainees reported these behaviours, compared to 28% (↑3pp) and 30% (↓1pp) of their male colleagues, respectively.
- Lower proportions were reported in GP trainees: 12% (↓1pp) of females and 8% (↓2pp) of males.

Ethnicity and qualification

- 28% (↓1pp) of trainees with a UK PMQ reported hearing such comments, compared to 19% (↓1pp) of those with an overseas PMQ.
- A slightly higher proportion of ethnic minority doctors with a UK PMQ (30% as 2024) reported these behaviours compared to their white peers (28% as 2024).

Sexual orientation

- 46% (↑2pp) of gay and 47% (↓4pp) of bisexual female trainees reported these behaviours, compared to 26% (↓1pp) of heterosexual female trainees.
- 36% (as 2024) of gay and 37% (↑2pp) of bisexual male trainees reported these behaviours, compared to 20% (↓1pp) of heterosexual male trainees.

Disability

- 31% (↑2pp) of male trainees with a disability reported these behaviours, compared to 21% (↓1pp) without a disability.
- 36% (↓1pp) of female trainees with a disability reported these behaviours, compared to 27% (as 2024) without a disability.

In your current post how often, if at all, do you experience micro-aggressions, negative comments, or oppressive body language from colleagues?

Ethnicity and qualification

- 31% (↓1pp) of ethnic minority trainees experienced these behaviours, compared to 25% (↓1pp) of white trainees.
- 38% (↑1pp) of black and 36% (as 2024) of Asian female doctors with a UK PMQ experienced these behaviours, compared to 29% (↓4pp) of mixed heritage and 26% (↓1pp) of their white female peers.
- 26% (↓9pp) of black and 33% (as 2024) of Asian male trainees with a UK PMQ experienced these behaviours, compared to 30% (↑5pp) of mixed heritage and 22% (↓1pp) of their white male peers.

Disability

- 36% (↓1pp) of female and 31% (↓3pp) of male trainees with a declared disability experienced these behaviours, compared to 28% (↓1pp) of female and 26% (as 2024) of male trainees without a disability.

Religion

- 30% (↓3pp) of Sikh, 32% (as 2024) of Muslim, and 31% (↓1pp) of Hindu trainees experienced these behaviours, compared to 27% (as 2024) of Christian trainees and 26% (↓1pp) of those without a faith.

Training stage

- A larger proportion of trainees in the earlier stages of their training experienced these behaviours: (37% ↓1pp) of female trainees in the first foundation year, compared to 27% (↓1pp) at ST3/CT3 and above.

In your current post how often, if at all, are you not given the same training opportunities as your peers at the same stage of training? (eg opportunity to observe an unusual case)

Specialty and gender

- Obstetrics and gynaecology: 29% (↓2pp) of female and 24% (↓3pp) of male trainees felt they were not given the same training opportunities as their peers. This compared to 21% (↓1pp) of female and 14% (↓3pp) of male anaesthetics trainees.

Ethnicity and qualification

- 22% (↑1pp) of ethnic minority trainees with a UK PMQ felt they were not given the same opportunities, compared to 16% (as 2024) of white trainees with a UK PMQ.

Religion

- 21% (↓1pp) of Muslim, 22% (↓1pp) of Hindu, and 21% (↓4pp) of Sikh trainees felt they were not given the same opportunities, compared to 18% (as 2024) of Christian trainees and 16% (as 2024) of those without a religion.

In your current post how often, if at all, are you ignored or excluded from conversations, groups, or meetings?

Specialty and gender

- Surgery: 25% (↓1pp) of female trainees and 16% (as 2024) of male trainees reported being ignored or excluded.
- Anaesthetics: 19% (as 2024) of female trainees and 15% (↓1pp) of male trainees experienced this behaviour.
- Ophthalmology: 12% (as 2024) of female trainees and 11% (↑5pp) of male trainees experienced this behaviour.

