General Medical Council

Regulating doctors
Ensuring good medical practice

National training survey 2013: concerns about patient safety

Since 2012, we have asked doctors in training if they have a concern about patient safety in their workplace. This report summarises the types of concerns that doctors in training raised in 2013, the themes that emerged across those concerns and the areas of practice where concerns are most likely to occur.

- The public profile of patient safety has risen in the light of the Francis Inquiry (among others) and this is reflected with a small rise in concerns raised in this year's national training survey.
- Doctors nearer the beginning of their training are more likely to raise concerns, as are doctors whose primary medical qualification is from the UK.
- More than half of the concerns raised relate to lack of staffing or resources.
- We believe that doctors in training should raise their concerns through local channels where possible; however, the survey remains an important mechanism for raising concerns.
- We strongly support openness and transparency and we take very seriously that doctors in training should be able to raise their concerns without fear of disadvantage or reprisal.

Introduction

Since the first national training survey in 2005, doctors in training have raised concerns about patient safety. Before 2012, these concerns were raised in a generic comments section, which meant that we had to review and categorise general comments before we could appropriately address the specific patient safety concerns.

In 2012, we introduced specific patient safety questions to help us identify concerns immediately. This meant that we were able to share patient safety concerns with postgraduate deaneries and local education and training boards (LETBs) while the survey was still open, or soon after it had closed.

For the 2013 national training survey, we categorised patient safety concerns in greater detail than ever before. This means that, for the first time, we can give an overview of the types of patient safety concerns raised and who raised them.

Results of patient safety concerns from the 2013 survey

- 2,746 survey respondents (5.2%)* raised a concern about patient safety in 2013, compared with 2,444 (4.7%) in 2012.
- A further 5,863 (11.1%) said that they did have a concern, but that it had been addressed.
- 44,016 (83.5%) did not have a concern about patient safety.

This was the first year that doctors in training could tell us that they had been concerned, but that their concerns had been addressed. The number of doctors who stated they had been concerned, but their concern had been addressed was more than double the number who had raised concerns that were still outstanding, which could indicate that local systems are getting better at dealing with concerns.

Of the 2,746 doctors with outstanding concerns, 68.6% had already reported their concern: 1,573 to their employer, 303 to their deanery, 28 to the General Medical Council (GMC), and 171 to another body. This shows that, generally, concerns are raised locally, but more doctors in training need to be made aware of those channels and encouraged to use them.

We found that the longer a problem goes on, the more likely it is to be raised. Of those with outstanding concerns:

- 451 had first become concerned within the last month
- 950 had first become concerned over a month ago, but less than three months ago
- 1,345 had first become concerned over three months ago.

Of the 1,345 doctors with the oldest concerns, 1,151 had raised their concerns previously: 826 to employers, 203 to deaneries, 102 to another body, and 20 to the GMC. The concerns have been given to the postgraduate deaneries and LETBs who report to the GMC on the action taken. The dean's reports will be published on our website in early 2014.

Who raises concerns?

Doctors who are nearer the start of their training are much more likely to raise concerns than those in the later stages of training: 8.7% of doctors (627 of 7,231) in the first year of foundation training (F1) versus 2.8% (21 of 741) in the eighth year of specialty training (ST8). Similarly, doctors who are nearer to the start of a specialty or GP training programme are more likely to raise concerns than those nearer to the end of the programme.

These figures reinforce Robert Francis QC's suggestion that doctors in training are 'not likely to be immediately infected by any unhealthy local culture'.† His suggestion is further supported by the fact that doctors training in a post that is not their main specialty are far more likely to raise a concern: 7.0% of doctors (2,068 of 29,693) working outside their main specialty, compared with 2.9% (678 of 22,993) working in their main specialty.

Doctors in foundation and core training posts will always work outside their main specialty because of the rotational nature of their programme. But the point stands that they bring a fresh pair of eyes to a healthcare setting.

Female doctors are slightly more likely to raise concerns than male doctors: 5.3% (1,522 of 28,972) versus 5.2% (1,224 of 23,714).

When grouping doctors in training by royal college (post specialty),‡ those in emergency medicine posts are the most likely to raise a patient safety concern (9.5%), whereas doctors training as GPs (0.4%) or pathologists (1.6%) are highly unlikely to raise concerns (figure 1). Doctors training as physicians (8.4%) are more likely to raise concerns than those training as surgeons (6.2%), anaesthetists (3.9%), psychiatrists (3.2%) and paediatricians (2.6%).

* All percentages and scores in this report have been rounded to one decimal place.

† Mid Staffordshire Foundation Trust Public Inquiry (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* volume 2, chapter 18, paragraph 228, available at: www.midstaffspublicinquiry.com (accessed 9 September 2013).

‡ 'Post specialty' in this context means the specialty of the post the doctor is rotating through, rather than the specialty of their training programme generally. For example, a doctor training to be a GP might be in an emergency medicine post; emergency medicine would be their post specialty, general practice would be their programme specialty.

