Ref: RCPsych and HEE Invitation to tender

Understanding career choices in psychiatry

Final Report

31st March 2020

Prepared for the Royal College of Psychiatrists (RCPsych) and Health Education England (HEE)

By the Research Department of Medical Education, UCL Medical School

Dr Asta Medisauskaite
Dr Antonia Rich
Dr Milou Silkens
Dr Kirsty Alexander
Dr Oluseyi Adesalu
Dr Laura Knight
Professor Ann Griffin

UCL Medical School
RDME
Research Department
of Medical Education

Acknowledgments

We would like to acknowledge the contribution of Dr Shah-Jalal Sarker and Prof Chris McManus who explored the datasets and provided their advice and support for constructing the secondary data analysis (Research Objective 1), and thank Dr Bettina Friedrich for helping with the Survey Part 1 analysis.

We are very grateful for all the support the Royal College of Psychiatrists (RCPsych) and Health Education England (HEE) provided us with in data recruitment and throughout the project.

We would like to thank the doctors who took part in this study.

Executive summary

Background

Each year, the Royal College of Psychiatry training programme struggles to produce sufficient numbers of fully trained psychiatrists to fill the vacant consultant posts in the UK. As a result, psychiatry units may be understaffed, which can put substantial pressure on the remaining staff, and potentially negatively impact both their wellbeing and the care of their patients.

To date, initiatives to tackle this shortfall have predominantly focussed on increasing recruitment to psychiatry. If the training programme is subsequently unable to retain their trainees, however, it risks losing the benefits of increased recruitment. Attrition from the speciality is therefore a crucial issue to be addressed. The reasons for trainees' attrition appear to stem from a number of complex and interlinking factors (e.g. poor work conditions, high workload, etc.), which vary between individuals and contexts. Pinning down the key causes of their dissatisfaction is important, however, as poor job satisfaction appears to be central to trainees' decision to leave.

For those planning the workforce, a lack of understanding about how trainees choose to progress through training also provokes a substantial challenge. There is little clear evidence on what a 'typical' training pathway to psychiatry consultancy currently looks like: how long on average it takes trainees to complete, when and why trainees take time out of programme, and when and whether they choose to return. Without accurate information about trainees' trajectories and decision-making, forming policy and initiatives to manage recruitment and retention and mitigate attrition from the programme becomes increasingly problematic. This may have knock on effects for maintaining the wellbeing and satisfaction of trainees, and in turn, maintaining a healthy flow of qualified consultants each year.

This programme of research therefore aims to explore career progression and attrition in psychiatry training on a national and local level: to elucidate wider trends and patterns of progression amongst UK psychiatry training as a whole and across a number of years; and to focus on the 'lived experiences' of trainees within a specific context (London) to explore the reasons behind these trends in greater detail. The following research objectives guided our analysis:

1. Explore rates of and reasons for trainees' progression with and without delays;
2. Identify the factors that contribute to psychiatry trainees leaving (or intending to leave) their training and the factors that contribute to trainees staying;
3. Examine, qualitatively, how and why these (and other) factors contribute to attrition or retention.

Methods

This study is a mixed method study combining two secondary data sources (reaching Research Objective 1), an empirical survey study providing qualitative and quantitative data (reaching Research Objective 2) and an interview study (reaching Research Objective 3).

Research Objective 1: Secondary data analysis

Two administrative databases were analysed to explore psychiatry trainees' progression: the List of Registered Medical Practitioners (LRMP) and the analysis of the UK Medical Education Database (UKMED).

The LRMP is a database of all doctors eligible to practice in the UK. We accessed the database on the 9th January 2020 to explore UK graduates' progression from their medical qualification to entry to the Specialist Register in psychiatry. The expected progression for the analysis of this dataset is eight years (two Foundation + three Core training + three Speciality training).

The UKMED is a database that allows longitudinal investigation of medical training paths and includes such information as training levels, exam results, and trainees' personal characteristics. We requested data (permission granted in February 2019) on trainees that were in psychiatry training at any time and at any training level between 2012 and 2018. Our aim was to identify how many trainees progressed in the (un)expected way through their psychiatry training and how the trends differed between groups of trainees (UK vs non-UK graduates; male vs female). We also explored possible reasons for trainees not progressing in the expected way. The expected progression for the analysis of this dataset is six years (three Core training + three Speciality training).

Research Objective 2: Survey analysis

Current and former trainees on the training programme in London were invited to complete a web-based survey (on the *Online survey©* platform) from July to November 2019. The survey measured trainees' views concerning their training programme and factors that contribute to psychiatry trainees' decision to stay on or leave their training. The survey included previously validated questionnaires and open and closed items created specifically for this study. Findings from the open-ended questions were analysed through inductive content analysis and quantitative information was analysed using statistical methods.

Research Objective 3: Interviews analysis

Current and former trainees on the London training programme were invited to participate in a one-to-one interview between August and October 2019. Broad open-ended questions were used for the interviews to encourage trainees to tell their 'stories' freely. This narrative style approach to interviewing encouraged seminal and impactful moments in trainees' experiences to come to light and be discussed in their own words.

Ethics and Data protection

The project received ethical permission from the UCL Research Ethics Committee (REF: 10121/001), and Data Protection approval (REF: Z6364106/2019/06/28).

Results

Research Objective 1

The analysis of time taken from medical qualification to consultancy showed that UK graduates (UKGs) enter the Specialist Register on average 11 (95% CI: 8, 16) years after their medical qualification, with some doctors taking more than 20 years to get onto the Register. Comparing trends over time, we found that more recent UKGs enter the Specialist Register more quickly. We also found that males enter the Register more quickly than females and that this difference between male and female doctors has been increasing in recent years.

The analysis of time taken for psychiatry training showed that on average 14.7% of trainees progress through psychiatry training without delays, e.g. from CT1 to ST6 in six years. We found differences in progression patterns between groups of doctors: a higher percentage of UKGs (18.4%) than non-UKGs (6.5%) and a higher percentage of males (17.8%) than females (12.8%) progress through training without delays. Approximately

62.7% of trainees progress through their Core Training and about 53.8% progress through their Specialty Training without delays (in three years). The largest drop in trainee numbers is at the transition from CT3 to ST4; just 41.6% of CT3 trainees progressed to ST4 the next year. Even though the largest number of trainees who do not progress to ST4 stay at the same training level at this point (37.1%), failing the MRCPsych Clinical Assessment of Skills and Competences (CASC) exam did not fully explain why trainees did not progress from CT3 to ST4.

Research Objective 2

One hundred and sixty-three trainees completed the survey (159 current; 4 former) and shared their training programme experiences and considerations of staying or leaving training. Generally, trainees *enjoyed* various aspects of their training, including interacting with patients, the nature of work, and training arrangements. These and other reasons encouraged trainees to remain in their training. Some trainees also described staying in their training for job security reasons.

The factors the majority of trainees found *challenging* were system and trust-wide issues, different cultures and social norms in psychiatry compared to other specialties, and stress/workload. Trainees also highlighted the perception of risk (e.g. aggression from patients) as being challenging, with 35.2% of trainees experiencing verbal and behaviour aggression often or frequently.

To be able to deal with challenges most trainees *voiced their concerns* about their training to work and personal contacts which they found helpful. However, not all trainees (11.9% of current trainees) were willing to talk about the challenges they were experiencing.

When asked what *the Colleges*, *Deaneries and supervisors* could do to support trainees who were considering leaving, trainees highlighted the importance of exploring trainees' reasons for wanting to leave. Trainees also suggested implementing changes which would encourage trainees to stay (e.g. more flexibility with less than full-time hours, increased accessibility to out of programme experiences, and addressing systemic and trust-wide issues).

Nearly one third (26.7%) of trainees had taken *time out during psychiatric training.* The reasons for taking time out of programme varied from personal reasons (e.g. maternity leave, recovery from burnout) to curriculum vitae (CV) building (e.g. education, research). Trainees gained what they expected from out of programme experiences which helped them to find new appreciation for their specialty and increased their confidence.

The analysis of factors predicting trainees' *intentions to leave* showed that current trainees who were more committed to their profession were less likely to consider leaving their training. Stronger commitment in turn was predicted by trainees' wellbeing (low burnout and high engagement). Work environment (demands and resources) and recovery experiences from work had a significant impact on trainees' wellbeing (work engagement and burnout levels).

Those trainees who *left training or considered leaving* deliberated a wide variety of alternative careers. The most often mentioned option was non-training psychiatry posts. However, trainees also considered working in non-psychiatry posts, e.g. retrain in another specialty or work in management and leadership.

Research Objective 3

Twenty-eight one-to-one interviews were conducted with Core trainees (ten), Specialty trainees (ten), and trainees who left or were planning to leave training (eight). Participants possessed diverse characteristics (various training levels, UKGs and non-UKGs, a mix of genders and ethnic groups).

When sharing their *attitudes to the training programme*, trainees were generally very positive about their teaching, especially the dedicated time and priority that was given to their supervision, training and teaching days. The quality and quantity of supervision was also very influential on trainees' experience of training. Approachable and supportive seniors were seen as inspiring role models, whilst critical and disapproving seniors could be very damaging to trainees' confidence.

Similarly to survey findings, trainees in the interviews explained that they took time out of the programme because of personal (e.g. life events) or CV building (e.g. develop professional skills) reasons. Time out of programme and breaks also allowed trainees to avoid their current situation, e.g. escape a stressful placement or delay becoming a consultant if they did not yet feel ready.

Trainees shared numerous *challenges they had to manage*. Working in an under-resourced system contributed to a culture of defensiveness and disengagement and led trainees to feeling negatively about their work and training programme, e.g. frustration related to delivery of patient care or feelings of resentment if service pressures prevented them from completing training requirements.

Trainees also felt anxious or burnt-out because of the emotional burden created by stressful daily clinical work and/or traumatic experiences. When discussing aggression from patients, trainees felt that this was expected and could be managed if conditions and staffing levels were appropriate. However, even a minor incident could trigger a strong negative reaction if a trainee felt unsafe in their work environment or was already in a vulnerable state, e.g. burnt-out, anxious or pregnant.

Autonomy and responsibility are appreciated by trainees when seen as appropriate. However, responsibilities triggered anxiety if these were beyond a trainee's role or were unsupported. Trainees felt on-calls were particularly challenging due to a lack of senior and peer support whilst making difficult decisions.

Even when experiencing challenges, *the culture* trainees worked in could discourage them from expressing their concerns or wishes. Therefore, trainees were often already seriously considering leaving, or had made a decision to leave, before they had a serious conversation about this with a senior. The culture also strongly pressured trainees to continue with training and achieve consultancy as their end goal. Trainees' perceptions of their seniors' working lives strongly influenced their motivation to continue on to consultancy: for some full-time clinical work as a consultant was perceived as too stressful to be attractive.

Discussion

True *attrition* is difficult to measure, as trainees who decide to leave their training do not necessarily leave for good. Although a small number of trainees move to other careers, for many trainees a decision to leave is rarely followed by an action (definitive leave), but rather it initiates a process (e.g. taking breaks). For some trainees, if the circumstances that were previously causing them distress then change, enjoyment might return. For others, however, taking breaks meant uncertainty about long-term plans. The decision to return to training after a longer break could be extremely difficult to action for emotional and/or financial reasons.

This finding reveals that the '*expected*' path through training should be redefined. Just a small number of trainees progress through their psychiatry training in six years – the 'expected' time. This means that, rather than expecting psychiatry training to be a six-year trajectory, it would be more appropriate to expect trainees to finish training in a longer time span and to follow a training trajectory interspersed with breaks and time out of training.

Trainees take various paths through their training and their decision to *stay, take breaks or leave* their training is influenced by numerous factors. Trainees who were committed to their profession and felt that being a psychiatrist was important to their self-identity, were less likely to consider leaving. Work environment and personal factors that impacted trainees' wellbeing played a significant role when making a decision regarding their progression through training. Working in under-resourced, unsafe and risky work environments, where trainees felt undervalued, (as trainees and as psychiatrists) led to trainees feeling stressed and anxious. Support during training was mentioned by trainees as important in multiple scenarios. Helpful and supportive seniors who served as inspiring role models encouraged trainees to continue with their training; peer support or Balint groups were useful for coping with the day-to-day emotional rigours; and professional support (e.g. therapy) was useful after experiencing traumatic events. In contrast, when trainees had critical supervisors, felt vulnerable and/or unsafe, trainees questioned whether they wanted to continue with training. These issues and insecurities often came to a head around on-calls, when trainees were less supported.

Trainees' decisions regarding their progression were also highly influenced by the wider culture in which they trained. Stigma towards psychiatrists acknowledging their own poor mental health resulted in trainees being reluctant to raise concerns or seek support, and the perception of leaving training as 'failing' pushed trainees into continuing with training even when struggling.