Ethnicity and qualification

- 18% (↑1pp) of ethnic minority trainees with a UK PMQ felt ignored or excluded, compared to 14% (as 2024) of white trainees with a UK PMQ.

  Breakdown of UK PMQ trainees by gender and ethnicity

  - Female trainees: 23% (↑2pp) of black, 19% (↑2pp) of mixed heritage, 19% (↑1pp) of Asian, and 16% (as 2024) of white.
  - Male trainees: 14% (as 2024) of black, 15% (↑2pp) of mixed heritage, 15% (as 2024) of Asian, and 10% (↓1pp) of white.

Religion

- 18% (as 2024) of Muslim and 17% (as 2024) of Hindu trainees reported being ignored or excluded, compared to 14% (as 2024) of Christian trainees and 15% (as 2024) of those who don’t belong to a faith.

In your current post how often, if at all, are you intentionally humiliated in front of others?

Specialty and gender

- 22% (as 2024) of female and 18% (↑2pp) of male surgery trainees experienced intentional humiliation.
- 20% (as 2024) of female and 17% (↓1pp) of male obstetrics and gynaecology trainees experienced this behaviour.

- This compares to 4% (as 2024) of female and 4% (↑1pp) of male GP trainees who reported intentional humiliation.

Ethnicity and qualification

- 17% (↑1pp) of ethnic minority trainees with a UK PMQ experienced intentional humiliation, compared to 11% (as 2024) of their white peers.

  Breakdown of UK PMQ trainees by gender and ethnicity

  - Female trainees: 20% (↑1pp) of black, 18% (↑2pp) of Asian, 14% (↑2pp) of mixed heritage and 12% (as 2024) of white.
  - Male trainees: 19% (↑6pp) of black, 14% (↓1pp) of Asian, 13% (↓1pp) of mixed heritage, and 9% (as 2024) of white.

Religion

- 15% of Sikh (as 2024), Hindu (↑1pp) and Muslim (↑1pp) trainees experienced intentional humiliation, compared to 12% of Christian trainees and those without a faith (↑1pp).

Disability

- 19% (as 2024) of female and 16% (as 2024) of male trainees with a declared disability experienced intentional humiliation compared to 13% (↑1pp) of female and 11% (as 2024) of male trainees without a disability.

In your current post how often, if at all, do you experience unwelcome sexual comments or advances causing you embarrassment, distress, or offence?