Figure 1: Specialty training post of doctors who raised a patient safety concern

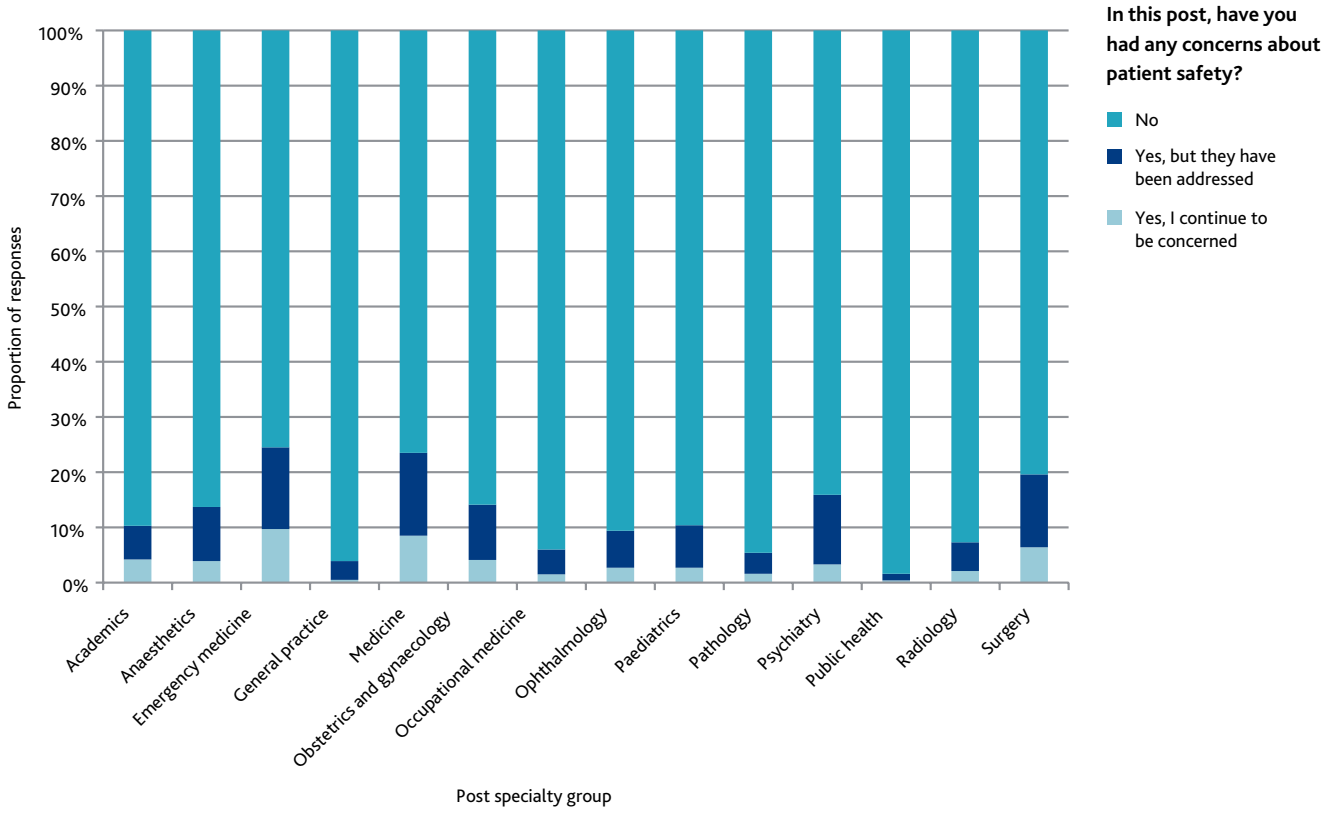


Figure 1 shows the percentage of respondents in each specialty group who have an outstanding patient safety concern. It also shows those who have previously had a concern that has since been dealt with.

It doesn't, however, show the impact of specialty culture on the likelihood of raising a concern. The difference between the likelihood of raising concerns among different specialties is complicated – different departments deal with different types of risk, which can lead to variable risk tolerance cultures across specialty types.

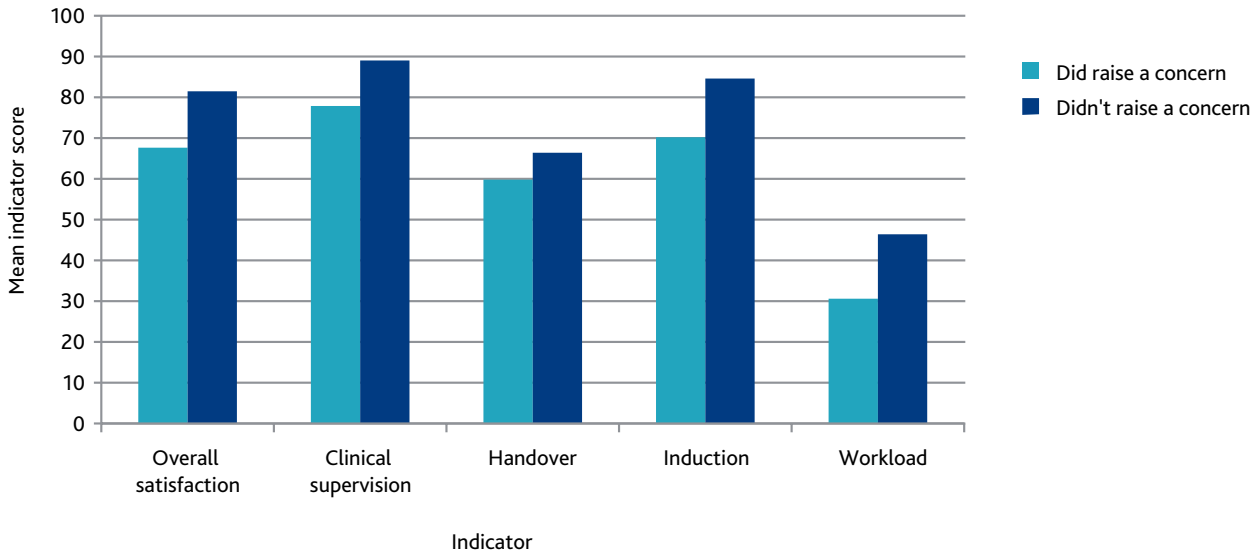
Perhaps counter-intuitively, doctors training across multiple sites are less likely than those at a single site to raise a concern.

- 4.1% of 17,725 multiple-site doctors in training raised a concern.
- 5.8% of 34,961 single-site doctors in training raised a concern.

It might be expected that doctors training at multiple sites would be more likely to have problems with supervision. Our analysis of the survey results shows that problems with supervision correlate with the number of concerns that are raised. This could be because doctors training at multiple sites are less likely to raise a concern as they have less exposure to the problems in each of their sites.