Psychiatry training programmes should therefore communicate and collaborate with trainees and stakeholders involved in training to find tailored solutions to the problems brought forward by trainees and presented in this research. Only by tailoring interventions to the needs of the target groups, will training programmes be able to improve the quality of training programmes and the wellbeing of their trainees.

Table of contents

List of Tables

List of Figures

List of Boxes

List of Appendices

List of abbreviations & Glossary

List of abbreviations

ARCP	Annual Review of Competency Progression
BME	Black minority ethnic group
CASC	Clinical Assessment of Skills and Competences
CI	Confidence interval
CT	Core training
EEA	European Economic Area
LRMP	List of Registered Medical Practitioners
LTFT	Less than full-time
Non-UKG	Non-UK graduate
NTS	National Training Survey
SAS	Specialty and Associate Specialist
SpR	Specialist Register
ST	Specialty training
PLAB	Professional and Linguistic Assessment Board
PMQ	Primary Medical Qualification
PSpR	Psychiatry Specialist Register
UKG	UK graduate
UKMED	UK Medical Education Database

Glossary

Attrition	A decrease in the number of trainees enrolled in the training programme, occurring due to trainees leaving the programme definitively by surrendering their training number.
Delayed progression	Any form of progression that is different than trainees' expected progression through their training programme.
Expected progression	Progression through training without delays, i.e. in the minimum amount of time possible. • *Expected progression* through psychiatry training is six years: three years of Core training + three years of Specialty training; • *Expected progression* for UK graduates from year of qualification to entering Specialist Register for psychiatry is eight years: two Foundation years + three years of Core training + three years of Specialty training.

Introduction

Every year the Royal College of Psychiatry's training programme aims to produce sufficient numbers of fully trained psychiatrists to fill the vacant consultant posts available annually. This has proved a major challenge, however, as in 2019 there were 708 vacant or unfilled consultant posts; a number that has tripled from 232 in 2013 (RCPSYCH, 2019). To tackle this issue, the College has focussed on boosting recruitment to the speciality, encouraging medical students and foundation doctors to 'choose psychiatry', by highlighting the attractive and fascinating aspects of the speciality (RCPSYCH, 2020). The reasons why applicants either choose, or are deterred from, psychiatry training has thus attracted growing research interest and understanding (Choudry & Farooq, 2017).

A perhaps more problematic and less well understood issue, however, is that of retention within psychiatry training. Evidence of high attrition from psychiatry training dates back to 2012, when only 65.8% of psychiatry trainees in the UK reported that they planned to stay in psychiatry (Barras & Harris, 2012). Attrition is particularly acute in the 'break' between Core training (the first three years) and Specialty training (the final three years). In 2017 the 'fill rate' for many specialty programmes in psychiatry was lower than 60% (NHS, 2017).

If the training programme is unable to retain the trainees it attracts, it risks losing the benefits of 'getting in' more trainees, especially if these individuals do not subsequently choose to 'stay in'. It is thus crucial to turn the tide on attrition in psychiatry to ensure that psychiatry trainees complete their training, are content and fulfilled by working in the speciality, and thus will fill the available consultant posts to relieve pressure from the current workforce and to safeguard patient care (RCPSYCH, 2019). As well as the negative effects a decision to leave the speciality may have for an individual trainee, the reasons which cause trainees to leave may be damaging to those working in the speciality as a whole, as well as their patients.

Nevertheless, there remains a lack of understanding about how psychiatry trainees progress through training. This includes an understanding of what a typical training pathway is: how long on average it takes trainees to complete, when and why trainees take time out of programme, and when and whether they choose to return. Moreover, little is known about what factors contribute to the different career paths: why trainees are making the choice to progress, repeat or take time out of programme at any given time-point. Previous studies have explored why trainees may be dissatisfied with their experience in training, see for example Barras and Harris (2012); Goldacre, Fazel, Smith, and Lambert (2013); Lambert, Turner, Fazel, and Goldacre (2006), with a recent survey of Core trainees by The London School of Psychiatry (2018) identifying that job dissatisfaction was central to the decision to step out of training. The reasons for this dissatisfaction are, however, understood to stem from a multitude of interlinking factors, which appear to vary between individual and context.

Acknowledging this complexity, we devised a longitudinal and in-depth research methodology to identify and explain current trends in career progression and attrition amongst psychiatry trainees. This large-scale approach aims to give a wider perspective of these issues within the whole UK training programme across a number of years. It then hones in on the 'lived experiences' of trainees within one area (London) to explore these trends, and the factors behind them, in greater detail. The research thus employed a mixed methods approach, which combined: two large longitudinal and national datasets (the List of Registered Medical Practitioners, LRMP; and UK Medical Education Database, UKMED) to explore progression patterns and possible reasons for these patterns; a survey study to identify and quantify factors that contribute to trainees' progression or attrition; and a qualitative interview study to help explain in depth how and why these and other factors contributed to trainees' decisions to stay in or leave training. Overall, this holistic approach

offers both a detailed overview of psychiatry trainees' career progression nationally, as well as an in-depth local exploration of the experiences of psychiatry trainees in London.

Aims and Research Objectives

The aim of this research is to investigate career progression and attrition in psychiatry training. This translates into three key research objectives:

1. Explore rates of and reasons for trainees' progression with and without delays;
2. Identify the factors that contribute to psychiatry trainees leaving (or intending to leave) their training and the factors that contribute to trainees staying;
3. Examine, qualitatively, how and why these (and other) factors contribute to attrition or retention.

The report is structured to address each of these three research objectives in turn. Each research objective section will describe the methodology used, results, and key findings. The first research objective is reached using the LRMP and UKMED data. The second research objective draws on the findings from the survey of London trainees. The third research objective is answered using data from the interviews with London trainees. After the research objectives have been reached the report presents a discussion section, strengths and limitations of the research, and finishes with conclusions and implications for the future of the training programme.

Ethics

Ethical permission was gained from the UCL Research Ethics Committee (REF: 10121/001). All survey and interview participants were given information sheets and provided written consent to participate in the study. The project also received Data Protection approval (REF: Z6364106/2019/06/28) and is in compliance with the General Data Protection Regulation 2018.

Research Objective 1: Explore rates of and reasons for trainees' progression with and without delays

This section consists of two parts: the analysis of the List of Registered Medical Practitioners (LRMP) and the analysis of the UK Medical Education Database (UKMED). While both analyses focus on trainees' progression, the section exploring the LRMP data will describe trainees' progression from their medical school graduation to entering the Specialist Register and the section exploring the UKMED data will focus on trainees' progression through psychiatry training only (Figure 1).

Figure 1 shows that the expected time from graduation to entering the Specialist Register is eight years (LRMP section) and the time from entering to completing psychiatry training is six years (UKMED section). More specifically, the years presented in Figure 1 indicate:

1. Year 0: Year of qualification (Foundation training start year);
2. Year 1-2: Two years of Foundation training;
3. Year 3-8: Six years of psychiatry training (Three years of Core and three years of Specialty training);
4. Start at the end of Year 8: Entering the Specialist Register (Year in which Specialty training is completed).

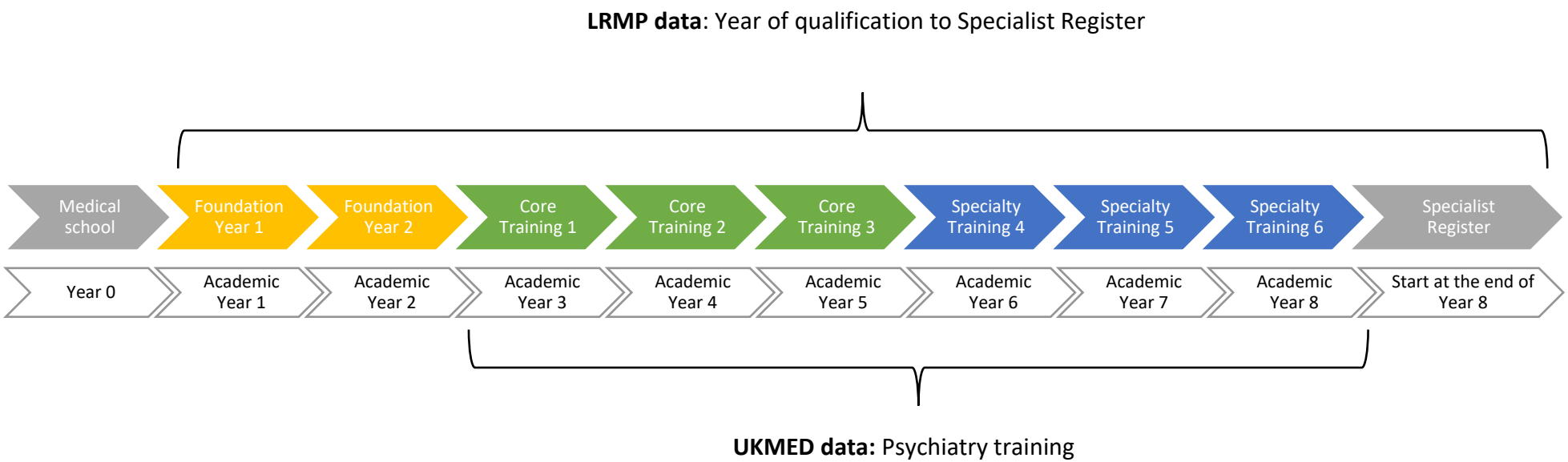

Figure 1. The expected time frame for doctors to progress from their medical qualification to the Specialist Register and differences in analysed data between the two datasets used: LRMP and UKMED.

This section describes the methodology of the two parts of the chapter in more detail, then presents the results and a summary of key findings.

Methodology: The List of Registered Medical Practitioners (LRMP)

The LRMP is a database of all doctors eligible to practice in the UK. The database holds information on doctors' key demographic characteristics, specialty, year of qualification, and full[1] and specialty registration. We accessed the database on the 9th January 2020. On this date, there were 124,428 doctors on the LRMP Specialist Register (SpR), of whom 69,647 were UK graduates (UKGs) and 54,781 were non-UK graduates (non-UKGs). A total of 12,807 were on the psychiatry SpR (PSpR) (10.3% of all specialist doctors), of whom 6,800 were UKGs (9.8%) and 6,007 were non-UKGs (11%). By using the LRMP our aim was to study longer-term trends in the numbers of psychiatrists, and to estimate the expected time to complete training for those who subsequently enter the PSpR. The results section will:

1. Provide an overview of all UKGs and non-UKG doctors (not only psychiatrists) on the LRMP SpR who received their full registration from 1975 to date.[2]
2. Discuss the time required for UKGs to progress from graduation to a consultant post in psychiatry (PSpR). For this analysis it is important to note that, in line with Figure 1, an uninterrupted route through training should take eight years for UKGs if we count the time from their year of qualification to PSpR (two Foundation years[3] + three years of Core training + three years of Specialty training).
3. Provide a comparison of trends for male and female UKGs on PSpR.

The overview (point 1 above) will include the analysis of UKGs and non-UKGs. As non-UKGs have a range of routes to enter the SpR but there is very limited information about these routes included in the LRMP,[4] we chose to analyse just UKGs' progression from graduation to entering the PSpR (point 2 and 3).

Specialty registration for psychiatry started in the calendar year 1996. Doctors entering the PSpR in 1996 came from many generations of doctors, in some cases having qualified 40 or 50 years earlier. Therefore, we restricted the UKGs sample to include only those specialists that acquired their primary medical qualification in or after 1991. This approach guaranteed the exclusion of psychiatry consultants who were practicing before 1996 but were only registered later. We used the academic year in which doctors went on the PSpR, instead of the calendar year, because it represents a more natural way of counting the time after doctors had finished their training (which is at the end of an academic year).

---

[1] Doctors are eligible for full registration if they complete Foundation year 1 in the UK or are non-UKGs with an acceptable primary medical qualification and/or enough clinical experience.

[2] For this analysis, we investigated the time between doctors' year of full registration and appearance on the SpR. Using the year of qualification instead of the year of full registration was not possible as the year of qualification has a different meaning for UKGs and non-UKGs. Non-UKGs often qualify years before coming to the UK and achieving their full registration. From the viewpoint of workforce planning, particularly for assessing training and progression, it is years in practice in the UK that matters, and that begins with full GMC registration.

[3] Foundation year counted as one year until 2005 and two years after 2005. However, many trainees before 2005 would take an additional year of training; therefore, for the majority of trainees it should have taken a minimum of eight years of training.

[4] Non-UKGs have two routes onto SpR: passing the Professional and Linguistic Assessment Board (PLAB) test and then going into standard psychiatry training (six years) (some small differences between EEA/EU and international medical graduate doctors exists but those matter little here) or getting in via a special entry route for doctors who are already trained elsewhere as psychiatrists and their qualifications are acceptable (the process takes one or two years at most). Information about these routes is not provided in the LRMP.

Results: LRMP

Overview of doctors on the SpR: From 1975 to present

In order to review the overall trends in numbers of specialist doctors, we investigated all doctors that were on the SpR and received their full registration from 1975 onwards. We then divided these doctors into four categories (Figure 2): UKGs on the PSpR, non-UKGs on the PSpR, and UKGs and non-UKGs who are not on the PSpR.