Specialty and gender

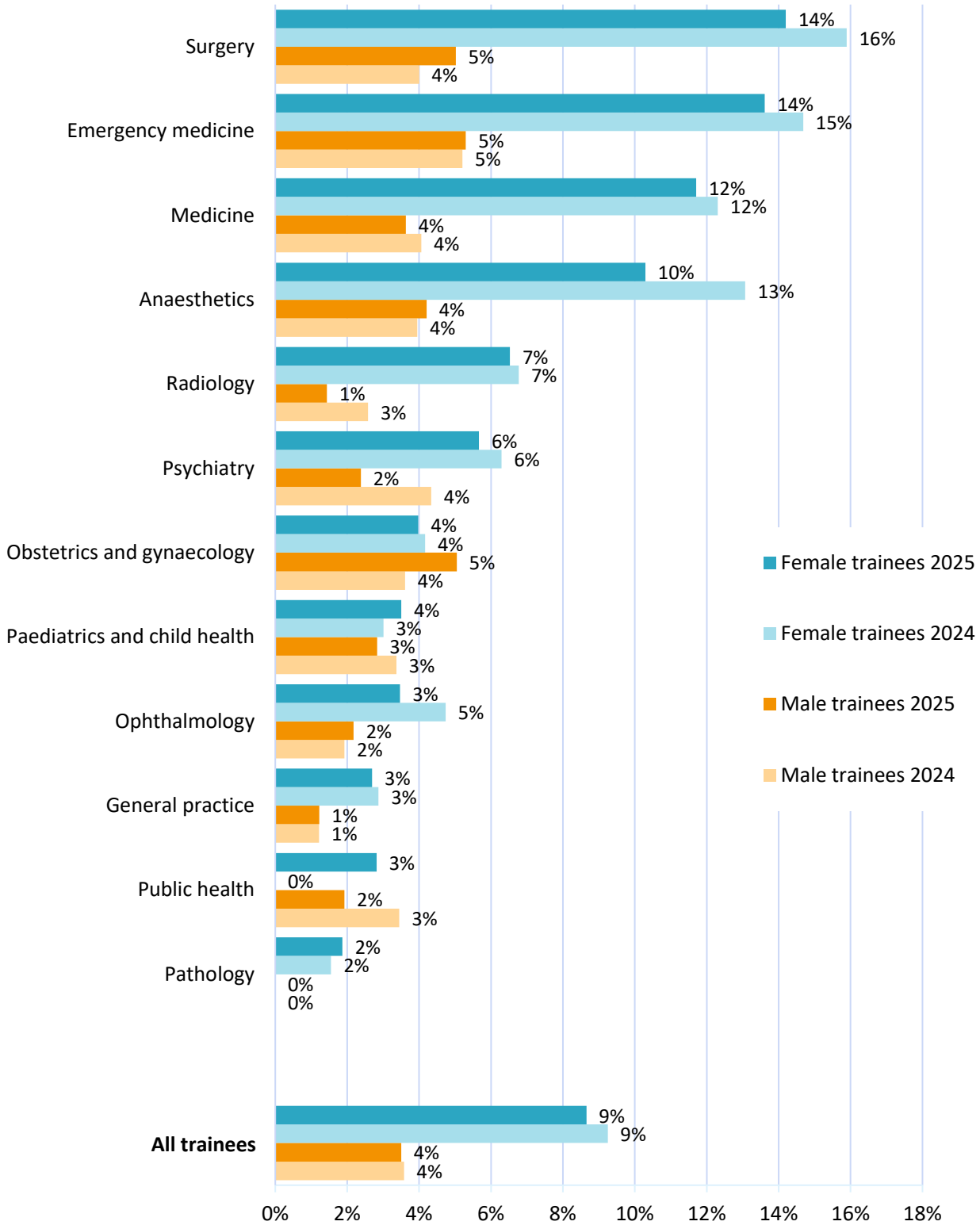
- 9% (as 2024) of female doctors in training experienced unwelcome sexual comments or advances causing embarrassment, distress, or offence, compared to 4% (as 2024) of male doctors in training.
- 14% of female surgery (↓2pp) and emergency medicine (↓1pp) trainees experienced these behaviours, compared to 3% (as 2024) of female GP trainees (see Figure 12).

Training stage

- 17% (↓1pp) of F1 and 12% (↓1pp) of F2 female doctors experienced unwelcome sexual comments or advances, compared to 5% (↓1pp) of those at higher training levels.

Figure 12: Trainees – In your current post how often, if at all, do you experience unwelcome sexual comments or advances causing you embarrassment, distress, or offence?