Similar to the 2012 national training survey, doctors with a primary medical qualification from the UK (5.8% of 42,282) were more likely to raise concerns than those with a primary medical qualification from the European Economic Area (4.0% of 1,940) or the rest of the world (2.4% of 8,464). This could be because of a number of factors, such as familiarity with reporting mechanisms, confidence that there won't be disadvantage and a different culture of reporting concerns.

Figure 2: How key indicator scores are affected when concerns are raised



Unsurprisingly, indicator scores from respondents who raised a patient safety concern were lower than scores from those who didn't raise a concern, particularly overall satisfaction (67.6 compared with 81.5), and clinical supervision (77.9 compared with 89.0) (figure 2).

Other indicators showing low scores from respondents raising concerns are handover (59.8 compared with 66.4), induction (70.2 compared with 84.6) and workload (30.6 compared with 46.4). These comparisons are helpful because they validate the survey indicators, but also underline the themes arising from the analysis of the comments themselves.

In which specialties are concerns being raised?

As with the 2012 survey, there is a large concentration of patient safety concerns in acute, hospital-based, medical specialties (such as, acute medicine, geriatric medicine, endocrinology and diabetes mellitus, respiratory medicine, or general (internal) medicine).

Perhaps not surprisingly, concerns raised by doctors training in emergency medicine posts have increased since 2012 (from 204 to 287). This reflects a general and national concern about service pressures in emergency medicine departments.

Between December 2012 and February 2013, we completed checks (short, targeted visits) to seven local education providers in England and Jersey to review the delivery of training in emergency medicine.*

Training doctors to care for acutely ill patients is a particular focus of the Shape of Training review, and bearing in mind the government's view that the 'crisis in emergency care will likely deepen',† one of the themes that emerges is that there should be a shift towards a broader approach to training within specialties. One of the benefits of broad based training would be to create doctors who are able to provide general specialty care including acute care relevant to those specialties. This should help ease the pressure on doctors training in these areas by spreading the workload across more of the medical workforce.

* General Medical Council (2013) *Emergency Medicine Checks* available at: www.gmc-uk.org/education/23174.asp (accessed 10 October 2013).

† Shape of Training (2013) *Securing the future of excellent patient care* paragraph 102, available at: www.shapeoftraining.co.uk/reviewsofar/1788.asp (accessed 6 November 2013).

Underpinning broad based training will be the need to ensure that doctors have the full range of professional skills which are integral to ensuring patient safety. In this context, our core guidance for doctors, *Good medical practice*, sets out what is expected of doctors, including communication and working in partnership with patients. We are examining how these and other professional skills – or generic professional capabilities – can be better reflected and integrated in all postgraduate training.

Very few concerns were raised in GP practices (25 of 5,989 respondents) or pathology labs (11 of 686).

All 11 trusts placed into 'special measures' by Bruce Keogh* have a higher-than-average proportion of doctors in training who raised concerns in 2013 (ranging from 5.2% to 21.9%). This pattern broadly reflects the some of the problems across the service, which have been reflected in the media and shows that the issues are being focused on.

The same figures for the 18 trusts being inspected by Mike Richards† are less conclusive (ranging from 1.1% to 11.8% across high risk, low risk and various risk points trusts). However, the model for selecting these trusts for inspection is based on a large range of outcomes and data, showing that our national training survey should not be solely depended on for catching all patient safety concerns.

Working with trusts and health boards to address concerns of doctors in training

In July 2013, a postgraduate dean asked us to accompany his team on a visit to a busy emergency department in a large hospital. This was triggered by a number of immediate patient safety concerns, which had been raised in the 2013 national training survey. There had also been a significant increase in negative survey outcomes (red flags), as well as evidence that highlighted concerns from routine deanery quality management processes.

We visited in early August and found that the unit was under-staffed, which was having a significant impact on the clinical and educational supervision of the doctors in training. There was variable middle grade cover (mostly by locums), and departmental inductions were unsatisfactory.

The hospital responded very positively to the problems raised, allocating money to recruit permanent staff. The hospital immediately appointed extra locum consultants and clinical fellows to provide short-term support, but acknowledged that over-reliance on locums is not sustainable. It has therefore advertised a number of substantive consultant posts to replace these.

We visited again in late September and found that the problems had significantly reduced. Meetings with doctors in training were very positive – they told us they were much happier with rota arrangements, they had received a comprehensive induction, and that there was now clear leadership around the management of patients during busy periods.

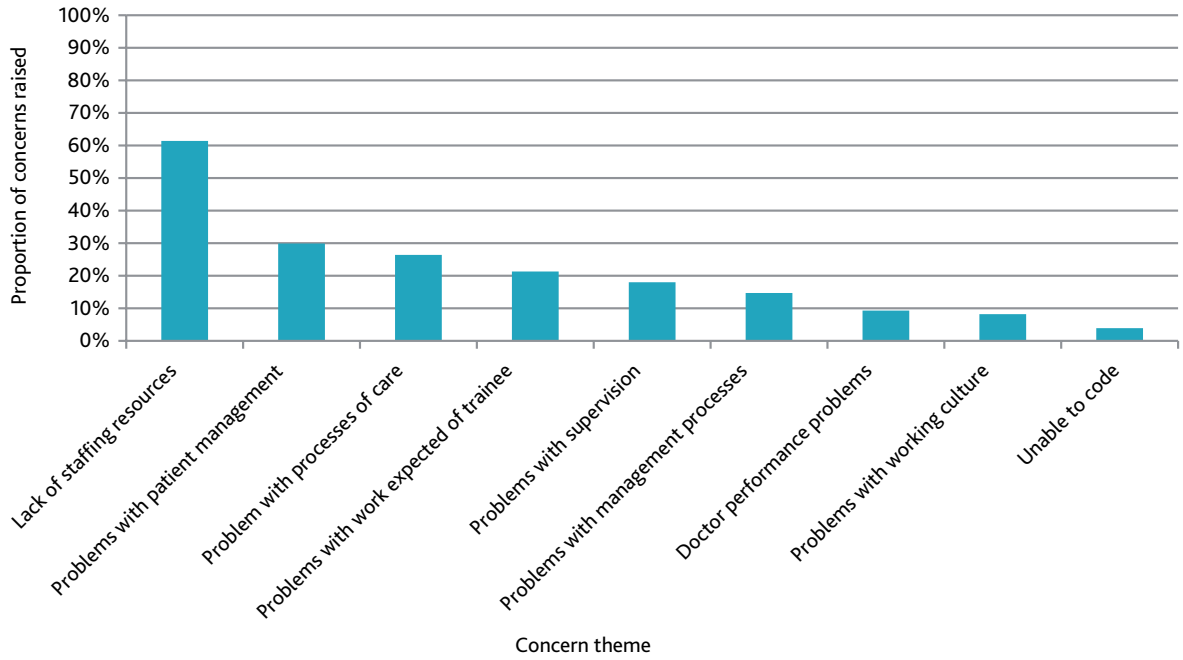
Clear roles were now allocated, appropriate to the experience of the doctors in training. It was evident that the hospital had invested considerable effort and finances to improve the quality of training and education.