The proportion of doctors on the PSpR is relatively small, as can be seen from the orange and green areas at the bottom of Figure 2. As mentioned in the Methodology section, psychiatry consultants account for 10.3% of all consultants on the LRMP SpR. Figure 2 also shows that the overall numbers of UKGs has increased over time.

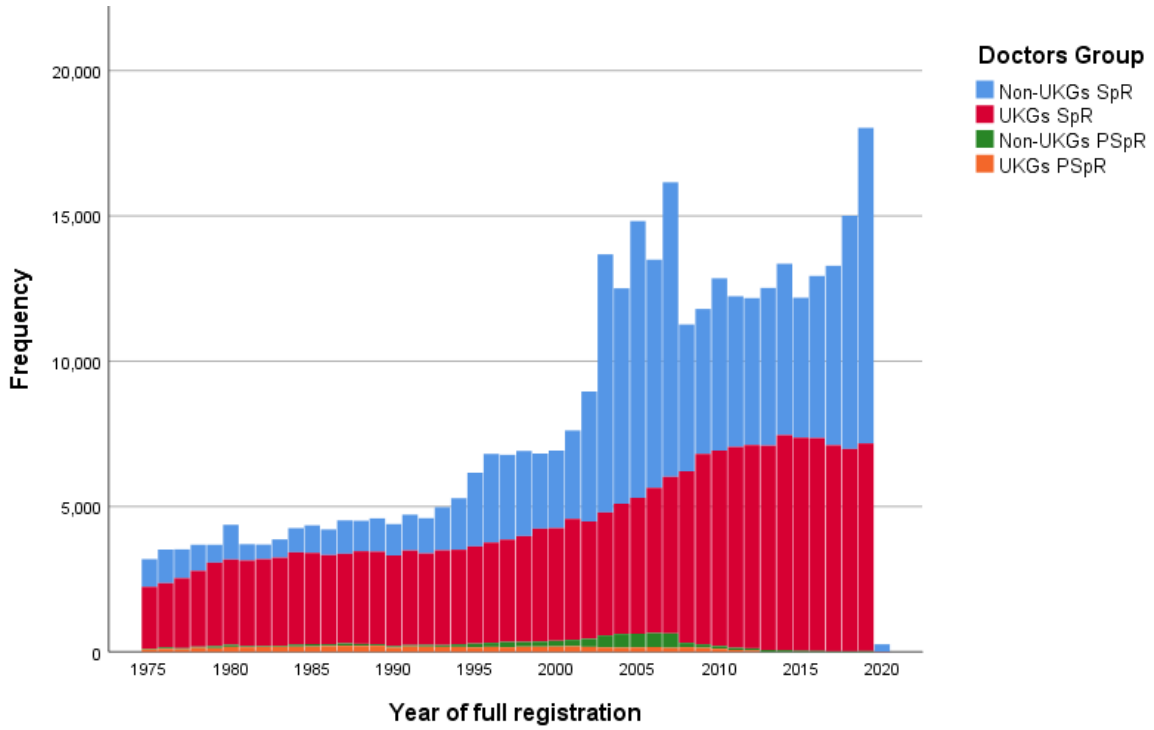

Figure 2. All doctors on the LRMP SpR by year of full registration (1975 to 2020), place of qualification (UK vs non-UK), and specialty (PSpR vs non-PSpR).

Figure 3 presents the same data but only for doctors on the PSpR. Numbers of UKGs appear to be fairly stable until approximately 2009 but drop steeply after. This drop reflects delays in progression through training: if doctors were to progress without delays the distribution should have been more stable until approximately 2012. UKGs who received full registration after 2012 are not yet on the PSpR as there was not enough time for them to complete their training.[5]

Although the numbers of UKGs entering the PSpR appear to be stable (Figure 3), we would, however, expect numbers to increase considering the overall increase in numbers of UKGs indicated in Figure 2. This means the percentage of UKGs on the PSpR is no longer proportionate of the numbers of UKGs on the SpR in other

[5] It takes approximately seven years for UKGs to go from full to specialty registration.

specialities. The reason for this observed trend should be investigated further but is outside the scope of this study.

Figure 3 also shows more variability in the numbers of non-UKGs with a large peak from 2003 to 2007. Non-UKGs are also visible on the PSpR after 2012 and even until 2019. These are most probably doctors entering the SpR via special entry routes and who are not required to complete the full six years of training, therefore entering the SpR after one or two years.

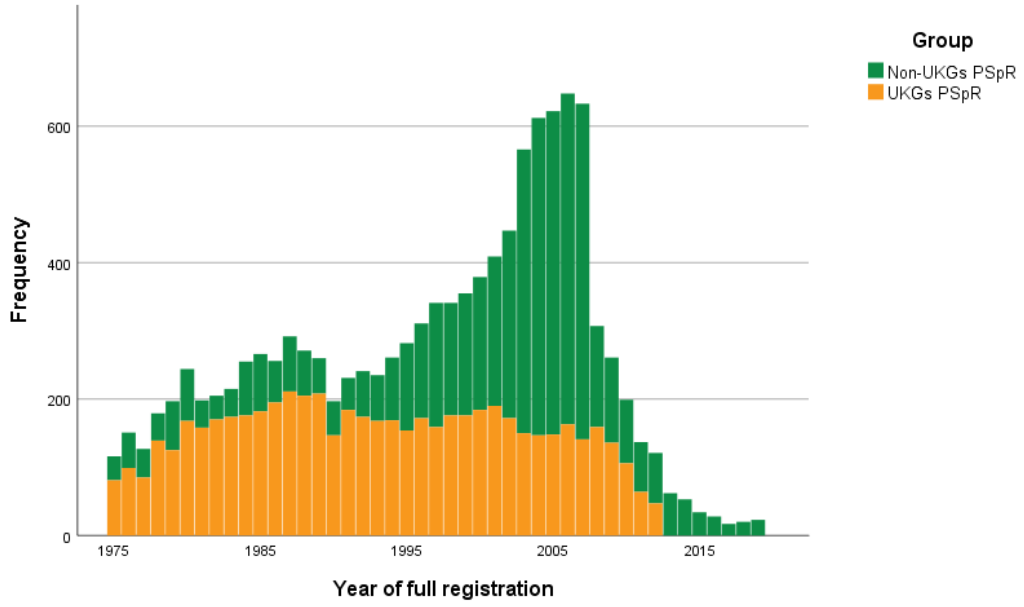

Figure 3. UKGs and non-UKGS on the LRMP PSpR by year of full registration.

Time from graduation to consultant post: UKGs

We performed a further analysis on UKGs in psychiatry (see reasons for excluding non-UKGs in the Methodology section) to investigate the time taken between their year of primary medical qualification (graduation from medical school) and the academic year in which they entered the PSpR (consultancy).

Figure 4 shows the number of academic years from graduation to entering the PSpR for UKGs, graduating from 1991 to 2011,[6] and divided into three tertile groups each containing seven years of qualifications: 1991 to 1997; 1998 to 2004; 2005 to 2011.

The earliest tertile, describing UKGs from 1991 to 1997, shows that most doctors take 11 (95% CI: 8, 18) years from qualifying to enter the PSpR, with some doctors taking as many as 27 years. The two later cohorts appear to be entering the PSpR more quickly (1998-2004 UKGs: 10 years, 95% CI: 8, 15; 2005-2011 UKGs: 9 years, 95% CI: 8, 12) but this may be an artefact due to truncation of the data, i.e. there are almost certainly doctors in the most recent tertile (2005 to 2011), who are still in training and who will enter the PSpR at some time from 2020 onwards and who are not yet present on the LRMP at the time of our investigation.[7]

[6] For practical reasons we have considered graduates in the twenty-one year period from 1991 to 2011, because PSpR was introduced in 1996 and graduates in 2011 could, as long as they progressed through training without delays, get onto the PSpR in 2019 and be in our LRMP dataset.

[7] It takes a minimum of eight years from graduation to enter the PSpR. To take an extreme case, for those graduating in 2011, 2019 is the first and only year for which these graduates can be seen in the LRMP (2019 – 2011 = 8).

Therefore, the most robust estimates are for the 1991-1997 tertile, and they clearly show that doctors can enter the PSpR many years after the eight years it would take to progress directly through training.

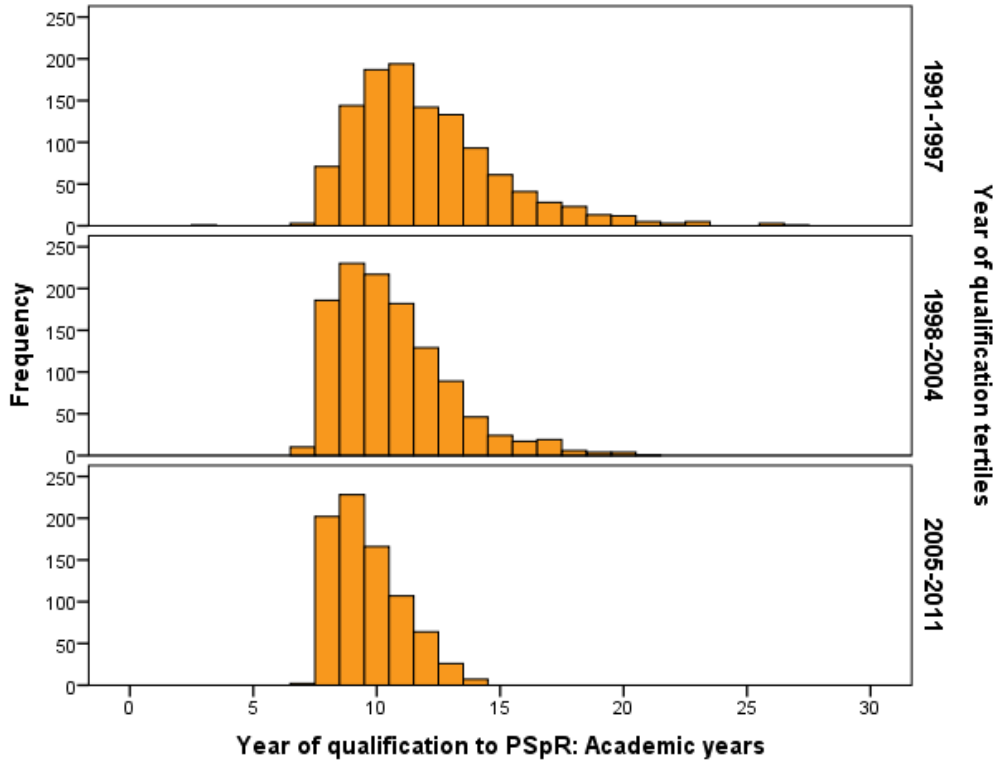

Figure 4. Academic years from graduation to entering PSpR for UKGs, for three groupings (tertiles) of qualification years.

To take account of the truncation issue, a partial solution was to only look at cohorts of data (organised by year of entry onto the PSpR as in Table 1) who have all been followed up for a fixed amount of time. This means that the longer the follow-up time, the less recent date of qualification and the fewer the numbers of doctors in the cohorts would be. A reasonable compromise in this scenario was to only look at the set of doctors who qualified between 1991 and 2007 as they all had minimum 12 years from graduation to the PSpR: eight years of expected progression through training plus a minimum of four years of delayed entry (to be able to observe the ones who come onto the PSpR later than in the expected eight years). Further analyses therefore only include doctors graduating between 1991 and 2007.[8]

[8] Since 2019 is the most recent PSpR at the time of study, 2007 UKGs are the most recent group that can be studied. For 2007 UKGs the expected year on the PSpR without delay (eight years) would be 2015. Adding four years of follow-up, it would add up to 2019 which is the latest possible time of investigation for the present analysis.

Table 1. The number of UKGs who come onto the PSpR each year according to the LRMP.