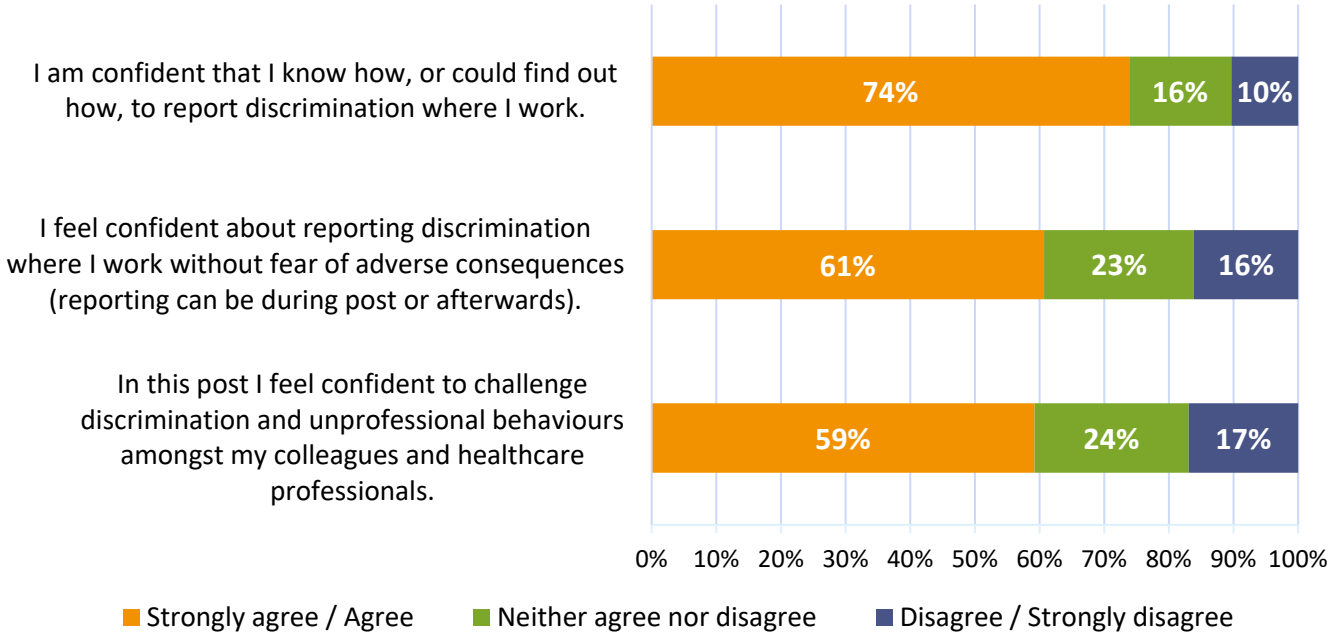
By post specialty and gender, % negative responses 2025 vs 2024



Reporting discrimination

Discrimination of any kind is unacceptable and has no place in medicine. Standard 58 in *Good medical practice* specifies the responsibility all doctors have – to themselves and their colleagues – to do something to prevent discriminatory behaviours continuing and contributing to a negative, unsafe environment. The results from our questions asking about confidence to challenge and report discrimination are similar to those in 2024 (Figure 13).

Figure 13: Trainees – Confidence in reporting discrimination



I am confident that I know how, or could find out how, to report discrimination where I work.

Specialty and gender

- 73% (↑2pp) of female trainees are confident they know how, or could find out how, to report discrimination, compared to 76% (↑1pp) of male doctors in training.
- There's some variation between specialties: 69% (↑1pp) of female surgery trainees are confident, compared to 72% (↓3pp) of male surgery trainees. 79% (↑1pp) of female GP trainees are confident, compared to 84% (↑2pp) of male GP trainees.

Ethnicity and qualification

- 69% (↑2pp) of ethnic minority trainees are confident, compared to 80% (↑1pp) of white trainees.
- 70% (↑2pp) of trainees who graduated overseas are confident, compared to 76% (↑2pp) of those with a UK PMQ.

Breakdown of UK PMQ trainees by gender and ethnicity

- Female trainees: 62% (↑4pp) of black, 73% (↑1pp) of mixed heritage, 66% (↑2pp) of Asian, and 79% (↑2pp) of white are confident. Notably, 18% (↓4pp) of black female trainees disagreed with the statement.
- Male trainees: 68% (as 2024) of black, 75% (↓1pp) of mixed heritage, 71% (↑1pp) of Asian, and 83% (↑1pp) of white are confident.

Religion

- 67% (as 2024) of Muslim trainees are confident, compared to 76% (↑2pp) of Christian trainees and 78% (↑1pp) of those who do not follow a faith.

I feel confident about reporting discrimination where I work without fear of adverse consequences (reporting can be during your post or afterwards).