We will visit again before early 2014 to check that the improvements are continuing.

* See www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx (accessed 9 October 2013).

† See www.cqc.org.uk/public/news/prof-sir-mike-richards-chief-inspector-hospitals-announces-our-inspection-plans.

Figure 3: Themes in patient safety concerns



Concerns could be coded to more than one category, so total percentages may not equal 100%.

What are the concerns about?

More than half of patient safety concerns raised by doctors in training relate to a lack of staffing or resources (61.4%), and significantly high numbers are related to problems with patient management (29.9%) or problems with the processes of care (26.4%) (figure 3).

This largely reflects the wider problems caused by service and economic pressures. However, because they tend to relate to general pressures, rather than specific incidents, this pattern might show us that local systems are reasonably good at handling isolated incidents.

Problems with work expected of the doctors in training (21.3%), and problems with supervision (18%), further reflect economic and service challenges, but could also indicate issues with training culture and time available for training. Over the next few years, we'll conduct a national survey of trainers to gather their views on these challenges.

Furthermore, a significant percentage of issues raised through our responses to concerns process* in 2012–13 related to problems with supervision. We will publish further information from this process in the coming months, and will help local organisations to respond to the concerns.

Smaller, but still significant, are the numbers of concerns raised relating to problems with management processes (14.7%).

Smaller still are the numbers of concerns relating to problems with doctor performance (9.3%) and problems with working culture (8.2%).

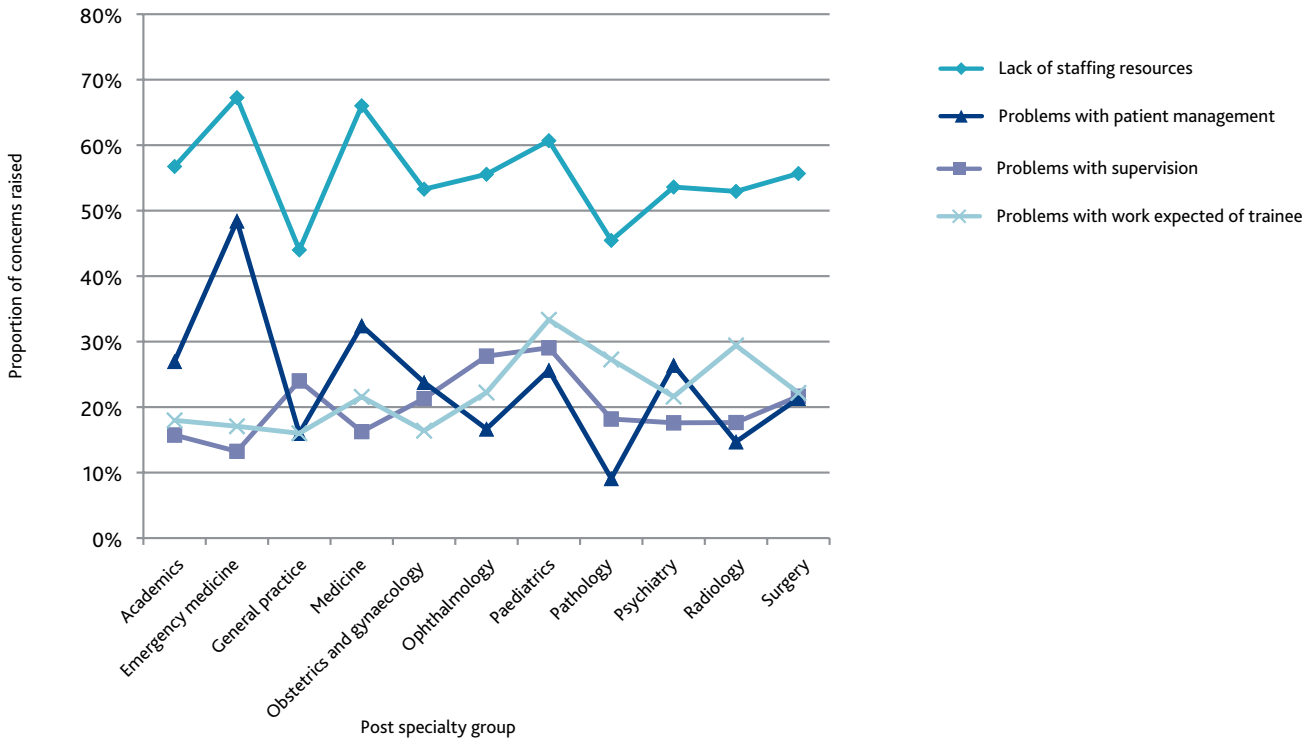
When we look at the specialties with the highest proportion of concerns within each theme, again, there are few surprises. Emergency medicine has the highest proportion of concerns about problems with patient management. Obstetrics and gynaecology has a high proportion of concerns about problems with working culture, which could link to their well-documented challenges with undermining across the specialty.† Paediatrics shows a significantly higher percentage of concerns with workload.