YoQ	Academic years of registration on PSpR																				Total
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	
1991	7	19	33	26	16	20	13	16	3	4	4	2	2	1	0	0	0	0	0	0	0	166
1992	0	3	17	25	29	28	18	12	15	6	5	5	2	2	1	0	1	0	0	1	1	171
1993	0	0	3	14	23	33	28	20	15	8	9	3	5	0	2	2	1	1	0	0	1	168
1994	0	0	1	8	23	23	25	17	20	12	5	6	3	5	4	1	0	0	1	0	0	154
1995	0	0	0	1	17	28	28	22	17	16	16	4	8	5	1	1	2	1	0	0	0	167
1996	0	0	0	0	1	14	17	23	35	21	15	11	7	4	3	2	0	2	0	2	2	159
1997	0	0	0	0	0	0	19	26	32	24	15	24	14	6	5	5	1	4	1	0	0	176
1998	0	0	0	0	0	0	0	19	29	27	31	26	17	11	3	4	9	0	2	3	1	182
1999	0	0	0	0	0	0	0	1	25	27	34	41	22	14	7	3	3	3	0	0	1	181
2000	0	0	0	0	0	0	0	0	1	17	38	53	33	17	13	10	4	2	2	3	2	195
2001	0	0	0	0	0	0	0	0	0	2	23	46	33	17	18	11	4	3	4	1	3	165
2002	0	0	0	0	0	0	0	0	0	0	0	29	29	30	16	21	10	2	3	3	4	147
2003	0	0	0	0	0	0	0	0	0	0	0	0	29	29	24	26	13	13	5	6	0	145
2004	0	0	0	0	0	0	0	0	0	0	0	0	6	44	32	16	18	12	11	7	2	148
2005	0	0	0	0	0	0	0	0	0	0	0	0	0	1	31	44	33	21	17	11	4	162
2006	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	22	37	25	24	17	12	137
2007	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	33	35	33	24	25	150
2008	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	27	33	37	35	132
2009	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24	43	32	99
2010	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	26	32	58
2011	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	39	40
Total	7	22	54	74	109	146	148	156	192	164	195	250	210	186	160	168	169	151	160	185	196	3102

Note. YoQ – year of qualification; Light yellow cells: expected progression time between graduation and registration on the PSpR (eight years). Light red cells: truncated data which, together with the expected progression of eight years or less (making it up to 12 years after graduation), is used for the analysis of gender differences. The black line after 2007 shows till what time point data is selected for further analysis (see text for more details).

When analysing just the 1991-2007 UKGs, data revealed that:

- It takes on average 11 years (95% CI: 8, 16) for these graduates to enter the PSpR;
- Approximately 12.9% of all UKGs get on the PSpR without delays (Table 2);
- 17.7 to 17.9% of UKGs appear on the PSpR with a delayed progression of one to two years respectively (Table 2);
- 76.3% of UKGs are on the PSpR within 12 years of graduation (four years of delay) (Table 2).

Table 2. The percentages of UKGs registered on the PSpR in eight years (expected progression) and percentages of those with delays.

	Delays in years between year of qualification and getting onto the PSpR									
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8+**	**TOTAL**
Number on PSpR	357	490	495	445	330	245	143	85	183	2773
Percent on PSpR	12.9%	17.7%	17.9%	16%	11.9%	8.8%	5.2%	3.1%	6.6%	100%
Cumulative %	12.9%	30.5%	48.4%	64.4%	76.3%	85.2%	90.3%	93.4%	100%	

Note. PSpR – Psychiatry Specialist Register; Year of qualification: 1991-2007; Academic year of the PSpR: 1999-2019; 0 – eight years or less between year of qualification and registration on the PSpR.

From graduation to consultant post for UKGs: Male vs female progression

Figure 5 shows the mean time (truncated up to 12 years after qualification)[9] for entry onto the PSpR by year of graduation divided into quartiles (four groups of four/five years: 1991-1994; 1995-1998; 1999-2002; 2003-2007) and sex. Three trends are clear and are supported by multiple regressions:

1. More recent UKGs enter the PSpR more quickly (b = -.06 years per annual cohort, $t(2114) = -9.7$, $p < 0.001$);
2. Female doctors enter the PSpR less quickly compared to male doctors (b = .39 years, $t(2114) = 6.9$, $p < 0.001$);
3. There is an interaction between sex and year of qualification, which shows that the difference between males and females is increasing with more recent years of qualification ($t(2113) = 3.3$, $p = 0.001$).

[9] To be able to investigate trends over time, we chose to look at UKGs entering the PSpR within 12 years: eight years of expected time to progress through training + four extra years to observe those trainees who come into the PSpR later than expected. See yellow and red cells in Table 1.

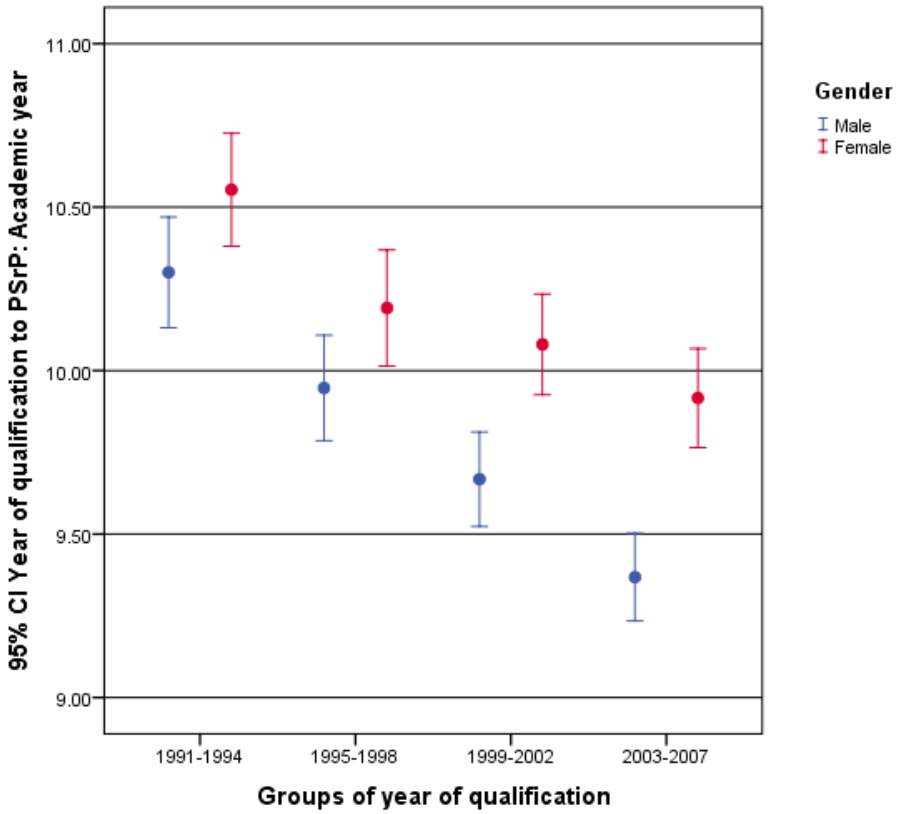

Figure 5. Mean academic years (95% CI) from graduation to the PSpR for UKGs graduating from 1991 to 2007, grouped into four subgroups by year of qualification.

Key findings

Overall, the LRMP provides a useful picture of the most important feature of psychiatry training: when trainees enter the Specialist Register for psychiatry (PSpR) and are thus eligible for consultancy posts. From the analyses of the LRMP dataset several key findings can be derived (Box 1).

Box 1. Key findings from the analysis of the LRMP.

- 10.3% of all doctors on the LRMP SpR on January 2020 were psychiatry consultants (9.8% UKGs and 11% non-UKGs).
- The number of UKGs on the PSpR has remained relatively constant and the number of non-UKGs peaked largely from 2003 to 2007.
- UKGs typically enter the PSpR about 11 (95% CI: 8, 16) years after medical school qualification, with a small proportion (approximately 12.9%) getting onto the Register without delays (in the expected eight years).
- 76.3% of UKGs on the PSpR are registered within 12 years after medical school qualification (four years of delay). However, some doctors take much longer to get onto the PSpR: up to 27 years.
- When analysing UKGs who entered the PSpR within 12 years (76.3% mentioned above), it can be seen that:
    - The time it takes for UKGs to enter the PSpR has been significantly decreasing: more recent UKGs enter the PSpR more quickly.
    - It takes longer for female UKGs to get on the PSpR compared to male UKGs. This difference between male and female doctors has been increasing in recent years.

Methodology: The UK Medical Education Database (UKMED)

The UKMED combines undergraduate and postgraduate data on the performance of medical students and trainee doctors in the UK. The database aims to provide insight into the paths that medical students and doctors take through their education, training and career progression. We requested data on trainees that were in psychiatry training at any time and at any training level between 2012 and 2018.[10] For these trainees we requested information on their personal characteristics, Annual Review of Competency Progression (ARCP) and postgraduate exam results, their responses to the National Training Survey (NTS) and (if applicable) their current registrations in the LRMP.[11] Permission to access this dataset was granted in February 2019.

Our complete dataset consisted of 6,724 psychiatry trainees of which 57.8% (3886) were UKGs and 42.2% (2838) were non-UKGs; 43.6% (2,930) were male versus 56.4% (3,794) female.

It was not possible to use the UKMED database to conclusively identify attrition (defined as a trainee definitively leaving the training program) because trainees could return to training outside of the time period that is currently available to study. Therefore, instead of focussing on attrition, we analysed trainees' expected progression (completing psychiatry training without any delays) and any other way of progressing through training to better understand trainees' training paths. Our aim was to identify how many and which trainees progressed with/without delays through their training. The results section will:

1. Provide an overview of the total number of trainees per training level and per academic years from 2011/2012 to 2017/2018.
2. Discuss the time required to progress from Core training (CT1) or Specialty training (ST4) to ST6 (last year of training) and provide a comparison of trends for UKGs and non-UKGs; male and female. In line with Figure 1, an uninterrupted route through the full psychiatry training programme should take six years (three years of Core training + three years of Specialty training). Where possible we also investigated how many trainees entered the PSpR within one calendar year of completing their training.
3. Explore the reasons for trainees not progressing in the expected way. This analysis also includes an examination of the role of the MRCPsych CASC in trainees' non-progression.

We based the numbers of trainees that progressed as expected, and those who did not, on NTS data, which was collected each year in spring. This means that if NTS data stated a trainee was CT1 in 2012, that trainee would most likely have started CT1 in autumn 2011 and was due to complete CT1 in summer 2012.

Due to the fact that we had data available from 2012 to 2018 only, we had only two cohorts available for a complete six year follow up analysis: the cohort of trainees in CT1 in 2011/2012 (finishing ST6 in 2016/2017) and those in CT1 in 2012/2013 (finishing ST6 in 2017/2018). For all later cohorts we were only able to partially follow their progression. In addition, we used the LRMP data (up to February 2020)[12] within the UKMED to analyse the number of trainees that entered onto the PSpR. Even though the vast

[10] At the time of request, the key information on Core and Specialty training programmes was only available from 2012 to 2018. This means that the dataset includes information on academic years between 2011/2012 and 2017/2018.

[11] The UKMED database inputs data which is primarily collected for administrative purposes and using this secondary data for research purposes is complex and required thorough cleaning (e.g. assessing missing data and decisions regarding which variables were complete enough to use) and transforming the database (e.g. construct new variables suited to reach the research objectives from a specific subset of existing variables in the UKMED).

[12] We have requested the most recent data available for the LRMP analysis in the UKMED.

majority of trainees in the UKMED have not yet entered the PSpR within the time span available for this study, we could analyse the cohorts that started their CT1 in the academic year 2011/2012 and 2012/2013 as they would enter the PSpR before the end of 2019 when progressing as expected. Similarly, we analysed those trainees that started their ST4 in the academic years 2011/2012 to 2015/2016. Unlike the analysis in the LRMP section, because of the limited information available for this analysis, we used calendar year instead of the academic year of entering the PSpR.

The following statistical disclosure controls were applied when presenting NTS data:

- we suppressed all numbers when less than three participants were involved (source: https://www.gmc-uk.org/help/education-data-reporting-tool-help/what-do-the-results-mean#how-do-i-read-reports). This was applied after initial calculations.

Data source acknowledgement: UKMED (project number: UKMED98) extract generated on 23 06 2019 and updated version provided on 02 2020. We are grateful to UKMED for the use of these data. However, UKMED bears no responsibility for their analysis or interpretation.

Results: UKMED

Overview of trainee numbers

Table 3 shows the number of trainees per training level from academic years 2011/2012 through to 2017/2018. Each training level at each year represents trainees who are at that training level for the first time, but also includes trainees who are repeating the year (e.g. staying at CT1 for two consecutive years) or delaying the progression to the next training level (e.g. having a break and progressing a year later).

When reviewing the numbers for each year it becomes clear that the number of trainees in each training level are fairly stable over the years. An average of 508 trainees start CT1 training each year and an average of 473 trainees reach ST6. When reviewing the mean numbers at each training level, a drop in trainee numbers can be seen between level CT3 and ST4.

Table 3. Total number and mean number of trainees at any given trainee level from year 2011/2012 to 2017/2018.

	2011/ 2012	**2012/ 2013**	**2013/ 2014**	**2014/ 2015**	**2015/ 2016**	**2016/ 2017**	**2017/ 2018**	**TOTAL: mean**
CT1	525	520	520	528	485	525	453	508
CT2	571	540	530	552	532	485	507	531
CT3	624	633	564	516	559	561	494	564
ST4	492	387	441	490	435	443	429	445
ST5	515	503	398	408	461	459	434	454
ST6	453	596	535	431	440	428	431	473

Expected progression

Expected progression through psychiatry training

To analyse expected progression we selected all trainees that started the psychiatry CT1 post between the academic years 2011/2012 and 2017/2018. Because of the nature of our dataset, our starting cohorts (represented by the CT1 row in Table 3) consisted of trainees that were starting CT1 for the first time as well as trainees who were delayed in their training.