Specialty and gender

- 67% (↑2pp) of male doctors in training said they feel confident about reporting discrimination without fear of adverse consequences, compared to 57% (↑1pp) of female doctors in training.
- 50% (↑1pp) of female surgery trainees said they feel confident about reporting discrimination without fear of adverse consequences, while 23% (↓3pp) disagreed. 61% (↓2pp) of male surgery trainees said they feel confident and 18% (↑23pp) disagreed.
- This compares to 69% (↑2pp) of female GP trainees and 80% (↑4pp) of male GP trainees who agreed with the statement.

Ethnicity and qualification

- 42% (↑1pp) of black, 55% (↑2pp) of mixed heritage, and 50% (↑1pp) of Asian female trainees with a UK PMQ said they feel confident, compared to 62% (↑1pp) of white female trainees.
- As in 2024, 32% of black female trainees with a UK PMQ disagreed with the statement.
- 57% (↑3pp) of black, 61% (↑1pp) of Asian, and 61% (↓5pp) of mixed heritage male trainees with a UK PMQ said they feel confident, compared to 74% (↑2pp) of white male trainees.

Religion

- 57% (as 2024) of Muslim and 55% (↓2pp) of Sikh trainees said they feel confident, while 19% (as 2024) and 21% (↑3pp) disagreed respectively.
- 63% (↑2pp) of Christian trainees and 64% (↑1pp) of those who don't follow a religion said they feel confident and 14% (as 2024) disagreed.

Disability

- 54% (↑3pp) of female and 62% (↓1pp) of male trainees with a declared disability said they feel confident. 24% (↓1pp) of females and 18% (↓1pp) of males disagreed.

- In comparison, 58% (↑1pp) of female and 68% (↑2pp) of male trainees without a disability said they feel confident.

In this post, I feel confident to challenge discrimination and unprofessional behaviours amongst my colleagues and healthcare professionals.

Specialty and gender

- As in 2024, 53% of female trainees said they feel confident to challenge discrimination and unprofessional behaviours among colleagues and healthcare professionals, compared to 68% (↑1pp) of male trainees. 20% (as 2024) of female trainees disagreed with the statement.
- 49% (↑1pp) of female trainees in obstetrics and gynaecology, and 47% (as 2024) in surgery said they feel confident to challenge discrimination, compared to 62% (↑5pp) and 65% (↓1pp) of male trainees in these specialties.

Ethnicity and qualification

- 56% (↑1pp) of trainees from an ethnic minority background said they feel confident to challenge discrimination, compared to 64% (as 2024) of white trainees.

  Breakdown of UK PMQ trainees by gender and ethnicity

  - Female trainees: 41% (↓3pp) of black, 51% (↓3pp) of mixed heritage, 46% (↓1pp) of Asian, and 58% (as 2024) of white said they feel confident.
  - Notably, 28% (↑1pp) of black and 25% (↓1pp) of Asian female trainees disagreed with the statement.
  - Male trainees: 64% (↑1pp) of black, 66% (↓3pp) of mixed heritage, 64% (↑2pp) of Asian, and 75% (↑1pp) of white said they feel confident to challenge discrimination.

Disability

- 50% (as 2024) of female and 65% (↓1pp) of male trainees with a declared disability said they feel confident to challenge discrimination, compared to 54% (as 2024) of female and 69% (↑1pp) of male trainees without a disability.

Tackling discrimination and building inclusive environments

The ethnic profile of doctors in formal postgraduate training is increasingly diverse. In 2023, almost half of doctors in training (49%) were from an ethnic minority, up from 40% in 2019.

Despite the changing demographic of the workforce, research indicates that ethnic minority UK graduates and non-UK graduates experience bias and a lack of trust from senior doctors, leading to increased anxiety and burnout. Analysis of our questions from the 2024 and 2025 surveys highlights the prevalence of unprofessional and discriminatory behaviours that some trainees encounter during training.