Figure 4 shows the most common themes across the specialties (grouped by college). The percentage shows the concerns raised within that theme. Each concern raised could have multiple themes.

* See www.gmc-uk.org/education/process.asp.

† See www.rcog.org.uk/news/rcogrcm-press-announcement-royal-colleges-jointly-address-issue-undermining-and-bullying-workpl.

Figure 4: Common themes by college group



Working with postgraduate deaneries and LETBs to address concerns of doctors in training

Our visit to the renal department of a large general hospital was triggered by a significant increase of significantly below-average scores in the 2013 national training survey. This led to concerns about staffing levels, rota issues and workload.

Evidence gathered through other channels suggested that a high number of doctors in training were being released from this department to academic out-of-programme experiences (OOPE), leading to problems with service delivery, education and training.

The visit found issues with induction in the department, problems with time allowed for training, problems associated with having two separate IT systems, and problems with consultants' time being stretched across a variety of professional activities.

Specifically, there were two different dialysis systems across two different wards, which meant that patients had to move between them. This meant there was a risk of problems relating to infection control if records were mixed up.

Following our visit, the Associate Postgraduate Dean has made several recommendations, including a review of the OOPE approval process, introducing protected time for dialysis unit experience and increasing consultant presence on the ward.

Some of these recommendations have already been implemented, and the department is due to give a progress report by the end of November. We will continue to monitor the department.

The role of the national training survey in identifying patient safety concerns

Our national training survey plays a key role in alerting us to possible patient safety issues. When a survey containing a patient safety concern is submitted, it is flagged on our system, allowing us to review it straight away.

For the 2013 national training survey, respondents were asked five questions about patient safety.

- Whether they had any concerns about patient safety.
- To give a description of their concern.
- To identify the trust or site where the concern applies.
- Who the concern has been reported to.
- When the concern first arose.

Our team of medical experts read and categorise each concern raised, first deciding whether or not the concern is 'immediate'. Immediate concerns were shared with the relevant deanery or local education and training board (LETB) within the same day. Concerns that are not immediate are packaged up with other supporting information shortly after the survey closes and shared with the relevant deanery or LETB.

An immediate concern is one that:

- describes actual harm, a near miss or continuing inadequate supervision
- is a first person account, not hearsay
- specifies a location, such as a ward or department in an identifiable hospital or other setting
- gives a clear description of a problem that could lead to a risk to patient safety.

Once the concerns have been passed on to deaneries and LETBs, they liaise with colleagues at the healthcare provider to investigate the concern. They also publish the provider's response in their dean's report.

In many cases, a number of concerns are raised about the same department, or the same concern is raised multiple times. In these cases deaneries and LETBs will investigate the whole range of concerns so that resources aren't wasted.

Many concerns raised in the survey are already known to deaneries, LETBs and local education providers through other channels of quality management. However, 37% of concerns raised in 2012 were new or not already known, falling to 28% in 2013. This decrease tells us following last year's process, deaneries, LETBs and local education providers are getting better at promoting methods for raising concerns. But new or unknown concerns continue to be raised, showing that the national training survey is still an important way for doctors in training to raise concerns and a valuable source of information about the training environment.

Increasing the efficiency of our survey

We are keen to reduce the impact that this process has on the workloads of deaneries, LETBs and local training providers. For the 2013 national training survey, we aimed to avoid the duplication of concerns by including an additional question, asking if doctors in training remained concerned about the issue they had raised.

In early 2013, we met with representatives from deaneries, LETBs, royal colleges and faculties, local education providers and groups of doctors in training, to get their feedback on the process of the 2012 national training survey. We will continue to liaise with them to improve the processes of future surveys.

Ahead of the 2014 national training survey, we aim to improve the clarity of patient safety concerns that are raised. While it's important that doctors in training have the opportunity to raise concerns, we need to improve their awareness of the process, to help them give information we can use.

Currently, some comments from doctors in training are too general (for example, 'long waiting times') – neither we nor the employers can act on concerns like this. We plan to improve our guidance for the survey and will speak to groups of doctors in training to help us understand how we can help respondents to give a clear description of their concern.

How we encourage openness and protect confidentiality

The Francis Inquiry report recommended that we take steps 'to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.'*

As standard practice, we do not share the identity of the respondent who raised the concern. And we have generally advised deaneries and LETBs that their focus should be on the investigation of the issue raised, rather than the identity of the respondent. However, we do share the department they are working in, and their specialty.

In some cases, this information could identify the respondent. In these cases, deaneries and LETBs do still need to ask us for permission to contact respondents directly if they required more information to investigate the concern. In our national training survey, we tell respondents that we can't guarantee anonymity when they raise a patient safety concern, because the interests of patients must come first. However, we take any incidents where doctors in training are confronted about their concerns very seriously.

In our standards for medical education and training, *The Trainee Doctor*,† we state:

Trainees must have full opportunity to raise, individually or collectively, matters of proper concern to the deanery without fear of disadvantage and in the knowledge that privacy and confidentiality will be respected. Standard 2.1

As such, we support openness and want to make sure that doctors in training can raise concerns without fear of reprisal. In the very small number of cases reported to us in 2013 where doctors in training had been confronted about their survey responses, we dealt swiftly and firmly with the individuals responsible and will continue to do so. We consider this to be a matter of probity and will not tolerate behaviour intended to intimidate or discourage openness and transparency. Furthermore, we are working with deaneries and LETBs to support their processes for handling these concerns, which will help reduce the likelihood of unnecessary identity disclosure in the future.