From the total number of trainees in CT1 on average only 14.7% progressed to ST6 in six years. That means that on average out of the 508 trainees in CT1, only 75 would progress to ST6 in six years' time. Of these 75 trainees, 64 (85.2%) would be on the PSpR within one year after their completion of ST6 (see Table 4).

Similar to Table 3, a large drop in numbers is visible for the transition from CT3 to ST4. Whereas an average of 62.7% (318) of trainees progress without delays from CT1 to CT3, only 26.1% (133) progress from CT1 to ST4 without delays. This means that on average just 41.6% of trainees who reach CT3 without delays progress to ST4 the next year (133 from 318 CT3s).

Table 4. Absolute numbers, averages and mean percentages of psychiatry trainees that progress through the total duration of training as expected (in six years without delays).

	CT1 in 2011/ 2012	**CT1 in 2012/ 2013**	**CT1 in 2013/ 2014**	**CT1 in 2014/ 2015**	**CT1 in 2015/ 2016**	**CT1 in 2016/ 2017**	**CT1 in 2017/ 2018**	**Mean**	**Cumulative mean %**
CT1	525	520	520	528	485	525	453	508	100%
CT2	408	406	406	415	384	427		408	80.2%
CT3	303	295	318	348	328			318	62.7%
ST4	130	119	144	137				133	26.1%
ST5	109	94	124					109	21.5%
ST6	72	77						75	14.7%
On PSpR	64	63						64	12.5%

Note. PSpR – Psychiatry Specialty Register on the LRMP within a calendar year of completion of ST6.

Figure 6 shows that the progression trends presented in Table 4 are similar for all cohorts, i.e. all trainees starting from academic year 2011/2012 through to 2017/2018. The decline is steepest between CT3 and ST4, which again confirms the large drop in numbers between CT3 and ST4.

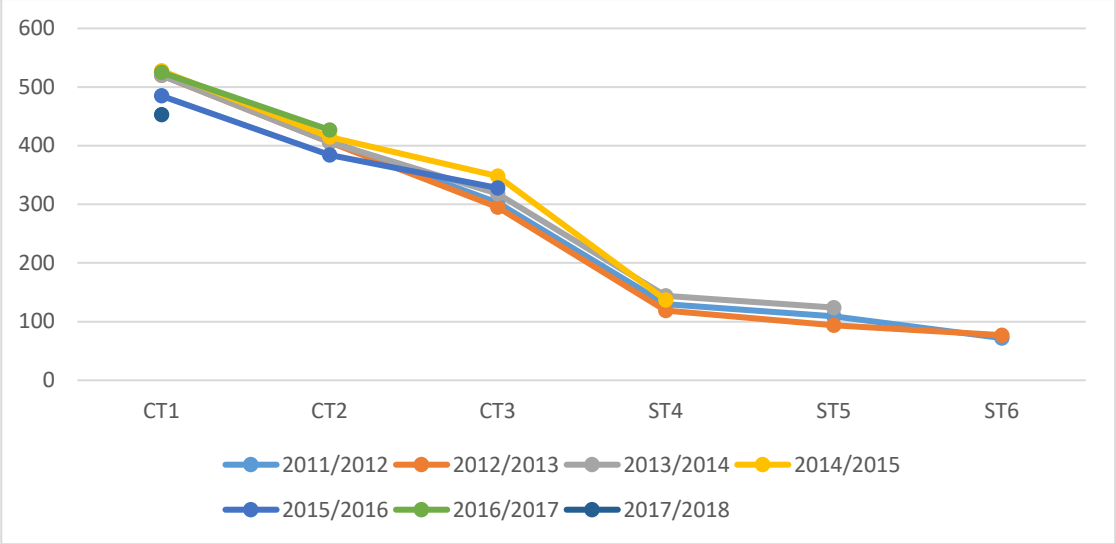

Figure 6. Absolute number of psychiatry trainees that progress through the total duration of training as expected (in six years without delays).

When comparing the number of trainees that progress as expected through training (Table 4) with the total number of trainees per training level (Table 3) it becomes clear that a substantial number of trainees do not progress as expected (Figure 7). However, this does not mean that those who do not progress as expected do not eventually reach ST6. For example, on average 75 of trainees progressed in six years from CT1 to ST6, but the total average of trainees at the ST6 level was 473. Therefore, on average 398 trainees (473 - 75 = 398) who didn't progress as expected are still eventually reaching ST6, just not within six years.

Although the trends differ slightly between the two cohorts (expected progression vs. total number of trainees), Figure 7 clearly shows that the decline in trainee numbers between CT3 and ST4 is evident in both cohorts.

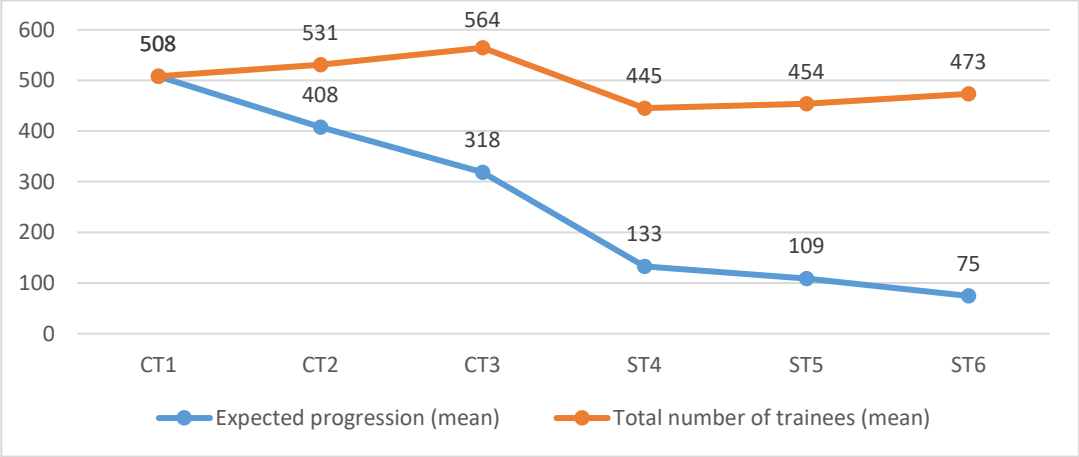

Figure 7. Average number of trainees that progress through training as expected (without delays) versus the total number of trainees that progress (both expected and alternative ways of progressing) through training for each training level.

Expected progression through psychiatry training: UKGs vs non-UKGs

To investigate possible differences in expected progression for different groups of doctors we compared UKGs and non-UKGs. Table 5 and Figure 8 present the results of this in-depth exploration. Of the average of 347 UKGs that started training, 18.4% (64) would progress to ST6 as expected (in six years). For non-UKGs only 6.5% (11) of trainees would achieve this. From the 2011/12 and 2012/13 cohorts, 54 out of the on average 64 UKGs that progressed as expected to ST6 were on the PSpR within one year after completing ST6 (83.6%). For non-UKGs this average number was 10 out of 11 (95.2%).

Figure 8 illustrates the mean percentages presented in Table 5. Figure 8 shows that the decline in trainee numbers is steeper for non-UKGs. This means that during this period of training, of all trainees that started CT1 relatively more non-UKGs than UKGs are not progressing in the expected way, i.e. without delays. It is important to note, however, that this trend is observed for trainees from levels CT1 to ST4, but not for training levels ST4 to ST6 (more detailed analysis for Specialty training is provided in the section below).

Table 5. Absolute numbers, averages and mean percentages of UKG and non-UKG psychiatry trainees that progress through the total duration of training as expected (in six years without delays).

		2011/ 2012	**2012/ 2013**	**2013/ 2014**	**2014/ 2015**	**2015/ 2016**	**2016/ 2017**	**2017/ 2018**	**Mean**	**Cumulative mean %**
CT1	*UK*	341	315	341	356	354	366	358	347	100%
	Non-UK	184	205	179	182	131	159	95	162	100%
CT2	*UK*	275	257	272	286	295	299		281	80.8%
	Non-UK	133	149	134	129	89	128		127	78.3%
CT3	*UK*	212	195	225	252	258			228	65.8%
	Non-UK	91	100	93	96	70			90	55.5%
ST4	*UK*	112	103	128	120				116	33.3%
	Non-UK	18	16	16	17				17	10.3%
ST5	*UK*	91	84	110					95	27.4%
	Non-UK	18	10	14					14	8.6%
ST6	*UK*	61	67						64	18.4%
	Non-UK	11	10						11	6.5%
On PSpR	*UK*	53	54						54	15.4%
	Non-UK	11	9						10	6.2%

Note. PSpR – Psychiatry Specialty Register on the LRMP within a calendar year of completion of ST6.

As reported earlier, Figure 8 also shows that the largest drop for both groups, UKGs and non-UKGs, is observed between CT3 and ST4. However, this drop is steeper for non-UKGs compared to UKGs: on average 50.7% (116 from 228) of UKGs move from CT3 to ST4 without delays, while just 18.6% (17 from 90) of non-UKGs do.

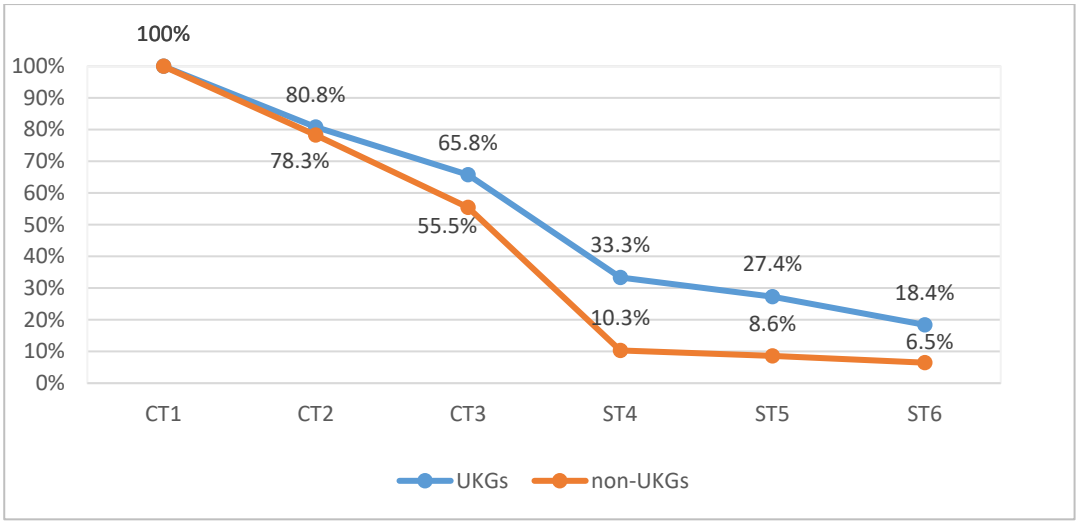

Figure 8. Percentage of UKGs vs non-UKGs who progress as expected (in six years) through all training levels from CT1 to ST6.

Expected progression through psychiatry training: Males vs females

Another grouping relevant to exploring expected trainee progression is male versus female trainees. Table 6 and Figure 9 show that on average 17.8% (35) out of 194 male trainees progress through their training in six years, whereas only 12.8% (40) out of 314 women do so. Of the average 35 male trainees in ST6 32 (91.3%) would be on the PSpR within one year after they completed the ST6 training level. For females this number would be lower: 80% (on average 32 out of 40).

Table 6. Absolute numbers, averages and mean percentages of male and female psychiatry trainees that progress through the total duration of training as expected (in six years without delays).

		2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	Mean	Cumulative mean %
CT1	*Male*	186	207	198	219	197	202	151	194	100%
	Female	339	313	322	309	288	323	302	314	100%
CT2	*Male*	144	168	157	178	163	178		165	84.8%
	Female	264	238	249	237	221	249		243	77.5%
CT3	*Male*	120	136	136	171	148			142	73.2%
	Female	183	159	182	177	180			176	56.2%
ST4	*Male*	48	43	68	74				58	30%
	Female	82	76	76	63				74	23.7%
ST5	*Male*	45	39	63					49	25.2%
	Female	64	55	61					60	19.1%
ST6	*Male*	35	34						35	17.8%
	Female	37	43						40	12.8%
On PSpR	*Male*	33	30						32	16.2%
	Female	31	33						32	10.2%

Note. PSpR – Psychiatry Specialty Register on the LRMP within a calendar year of completion of ST6.

Figure 9 shows that the overall decline in trainee numbers from CT1 to ST6 is steeper for females. Figure 9 also shows that while for both male and female trainees the most drastic drop in numbers is between CT3 to ST4, the slightly steeper decline at this point in training is visible for male trainees compared to female trainees: 41% (58 from 142) of male vs 42.1% (74 from 176) of female trainees progress from CT3 to ST4 without delays.