Understanding how doctors face multiple, overlapping forms of discrimination or disadvantage is

important, and guides our efforts to shape policies and initiatives that address specific inequalities. We'll continue to stress that discrimination in any form is unacceptable and use our insights to challenge it. Discrimination impacts not just individuals but also teamwork, communication, and collaboration. Embracing diverse perspectives, viewpoints, and experiences opens the door to positive change and enhanced decision-making.

We urge individuals and organisations to do all they can to create inclusive workplaces. This is not only the right thing to do but also essential for both attracting and retaining staff.

Insights and implications

The national training survey continues to be a vital source of insight into the state of postgraduate medical education and training across all four countries of the UK. Doctors in training and their trainers have highlighted many positive aspects, but to maintain high quality training their concerns must be addressed.

Encouragingly, burnout levels declined for the second year in a row. This positive trend underscores the importance of fostering supportive workplaces where doctors can maintain a healthy work-life balance. Environments that prioritise wellbeing are essential for retaining staff, reducing pressure, and ensuring safe, high-quality care for patients.

It's positive that, for the first time, over half of all trainers said that they were able to use the time allocated for training specifically for that purpose. However, three out of ten trainers in secondary care and over a quarter of their trainees reported training being adversely affected due to rota gaps not being dealt with appropriately. Trusts and boards must take proactive steps to remove local barriers that hinder effective training delivery.

Discriminatory behaviours remain a serious concern. Our demographic analysis shows that some doctors are not having the same training experience as their colleagues because of characteristics such as their gender, ethnicity, religion, sexual orientation or disability status. Trusts and boards must take active steps to make sure that all doctors can work free from discriminatory behaviours. Creating inclusive, fair, and supportive environments is essential for the sustainability of the UK's health services. We call on all organisations to take meaningful action, and we reaffirm our commitment to tackling inequality in medical education.

The 2025 survey data continue to highlight the disparities between different specialties, notably in the responses to our new questions about escalating a patient to a supervising clinician. Given the potential risk to patient safety, it's vital that doctors in training have access to the information and support they need to raise any concerns safely and effectively.

Over the past decade the health services have seen widespread change, alongside increasing patient demand and an aging population with increasingly complex needs. Expectations of both patients and healthcare professionals have evolved. Sustained workload pressures are driving doctors' decisions about their training and future careers. Meanwhile the makeup of the workforce is changing, and technologies are presenting fresh opportunities.

The national training survey is a window into how these developments impact those undertaking and delivering postgraduate medical training. Its findings add to the growing evidence for change.

Tackling these challenges and capitalising on new opportunities requires coordinated action across the healthcare system. For our part, we're working with stakeholders across the UK to develop a new education framework that promotes flexible, fair, and innovative learning. To support this, we'll seek the views of trainees, trainers, and patients as we review and update the standards and guidance that underpin medical education, helping to improve outcomes for all.

In addition, we'll continue sharing data and insights with workforce planners, employers, and policymakers, to make sure that the voices of trainees and trainers are heard. Only through collaboration can we adapt to change and secure the future of safe, high-quality patient care.

Survey development

Each year we review the survey to make sure that the questions remain relevant and deliver the data we need to quality assure postgraduate medical training. Any changes are the result of our ongoing engagement with doctors, medical educators, representative organisations, and employers.

After completing the survey, we invite doctors to help us develop and test proposed changes for future years. If you'd like to get involved, we'd value your input. Please email nts@gmc-uk.org.

Our data

Percentages in all tables and charts are rounded and may not add up to 100. The analysis in this report excludes 'not applicable' responses when appropriate.

Terminology

The terms doctor in training and trainee have been used interchangeably in this report to describe qualified doctors who are engaged in postgraduate medical training. We haven't used the term resident doctor as this can also refer to postgraduates in a non-training post.

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You are welcome to contact us in Welsh. We will respond in Welsh, without this causing additional delay.

Mae croeso i chi gysylltu â ni yn Gymraeg. Byddwn yn ymateb yn Gymraeg, heb i hyn achosi oedi ychwanegol.

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