How patient safety has risen in the public consciousness

Since our 2012 national training survey, the public profile of patient safety has grown across the UK. The 2013 restructure of NHS England and the Francis Inquiry into the events at Mid Staffordshire NHS Foundation Trust, among other things, have attracted public and media scrutiny into the safety of patients. In Scotland, the public inquiry into deaths and illness at the Vale of Leven Hospital‡ and the improvements being made by the Scottish Patient Safety Programme, coordinated by Healthcare Improvement Scotland,§ have added to the discussion.

The Welsh Government's acknowledgement that the Francis Inquiry contained valid lessons for Wales saw a renewed commitment to the publication of NHS performance data. This culminated in a new website allowing public access to performance and safety indicators for the first time.

Both Scotland and Wales launched new whistleblowing policies in light of the Francis Inquiry. In Northern Ireland, consideration is being given to any lessons from the Mid-Staffordshire inquiry that

* Mid Staffordshire Foundation Trust Public Inquiry (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* volume 2, recommendation 160, available at: www.midstaffspublicinquiry.com (accessed 9 October 2013).

† General Medical Council (2011) *The Trainee Doctor* London, GMC, available at www.gmc-uk.org/education/postgraduate/standards_and_guidance.asp (accessed 10 October 2013).

‡ See www.valeoflevenhospitalinquiry.org.

§ See www.scottishpatientsafetyprogramme.scot.nhs.uk/programme.

may be applicable locally, alongside the Department of Health, Social Services and Public Safety's ten-year *Quality 2020* strategy. The inquiry into hypernatremia-related deaths may lead to further patient safety actions being taken forward in Northern Ireland when it is published in 2014.

The Francis Inquiry report has a particular focus on the mechanisms for reporting concerns, suggesting that doctors in training are the 'invaluable eyes and ears in a hospital setting'.*

The report also says that doctors in training, being relatively new to a department, are more likely than established staff to perceive unacceptable practices. Our analysis supports this, showing that doctors newer to a department (ie, in the lower grades of a programme, such as F1, CT1 or ST3) are far more likely to raise a patient safety concern than those in higher grades.

The Francis Inquiry report calls our inclusion of patient safety questions in the national training survey an encouraging step, and says that gathering concerns needs to be maximised through surveys. The report recommends that surveys should be developed to 'optimise them as a source of feedback of the perceptions of the standards of care'.†

We believe that doctors in training should raise their concerns through local channels where possible, and that our national training survey is a last resort for raising a concern when all other channels have been exhausted. However, nearly a third of doctors in training who raised a concern in our 2013 national training survey said they had not reported their concern elsewhere (31.4%, n=862).

We will continue to give doctors in training the chance to raise concerns through our national training survey. But we also want to improve the way we handle patient safety concerns, by passing on our analysis to organisations who can use it to improve patient care.

Next steps

This year's national training survey revealed no particular surprises regarding patient safety concerns. The figures are broadly the same as those from the 2012 survey and generally reflect what we know from other sources of evidence.

However, the concerns raised remain important. Local systems are still the fastest and most effective route to dealing with local problems, but only two thirds of respondents who raised a concern said that they had also raised their concern locally. We need to understand why this is. We will be working with deaneries, LETBs and doctors in training over the coming year to gather information on this issue.

Historically, the survey has shown us that, even where local channels are good, respondents still want to raise concerns directly with us. Therefore, we'll continue to offer this facility.

We understand that there is room to improve the process for handling patient safety concerns, to make it more straight-forward and less labour intensive for all concerned.

Local education providers and employers are quick at responding to patient safety concerns that are raised with them through our quality management systems. But we know that improvements to our processes, and the processes of deaneries and or LETBs, could help to ease the pressure on local systems in future years.

We will continue to work with groups who have an interest in patient safety, to improve to the process further, to reduce duplication of effort and to improve the anonymity of survey respondents where possible.

* Mid Staffordshire Foundation Trust Public Inquiry (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* volume 2, recommendation 159, available at: www.midstaffspublicinquiry.com (accessed 10 October 2013).

† See www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx (accessed 9 October 2013).

Other resources for doctors raising concerns about patient safety

In 2012, we published guidance on *Raising and acting on concerns about patient safety*. We know that doctors face challenges in this area and this guidance describes the steps that we would expect a doctor to take to raise a concern. It places a duty on all doctors to act when they believe that the safety of patients is at risk, or that the care or dignity of patients is being compromised.

The guidance is intended to support doctors to meet their professional obligations to patients and to help and support them in raising concerns about patient safety and care.

Even though the law protects against victimisation when a doctor raises a concern, we understand it's not always easy to speak out, particularly for doctors in training. Often, they are worried about the implications of raising a patient safety concern, whether it is about policies and procedures or about a colleague.

We have also launched a confidential helpline, for doctors to raise patient safety concerns if they don't feel able to do so locally. It is staffed by specially-trained advisers who can discuss concerns and give advice on who to speak to if, for example, the concern isn't about another doctor.

The number for our confidential helpline is 0161 923 6399.

We have also developed online tools to help when a doctor is faced with a concern about patient safety.

Our online raising concerns decision tool is designed to guide doctors through the process of raising patient safety concerns. It sets out what they will need to do if worried about issues including how colleagues have behaved, policies and procedures. You can find the raising concerns decision tool at: **www.gmc-uk.org/guidance/ethical_guidance/decision_tool.asp**.