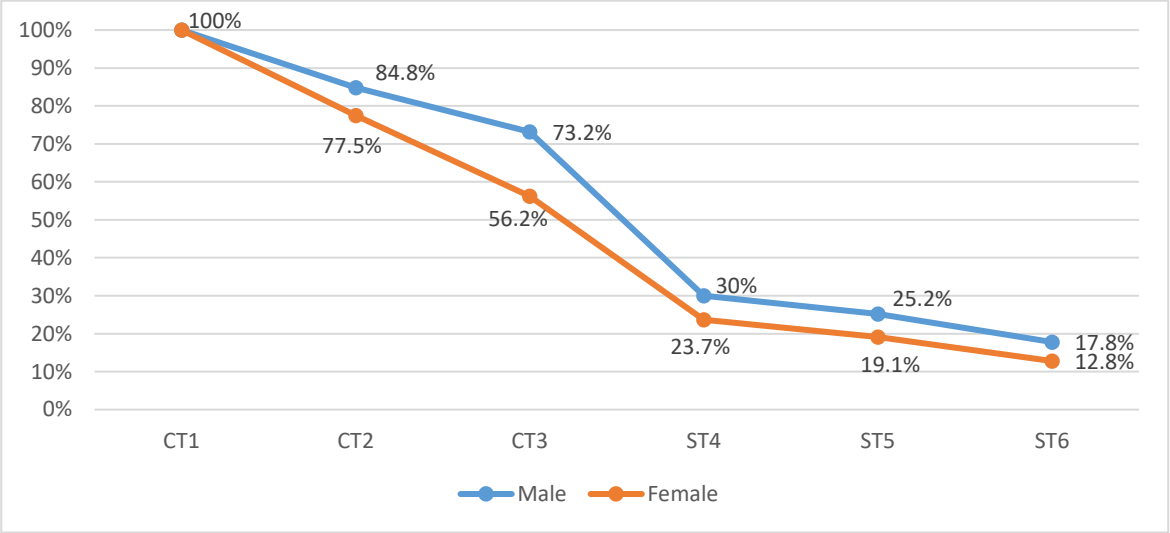

Figure 9. Percentage of male versus female psychiatry trainees that progress through training as expected (in six years without delays).

Expected progression through Specialty training

To analyse expected progression through Specialty training we selected all trainees that started ST4 between the academic years 2011/2012 and 2017/2018. It should be noted that, similarly to the CT1 cohorts, our starting cohorts (represented by the ST4 row in Table 7) consisted of trainees that were starting ST4 for the first time as well as trainees who were delayed in their training.

From the total number of trainees starting their Specialty training (ST4) on average 53.8% (240 out of 445) progress in three years to ST6. This percentage is lower compared to the expected progression in Core training (from CT1 to CT3: 62.7%). On average 87.1% (209) of all ST6 trainees (240) would be on the PSpR within one year after completing ST6 training level (Table 7).

Table 7. Absolute numbers, averages and mean percentages of psychiatry trainees that progress through Specialty training as expected (in six years without delays).

	ST4 in 2011/ 2012	**ST4 in 2012/ 2013**	**ST4 in 2013/ 2014**	**ST4 in 2014/ 2015**	**ST4 in 2015/ 2016**	**ST4 in 2016/ 2017**	**ST4 in 2017/ 2018**	**Mean**	**Cumulative mean %**
ST4	492	387	441	490	435	443	429	445	100%
ST5	385	284	300	354	312	316		325	73.1%
ST6	297	207	225	239	230			240	53.8%
On PSpR	267	183	191	203	199			209	46.9%

Note. PSpR – Psychiatry Specialty Register on the LRMP within a calendar year of completion of ST6.

Figure 10 shows that the trends of progression between academic years are similar. There seems to be a steady drop in numbers that is comparable between the progression from ST4 to ST5 and from ST5 to ST6.

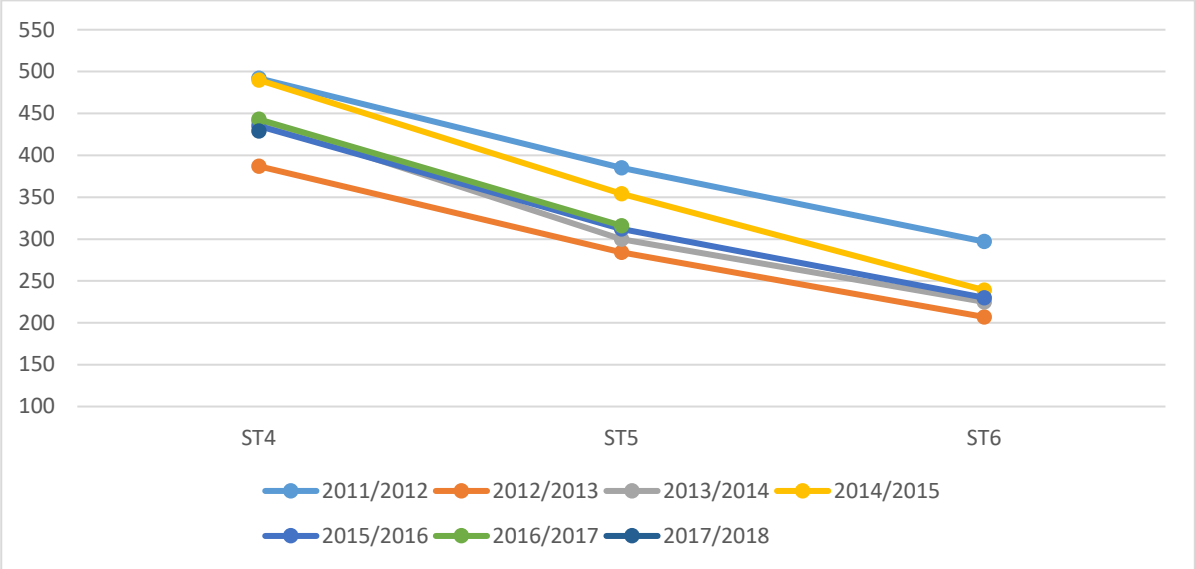

Figure 10. Absolute number of psychiatry trainees that progress through Specialty training as expected (in six years without delays).

Expected progression through Specialty training: UKGs vs non-UKGs

Table 5 shows that a smaller percentage of non-UKGs compared to UKGs complete their Core training without delays (55.5% for non-UKGs vs 65.8% for UKGs). Table 8 and Figure 11 show a reversed trend for Specialty training: on average 44.6% (116) of UKGs vs 66.7% (124) of non-UKGs progress through their Specialty training in three years.

From the 2011/12 and 2012/13 cohorts, of an average of the 116 UKG trainees at ST6 training level, 100 were on the PSpR within one year after completing ST6 (86.5%). For non-UKGs this number was 111, leading to a slightly higher percentage of 89.2% of all 124 non-UKGs at ST6.

Table 8. Absolute numbers and averaged percentages of UK and non-UK psychiatry trainees that progress through Specialty training as expected (in six years without delays).

		2011/ 2012	**2012/ 2013**	**2013/ 2014**	**2014/ 2015**	**2015/ 2016**	**2016/ 2017**	**2017/ 2018**	**Mean**	**Cumulative mean %**
ST4	*UK*	205	197	263	276	267	298	309	259	100%
	Non-UK	287	190	178	214	168	145	120	186	100%
ST5	*UK*	156	132	170	186	191	210		174	67.2%
	Non-UK	229	152	130	168	121	106		151	81.2%
ST6	*UK*	112	94	130	113	129			116	44.6%
	Non-UK	185	113	95	126	101			124	66.7%
On PSpR	*UK*	110	83	106	98	103			100	38.6%
	Non-UK	166	100	85	106	96			111	59.5%

Note. PSpR – Psychiatry Specialty Register on the LRMP within a calendar year of completion of ST6.

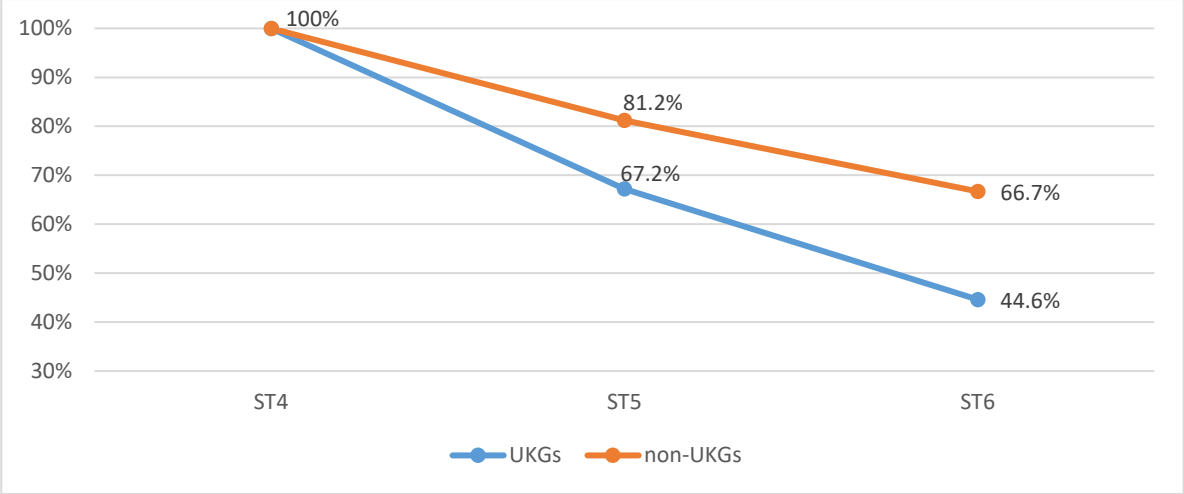

Figure 11. Percentage of UKGs versus non-UKGs that progress through Specialty training as expected (in six years without delays).

Expected progression through Specialty training: Males vs females

Table 6 shows that a smaller percentage of female compared to male trainees complete their Core training without delays (73.2% vs 56.2%). When comparing expected progression through Specialty training for male and female trainees, we can see similar trends: a higher percentage of male trainees progress through their training on time (in three years) compared to female trainees (65.1% vs 49%) (Table 9 and Figure 12). Of an average of 127 male trainees in ST6, 117 would be on the PSpR within one year after they completed the ST6 training level (91.7%). For females this would be 82% (92 out of 112).

Table 9. Absolute numbers and averaged percentages of male and female psychiatry trainees that progress through Specialty training as expected (in six years without delays).

		2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	Mean	Cumulative mean %
ST4	*Male*	243	164	185	187	156	125	309	196	100%
	Female	249	223	256	303	279	173	120	229	100%
ST5	*Male*	207	133	134	149	128	210		160	81.9%
	Female	178	151	166	205	184	106		165	72.1%
ST6	*Male*	179	110	116	121	111			127	65.1%
	Female	118	97	109	118	119			112	49%
On PSpR	*Male*	167	102	104	105	106			117	59.7%
	Female	100	81	87	99	93			92	40.2%

Note. PSpR – Psychiatry Specialty Register on the LRMP within a calendar year of completion of ST6.

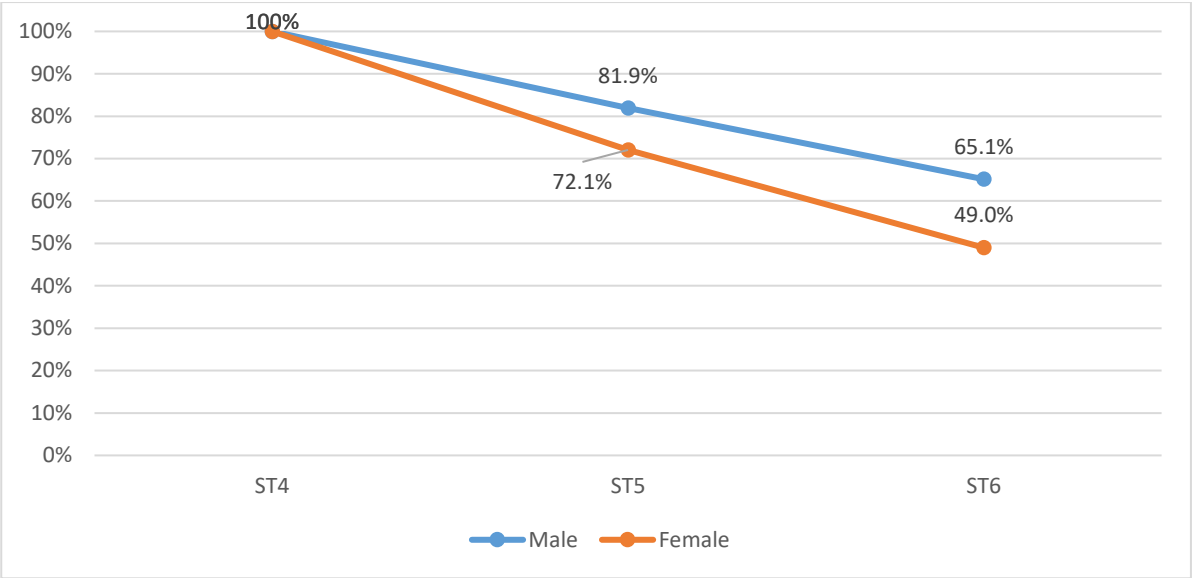

Figure 12. Percentage of male versus female graduate psychiatry trainees that progress through Specialty training as expected (in six years without delays).

Delayed progression

Exploring delayed progression through psychiatry training

From the results on expected progression, it becomes evident that a large number of psychiatry trainees are not progressing through training in the expected way, i.e. progressing through training in six years. This so-called *delayed* progression can occur because of various reasons. Although UKMED allowed us to identify gender differences and differences between UKGs' and non-UKGs' progression, the dataset was not comprehensive enough to make any claims on the underlying explanations of these differences with any certainty. Although straightforward explanations may come to mind (e.g. females may experience more delayed progression due to maternity leave), the qualitative and survey analysis described further on in the report uncover that underlying reasons are complex and reasons like maternity leave are not sufficient to explain a high number of non-progressing females trainees.

From the UKMED we were able to confidently identify three reasons for delayed progression: 1) trainees are staying at the same training level, 2) trainees are changing specialty to GP or 3) changing to another specialty (not GP). All other reasons could be grouped into: 4) other (unusual cases, e.g. regressing one training level down or jumping two training levels up) and 5) unknown (there is no information on these trainees' training level or specialty for the next training year). For the analysis of delayed progression we grouped all trainees that were not progressing as expected into three groups: Core trainees (from CT1 to CT2 and from CT2 to CT3); trainees at the point of going from Core to Specialty training (from CT3 to ST4); and Specialty trainees (from ST4 to ST5 and from ST5 to ST6). We analysed the five reasons for delayed progression mentioned above for these three trainee groups (see Table 10).

Table 10 shows that, on average, 38.2% (197 from 516) of trainees do not progress in the expected way during Core training (from CT1 to CT2 and then from CT2 to CT3 without delays). It can be seen that most of these trainees stay at the same training level (on average 59.3%; Table 10 and Figure 13). On average 9.9% (20) of trainees move to GP training and 2.7% (5) move to another specialty. Another large group of trainees (23.6%, 47) has no data available (unknown). About 4.4% (9) of the trainees take a

different path through training (category "other"), i.e. skipping one or more training levels from one year to the next.

Table 10 also shows that on average 58.1% (184 from 316) of trainees do not progress directly from CT3 to ST4. We see that information about training level and specialty is missing for most of these trainees (60.8%, 112) and most other trainees stay at the same training level (37.1%, 68). Compared to delayed progression during Core training, there are hardly any trainees changing specialties.

On average 40.2% (50 from 125) of ST4 trainees do not progress as expected during Specialty training (Table 10). Most of these trainees stay at the same training level (88%, 44). No trainees switch specialties at this stage and only a few of them are missing in the UKMED (8%, 4).

Table 10. Total and average numbers of trainees that started psychiatry training in 2011/2012 to 2015/2016 that show delayed progression through psychiatry training.

		2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	Mean	%
Core	Total delayed progression	222 (42.3% from 525 CT1)	225 (43.3% from 520 CT1)	202 (38.9% from 520 CT1)	180 (34.1% from 528 CT1)	157 (32.4% from 485 CT1)	197 (38.2% from 516 CT1)	100%
	Stay at the same training level	133	129	129	100	94	117	59.3%
	Move to GP	24	15	21	23	15	20	9.9%
	Move to other specialty	9	5	6	3	4	5	2.7%
	Unknown	53	67	38	41	34	47	23.6%
	Other	3	9	8	13	10	9	4.4%
CT3-ST4	Total delayed progression	173 (57% from 303 CT3)	176 (59.7% from 295 CT3)	174 (54.7% from 318 CT3)	211 (60.6% from 348 CT3)		184 (58.1% from 316 CT3)	100%
	Stay at the same training level	88	72	63	50		68	37.1%
	Move to GP	3	*	0	0		*	*
	Move to other specialty	*	*	0	0		*	*
	Unknown	77	100	110	159		112	60.8%
	Other	4	0	*	*		*	*
Specialty	Total delayed progression	58 (44.6% from 130 ST4)	42 (35.3% from 119 ST4)				50 (40.2% from 125 ST4)	100%
	Stay at the same training level	50	38				44	88%
	Move to GP	0	0				0	0%
	Move to other specialty	0	0				0	0%
	Unknown	6	*				4	8%
	Other	*	*				*	*

Note. Unknown means that there is no information in the UKMED about trainees' training level or specialty. Table is produced using NTS data: * represents supressed data (n<3).

Figure 13 represents the differences displayed in Table 10 and highlights key findings. It shows that most non-progressing trainees at Core and Specialty training stay at the same training level. Changing specialty occurs mainly during Core training. For most of the trainees that do not progress from CT3 to ST4 the next year there is limited information in the UKMED.

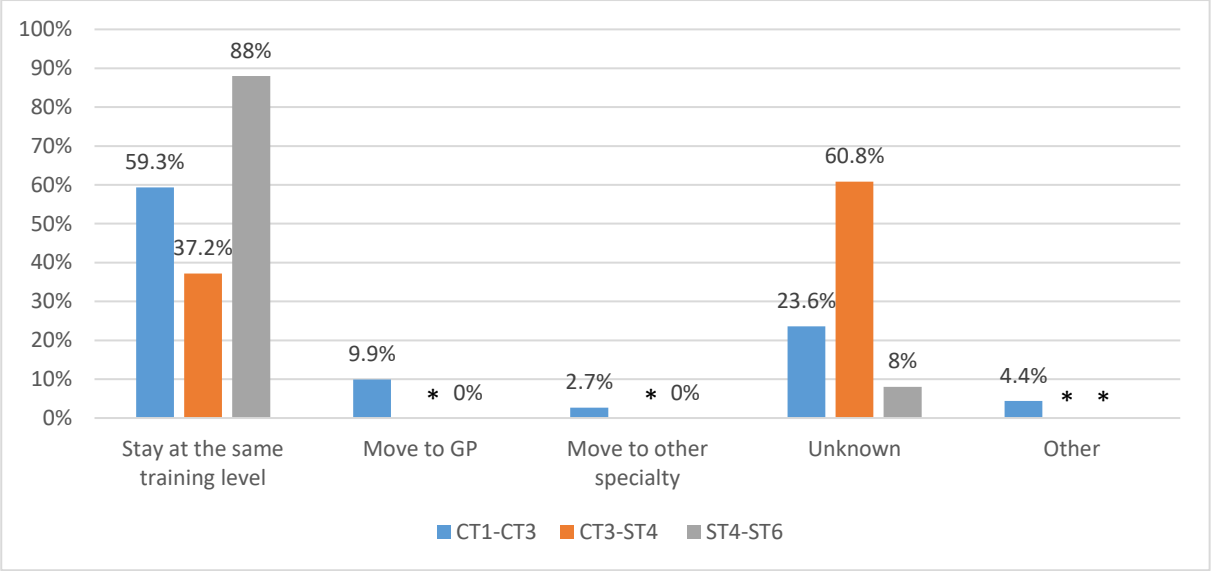

Figure 13. Average percentage of trainees that started psychiatry training in 2011/2012 to 2015/2016 that show delayed progression through psychiatry training. Figure is produced using NTS data: * represents supressed data (n<3).

Exploring the role of the CASC exam in delayed progression

Significant numbers of trainees do not progress from CT3 directly to ST4. In order to progress from CT3 to ST4 a trainee would have to pass the CASC exam. Therefore, failing the CASC exam may explain this delayed pattern of progression.

Table 11 shows how many trainees from those who do not progress from CT3 to ST4 pass or fail their exams and when. This table reveals that of trainees who do not progress from CT3 to ST4, on average 29% (53 from 184) pass their CASC exam on time and should be able to progress from Core to Specialty training as expected. For example, CT1s in 2011/2012 should progress from CT3 to ST4 in 2014, therefore, in order to progress in an expected way they should pass their exams no later than 2014 spring, i.e. exam should be taken in academic year of 2013.[13] From the trainees that started CT1 in 2011/2012, 173 reached CT3 in three years (without delays) but failed to progress as expected from CT3 to ST4, and 23.7% (41) of these trainees did pass their CASC exams and were technically able to progress on time. This analysis shows that failing exams does not fully explain trainees' non-progression from Core to Specialty training.

Table 11 also shows that on average 65.9% (121 from 184) of trainees who do not progress from CT3 to ST4 the next year pass their exam at some point. The information about exams is missing for on average 23.8% (44 from 184) of trainees.

[13] The date at which a trainee passes or fails the CASC exam is registered as the academic year.

Table 11. Number of trainees that pass and fail their CASC exams before and after their transition time from CT3 to ST4.

		TOTAL N of delayed progression between CT3/ST4				TOTAL average
		CT1 in 2011/2012	CT1 in 2012/2013	CT1 in 2013/2014	CT1 in 2014/2015	
		173 (100%)	176 (100%)	174 (100%)	211 (100%)	184 (100%)
CASC in 2013[1]	Fail	21	1			
	Pass	41	0			
CASC in 2014[1]	Fail	39	23	1		
	Pass	45	50	0		
CASC in 2015[1]	Fail	32	50	30	0	
	Pass	18	38	44	1	
CASC in 2016[1]	Fail	20	53	49	10	
	Pass	15	24	48	78	
CASC in 2017[1]	Fail	6	35	28	29	
	Pass	2	15	15	50	
Total pass at any time		121 (69.9%)	127 (72.2%)	107 (61.5%)	129 (61.1%)	121 (65.9%)
Total pass till the end of CT3		41 (23.7%)	50 (28.4%)	44 (25.3%)	78 (37.4%)	53 (29%)
Missing exam data		34 (19.7%)	30 (17%)	46 (26.4%)	65 (30.8%)	44 (23.8%)

Note. Light yellow cells: exam is passed before the expected progression time. [1] Academic year.

Key findings

From the analyses of UKMED several key findings can be derived which are presented in Box 2.

Box 2. Key findings from the analysis of the UKMED.

- On average, only 14.7% of trainees progress through the total duration of training as expected, meaning they progress through their training from CT1 to ST6 in six years total. However, approximately 62.7% of trainees progress through their Core training without delays (CT1 to CT3 in 3 years) and about 53.8% progress through their Specialty training without delays (ST4 to ST6 in 3 years).
- A higher percentage of UKGs (18.4%) than non-UKGs (6.5%) progress through the total duration of training as expected. However, a higher percentage of non-UKGs (66.7%) than UKGs (44.6%) progress as expected from ST4 to ST6.
- A higher percentage of males (17.8%) than females (12.8%) progress through the total duration of training as expected. Likewise, more males (65.1%) than females (49%) progress as expected from ST4 to ST6.
- Although trainees in general are lost at each level of training, by far the largest drop in trainee numbers is at the transition from CT3 to ST4. On average, only 133 of the 318 (41.6%) trainees that made it to CT3 as expected are continuing to progress to ST4 the next year. Failing the CASC exam does not fully explain trainees' non-progression from CT3 to ST4: on average 29% of CT3 trainees pass their CASC exam on time and should be able to progress from Core to Specialty training as expected but do not do that.
- After completing training as expected 85.2% of the trainees in ST6 are on the PSpR within one year after completion of ST6. For trainees that progressed as expected from ST4 onwards, this percentage is 87.1%.
- Although on average only 75 trainees progress through their training program in an expected way each year, there are still on average 473 trainees reaching ST6 each year. This means that most trainees reach ST6 in a delayed way.
- The largest percentage of trainees who do not progress in the expected way stay at least one year at the same trainee level (59.3% during the transition through Core training, 37.2% in the transition from CT3 to ST4 and 88% during the transition through Specialty training).
- On average 9.9% of trainees who do not progress in Core training move to GP and 2.7% move to another specialty. After Core training it is very unlikely for trainees to switch to another specialty.

Research Objective 2: Identify the factors that contribute to psychiatry trainees leaving (or intending to leave) their training and the factors that contribute to trainees staying.

This section will present the findings from the survey analysis. Qualitative and quantitative data will help to explore what factors contribute to psychiatry trainees leaving (or intending to leave) or staying in their training (Research Objective 2).

Methodology

Sample and recruitment

All current and former (who left or made official plans to leave) Core and Specialty psychiatry trainees in London were invited to complete a web-based survey (on the *Online survey©* platform) from July to November 2019. Current trainees and trainees who made official plans to leave their training were invited via email distributed by London Deaneries and via social media platforms. Trainees who had left their training were invited to participate via social media platforms. In total 163 trainees took part in this part of the research (distribution by region in Table 12).

Table 12. Number of participants by London region.