Annex – frequency charts

Figure 5: Concerns by deanery

Deanery	Concerns	Respondents	Proportion
Severn Deanery	147	1983	7.4%
Wales Deanery	160	2237	7.2%
NHS Education for Scotland (East Region)	33	499	6.6%
Kent, Surrey and Sussex Deanery	199	3285	6.1%
Oxford Deanery	107	1769	6.0%
South West Peninsula Deanery	81	1361	6.0%
East of England Multi-Professional Deanery	180	3149	5.7%
Wessex Deanery	112	2005	5.6%
NHS West Midlands Workforce Deanery	241	4479	5.4%
Yorkshire and the Humber Postgraduate Deanery	245	4709	5.2%
NHS Education for Scotland (West Region)	129	2502	5.2%
Northern Ireland Medical & Dental Training Agency	84	1651	5.1%
Mersey Deanery	113	2318	4.9%
North Western Deanery	172	3530	4.9%
East Midlands Healthcare Workforce Deanery	142	3039	4.7%
London Deanery	441	9616	4.6%
NHS Education for Scotland (South-East Region)	46	1199	3.8%
NHS Education for Scotland (North Region)	26	713	3.6%
Northern Deanery	86	2532	3.4%
Defence Postgraduate Medical Deanery	2	110	1.8%
Overall	**2746**	**52686**	**5.2%**

In April 2013 postgraduate deaneries in England were replaced with local education and training boards (LETBs) and some of the geographic boundaries have changed.

Figure 6: Concerns by training level

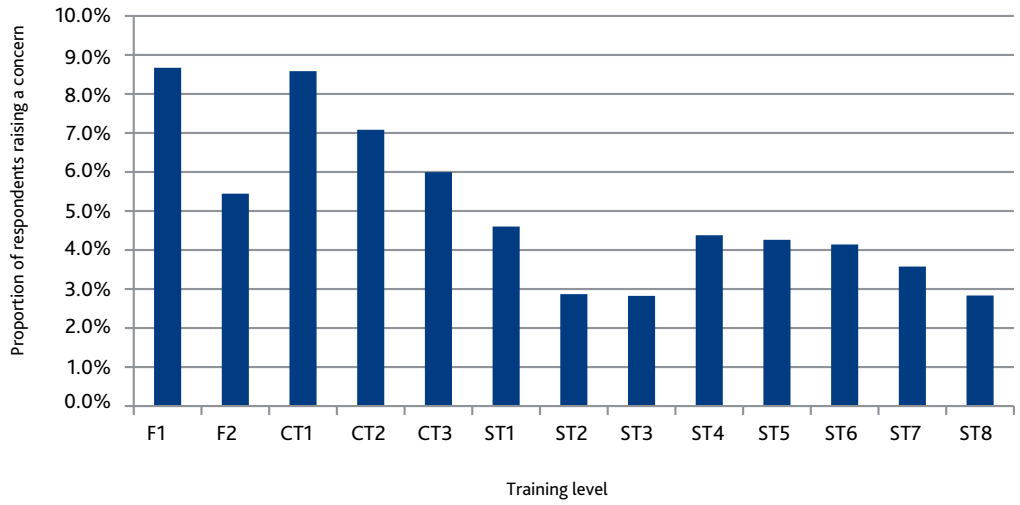


Figure 7: Concerns by place of primary medical qualification

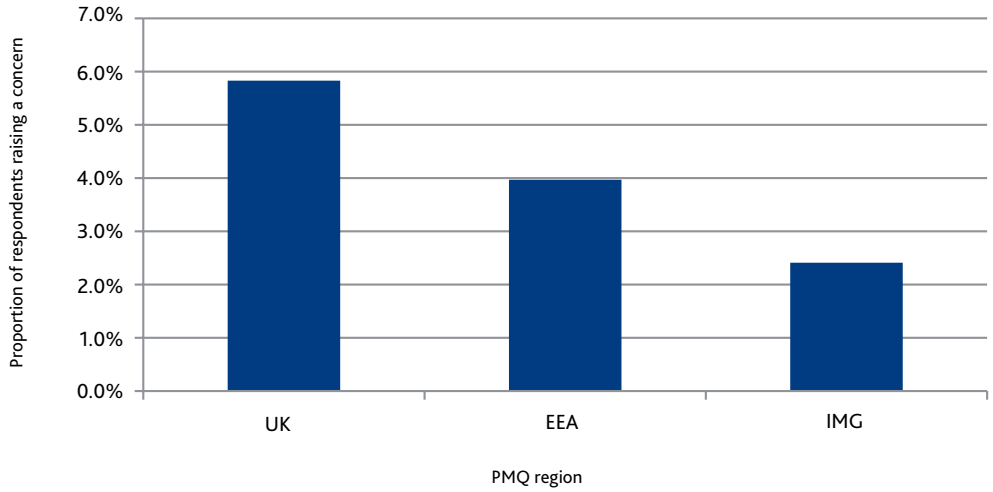


Figure 8: Concerns by gender

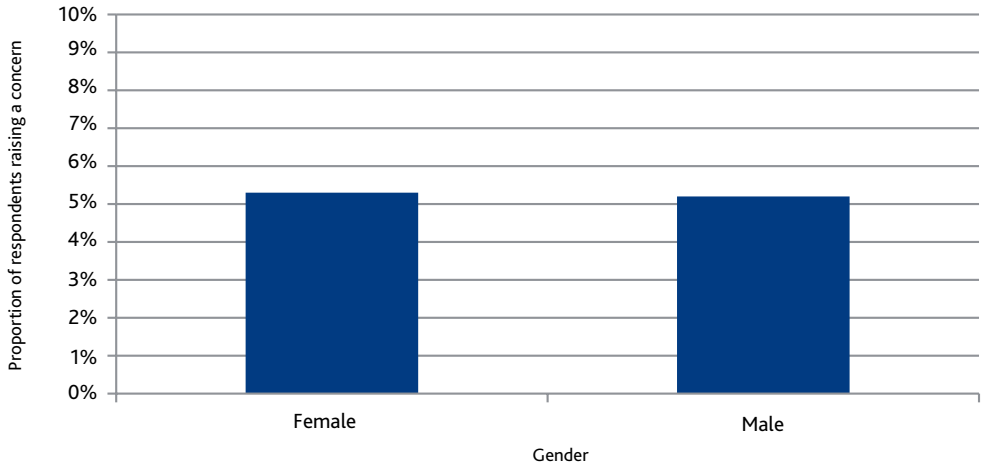


Figure 9: Concerns by post specialty

Post specialty	Frequency	Respondents	Proportion
Paediatric rheumatology	3	11	27.3%
Forensic pathology	1	4	25.0%
Acute medicine	41	334	12.3%
Respiratory medicine	132	1194	11.1%
Acute internal medicine	98	898	10.9%
General (internal) medicine	348	3256	10.7%
Geriatric medicine	223	2155	10.3%
Gastroenterology	102	1011	10.1%
Paediatric gastroenterology, hepatology and nutrition	4	40	10.0%
Emergency medicine	287	3004	9.6%
Endocrinology and diabetes mellitus	63	738	8.5%
Immunology	2	27	7.4%
Trauma and orthopaedic surgery	179	2428	7.4%
Paediatric neurology	4	55	7.3%
General surgery	311	4305	7.2%

Figure 9: Concerns by post specialty (continued)

Post specialty	Frequency	Respondents	Proportion
Cardiology	85	1234	6.9%
Rehabilitation psychiatry	1	15	6.7%
Infectious diseases	14	222	6.3%
Rehabilitation medicine	7	114	6.1%
Rheumatology	21	365	5.8%
Clinical pharmacology and therapeutics	2	35	5.7%
Neurosurgery	17	299	5.7%
Paediatric emergency medicine	2	36	5.6%
Paediatric immunology, infectious diseases and allergy	1	18	5.6%
Clinical oncology	24	440	5.5%
Forensic psychiatry	12	222	5.4%
Stroke medicine	5	95	5.3%
Medical oncology	14	293	4.8%
Paediatric nephrology	1	21	4.8%
Paediatric cardiology	2	44	4.5%
Urology	35	772	4.5%
Plastic surgery	18	430	4.2%
Anaesthetics	163	3967	4.1%
Obstetrics and gynaecology	122	3033	4.0%
Dermatology	11	276	4.0%
Academic	12	313	3.8%
Renal medicine	20	569	3.5%
Medical microbiology and virology	4	116	3.4%
General psychiatry	85	2467	3.4%
Haematology	21	626	3.4%
Old age psychiatry	16	478	3.3%
Cardio-thoracic surgery	7	230	3.0%
Paediatric respiratory medicine	1	35	2.9%
Paediatric oncology	1	37	2.7%
Ophthalmology	18	674	2.7%
Paediatrics	88	3461	2.5%
Community child health	5	202	2.5%
Otolaryngology	18	755	2.4%
Intensive care medicine	15	647	2.3%
Neurology	8	379	2.1%
Child and adolescent psychiatry	8	393	2.0%
Paediatric surgery	4	202	2.0%
Neonatal medicine	7	369	1.9%
Chemical pathology	1	65	1.5%
Occupational medicine	1	67	1.5%
Oral and maxillo-facial surgery	2	139	1.4%
Medical psychotherapy	1	71	1.4%
Genito-urinary medicine	3	224	1.3%
Psychiatry of learning disability	2	167	1.2%
Histopathology	4	377	1.1%
Medical microbiology	1	104	1.0%
Clinical radiology	10	1099	0.9%
Palliative medicine	2	361	0.6%
General practice	25	5989	0.4%
Public health medicine	1	242	0.4%

Figure 10: Concerns by programme specialty

Programme specialty	Frequency	Respondents	Proportion
Neonatal medicine	7	369	1.9%
Emergency medicine	67	489	13.7%
Geriatric medicine	73	592	12.3%
Respiratory medicine	58	510	11.4%
Core medical training	289	2781	10.4%
Acute internal medicine	30	304	9.9%
Acute care common stem	109	1184	9.2%
Immunology	2	23	8.7%
Infectious diseases	8	96	8.3%
Foundation programme	1029	14615	7.0%
General (internal) medicine	3	43	7.0%
Core surgical training	99	1427	6.9%
Endocrinology and diabetes mellitus	23	340	6.8%
Medical microbiology	1	15	6.7%
Gastroenterology	31	474	6.5%
Paediatric cardiology	2	38	5.3%
Core anaesthetics training	48	1054	4.6%
Obstetrics and gynaecology	86	1907	4.5%
Neurosurgery	10	228	4.4%
General surgery	50	1145	4.4%
Core psychiatry training	62	1497	4.1%
Anaesthetics	100	2426	4.1%
Forensic psychiatry	4	103	3.9%
Cardiology	21	544	3.9%
Rheumatology	8	224	3.6%
Renal medicine	10	285	3.5%
Clinical oncology	10	292	3.4%
Trauma and orthopaedic surgery	36	1053	3.4%
Clinical pharmacology and therapeutics	1	30	3.3%
Medical oncology	5	154	3.2%
Dermatology	6	195	3.1%
Paediatrics	93	3101	3.0%
Ophthalmology	17	577	2.9%
General practice	271	9382	2.9%
Paediatric surgery	3	106	2.8%
Medical psychotherapy	1	36	2.8%
Child and adolescent psychiatry	6	220	2.7%
Plastic surgery	7	257	2.7%
Intensive care medicine	3	114	2.6%
Rehabilitation medicine	1	40	2.5%
Urology	7	286	2.4%
Haematology	9	387	2.3%
Medical microbiology and virology	4	203	2.0%
Cardio-thoracic surgery	2	108	1.9%
General psychiatry	11	600	1.8%
Neurology	4	224	1.8%
Oral and maxillo-facial surgery	2	120	1.7%
Occupational medicine	1	64	1.6%
Old age psychiatry	3	195	1.5%
Otolaryngology	4	303	1.3%
Psychiatry of learning disability	1	89	1.1%
Histopathology	4	370	1.1%
Clinical radiology	10	1094	0.9%
Public health medicine	1	186	0.5%