Region	**% (n)**
South West	11% (18)
South East	35.6% (58)
North East	15.3% (25)
North West	13.5% (22)
North Central	24.5% (40)

The survey

To identify the factors that contribute to psychiatry trainees' decision to stay or leave their training programme, we developed and administered a survey. The survey consisted of a section on socio-demographic characteristics of trainees (i.e. trainees' gender, ethnicity, level of training, etc.) as well as two main parts, described in more detail below: Survey Part 1 and Survey Part 2. All current trainees and trainees who were planning to leave or had left training completed the questions on socio-demographic characteristics and parts of Survey Part 1 (see below). Trainees who were planning to leave or left training did not complete Survey Part 2.

Survey Part 1

The first part of the survey was developed based on previously published studies, see for example Choudry and Farooq (2017); Gafson, Currie, O'Dwyer, Woolf, and Griffin (2007); Lambert et al. (2006); Sarfraz, Merrony, and Atkins (2016), and in consultation with Health Education England (HEE) and the Royal College of Psychiatry (RCPsych). It consisted of open as well as closed items on trainees' views concerning attrition

and peri-attrition (consideration to leave). An overview of questions and which trainee group (current trainees, trainees who left and trainees who made official plans to leave) answered which questions is provided in Table 13 and all questions from Survey Part 1 are presented in Appendix A.

Table 13. Overview of the topics and questions that were used in Survey Part 1.

Question	Question type	Trainees		
		Current	Made official plans to leave	Left training
Positives about psychiatry training				
What do (did) you enjoy about your psychiatry training?	Multiple choice	X	X	X
Other	Open-ended	X	X	X
If you have had doubts but have chosen to stay, what has made you want to continue with psychiatry training?	Open-ended	X		
Challenges				
What do you find challenging about psychiatry training?	Multiple choice	X	X	X
Other	Open-ended	X	X	X
If you would like to expand on your answers, please do so here:	Open-ended	X	X	X
I am satisfied with the transport facilities at my workplace (e.g. car parking, public transport connections)	Likert scale	X		
I am satisfied with my workplace amenities (e.g. café, canteen, staff mess)	Likert scale	X		
Leaving training plans and experiences				
What are you doing now (considering doing) instead? / If you considered leaving the speciality, what were you planning on doing instead?	Open-ended	X	X	X
Out of Programme Experience				
Have you taken time out of programme during your psychiatry training?	Single choice	X	X	
If Yes: How long were you out of programme?	Single choice	X	X	
If Yes: Why did you take time out of programme?	Open-ended	X	X	
If Yes: What did you gain from your time out of programme?	Open-ended	X	X	
Voicing concerns				
Before leaving the speciality, did you voice your concerns to any of the following people? / Have you voiced your concerns/discussed these challenges with any of the following people?	Multiple choice	X	X	X
Other	Open-ended	X	X	X
If Yes: What was the advice from those you liaised with and was it useful?	Open-ended	X	X	X
Perceptions of the role of the Colleges, Deaneries, and supervisors				

What do you think the Deanery/College/supervisors could do to support trainees who are considering leaving?	Open-ended	X	X	X

Survey Part 2

Only trainees that were currently doing psychiatry training completed the second part of the survey. This part of the survey included questionnaires that had been validated through previous research. The survey covered the following topics: trainees' intentions to leave psychiatry training, burnout, work engagement, commitment to their occupation, perceived job demands and resources, and trainees' psychological detachment from work (which is part of the overarching concept of recovery experiences during time after work). A detailed description of these constructs and how these were measured is provided in Table 14.

Data analysis

We used SPSS Version 26.0 and the R Project for Statistical Computing Version 3.6.2 to analyse the quantitative information from the first and second part of the survey. To analyse Survey Part 1 (e.g. to describe the percentage of trainees finding work-life balance challenging because of training) we used descriptive analysis depicting frequencies and percentages. To analyse the factors that predict trainees' intentions to leave psychiatry training (Survey Part 2) we provide basic descriptive statistics and further calculated the internal consistency (Cronbach's α), correlations between constructs and performed structural equation modelling. We tested for mediating effects of recovery experiences (psychological detachment from work) and occupational commitment in the model by using linear multiple regression and Sobel's test.

Open-ended responses were analysed in NVivo 12 through inductive content analysis (Armat, Assarroudi, Rad, Sharifi, & Heydari, 2018). Questions were grouped into categories believed to elicit similar information (as shown in Table 13). Responses in each category were then analysed with codes being generated inductively throughout the analysis process. Codes were then grouped into broader themes. The more frequently entered comments and their corresponding themes are presented in the results.

Table 14. Detailed description of the constructs and questionnaires used in Survey Part 2.

Measured construct	**Description of the construct**	**Measure and subscale used** (if applicable)	**Scoring**	**Example item**	**Cronbach's α***
Intentions to leave psychiatry training	The extent to which trainees are thinking about leaving their profession and/or are looking for another job.	Measure: Turnover intentions (Cohen, 1998)	3 items; 5 point scale: *Strongly disagree - Strongly agree*	I think a lot about leaving the profession	0.9
Affective occupational commitment	The extent to which trainees are positively emotionally attached to the occupation.	Measure: Three-Component Model of Commitment Subscale: Affective commitment (Meyer & Allen, 1991)	6 items; 7 point scale: *Strongly disagree - Strongly agree*	I am proud to be in psychiatry training	0.8
Work engagement	Vigor (mental resilience at work/high energy), absorption (happily engrossed in one's work), and dedication (taking pride in one's work/strong involvement).	Measure: Utrecht Work engagement scale (Schaufeli & Bakker, 2003)	9 items; 7 point scale: *Never - Always/Every day*	I am enthusiastic about my job	0.9
Burnout	Exhaustion (loss of energy/mental or physical exhaustion), mental distancing (cynicism/psychological distancing from work), emotional impairment (feeling overwhelmed or having intense emotions), and cognitive impairment (memory issues/attention and concentration deficits).	Measure: Burnout Assessment Tool (Schaufeli, De Witte, & Desart, 2019)	23 items; 5 point scale: *Never - Always*	At work, I feel mentally exhausted	0.9
Job demands					0.9
Emotional demands	The extent to which one deals with emotional demands at work; e.g. patients with unrealistic expectations/emotional labour (displaying emotions that are inconsistent with current feelings).	Measure: Demand-Induced Strain Compensation Questionnaire Short Version Subscale: Emotional demands (De Jonge et al., 2007)	6 items; 5 point scale: *Never or very rarely - Very often or always*	I have to do a lot of emotionally draining work.	0.8
Job efforts	The extent to which one puts efforts in everyday work/deals with time pressure and disruptions.	Measure: Effort-Reward Imbalance Questionnaire Short Version Subscale: Job efforts	3 items; 4 point scale: *Strongly disagree - Strongly agree*	I have constant time pressure due to a heavy work load	0.8

			(Siegrist, Li, & Montano, 2014)			
	Aggression from patients	The frequency of being confronted with aggression at work.	Selected items from the Perception of Prevalence of Aggression questionnaire (Oud, 2001)	10 items: 5 items x 5 point scale: *Never - Frequently;* 5 items x "*how many times*"	To what extent have you been confronted with physical violence during the last year in the course of your work?	0.7
Job resources						0.9
	Support from the supervisor	The extent to which one receives support from the supervisor, such as advice, feedback, and sympathy.	Measure: Social support questionnaire (O'Driscoll, Brough, & Kalliath, 2004)	4 items; 5 point scale: *Never - All the time*	How often, over the previous three months, have you received support from your clinical supervisor: *Helpful information or advice*	0.9
	Autonomy	The extent to which a participant can choose how work is carried out.	Measure: Autonomy and control (Haynes, Wall, Bolden, Stride, & Rick, 1999)	6 items; 5 point scale: *Not at all - A great deal*	The following questions concern the amount of choice you have in your job. To what extent do you: *Plan your own work*	0.9
	Task significance	The degree to which one's work influences the lives of others.	Measure: The Work Design Questionnaire Subscale: Task Significance (Morgeson & Humphrey, 2006)	4 items; 5 point scale: *Strongly disagree - Strongly agree*	The job itself is very significant and important in the broader scheme of things	0.8
Recovery experiences (psychological detachment from work)		The extent to which one is psychologically detached from work, such as mental disengagement from work, not thinking about work or work problems after work hours.	Measure: Recovery Experience Measure Subscale: Psychological detachment (Sonnentag & Fritz, 2007)	4 items; 5 point scale: *Do not agree at all - Fully agree*	During time after work, I forget about work	0.8

*A Cronbach's α higher than 0.7 is considered to show high internal consistency (measure of reliability).

Results

Socio-demographic characteristics

One hundred and sixty-three trainees completed the survey. The majority of trainees were current trainees (97.5%, 159); four were planning to leave (1.2%, 2) or had left training (1.2%, 2). We asked participants who had left training when they had done so – one had left 1-2 months before taking the survey and one had left 3-5 months before taking the survey.

Socio-demographic characteristics of trainees who took part in this survey are presented in Table 15. The majority of current trainees were female (62.9%), white (64.8%), without children or other caring responsibilities (69.8%), UKGs (79.9%), and working full-time (82.4%). Similar numbers of Core (56.6%) and Specialty trainees took part in this study (41.5%). Participants mainly perceived that they worked contracted hours (47.8%) or 1-4 hours over contracted hours (39.6%) and were on-call for 1-5 nights per month (54.7%). A total of 93.9% of participants said that psychiatry was their first choice.

Table 15. Socio-demographic characteristics of the study sample.

Variables		Current trainees (N = 159)	Planning to leave or left training (N = 4)
Gender			
	Male	34.6% (55)	25% (1)
	Female	62.9% (100)	75% (3)
	Other	1.2% (2)	0% (0)
	Missing	1.3% (2)	0% (0)
Ethnicity			
	White	64.8% (103)	50% (2)
	BME	34% (54)	50% (2)
	Missing	1.3%(2)	0% (0)
Dependents			
	Yes	27.7% (44)	50% (2)
	No	69.8% (111)	50% (2)
	Missing	2.5% (4)	0% (0)
Region of PMQ			
	UK	79.9% (127)	75.0% (3)
	Non-UK	19.5% (31)	25% (1)
	Missing	0.6% (1)	0% (0)
Training level			
	Core	56.6% (90)	n/a
	Speciality	41.5% (66)	n/a
	Missing	1.9% (3)	n/a
Work pattern			
	Full-time	82.4% (131)	n/a
	Less than full-time	17% (27)	n/a
	Missing	0.6% (1)	n/a

Working hours per week			
	Contracted hours	47.8% (76)	n/a
	1 - 4h over contracted hours	39.6% (63)	n/a
	5 - 9h over contracted hours	8.8% (14)	n/a
	10 - 14h over contracted hours	1.3% (2)	n/a
	≥ 15h over contracted hours	0.6% (1)	n/a
	Missing	1.9% (3)	n/a
Nights on call per month			
	None	8.2% (13)	n/a
	1 - 5	54.7% (87)	n/a
	6 - 10	30.2% (48)	n/a
	11 - 15	3.1% (5)	n/a
	16 - 20	0% (0)	n/a
	≥ 21	1.3% (2)	n/a
	Missing	2.5% (4)	n/a
A clinical fellow or clinical lecturer funded or approved by NIHR			
	Yes	4.4% (7)	n/a
	No	93.7% (149)	n/a
	Missing	1.9% (3)	n/a
Psychiatry first choice			
	Yes	96.2% (153)	100% (4)
	No	3.8% (6)	0% (0)
	Missing	0% (0)	0% (0)

Note. PMQ – primary medical qualification; BME – black minority ethnic group.

Just four trainees who had left or made official plans to leave filled in the survey and therefore the distribution of socio-demographic characteristics is less diverse (Table 15). The majority of these trainees were female (75%) and UKGs (75%). There was an equal split between white and BME trainees (50%), and between those with and without dependents (50%). All trainees who were planning to leave or had left training said that psychiatry was their first choice.

Survey Part 1

This section will discuss trainees' views on: positives about psychiatry training, challenges in psychiatry training, leaving training plans and experiences, out of programme experience, voicing concerns, and perceptions of the role of the Colleges, Deaneries, and supervisors in supporting trainees who are considering leaving. This section will report on the combined quantitative and qualitative results for each of these overarching topics. See Table 13 for an overview of the questions. For open-ended responses, current trainees, those who had made plans to leave, and those who had already left training, described similar issues. Therefore, distinction will be made only if there is a clear divergence in responses between these groups.

Positives about psychiatry training

Table 16 shows what trainees enjoy(ed) about psychiatry training. The majority of current trainees enjoyed patient related aspects (complexity of conditions, more time for patients, and clinical diversity), the nature of work (intellectually comprehensive, working in a team, and holistic care), and training arrangements (supervision and hours). Trainees who left or made official plans to leave picked similar factors (e.g. complexity of conditions, more time for patients, intellectually comprehensive, and hours).

Table 16. Factors trainees enjoy(ed) about their training*.

	Current trainees (N = 159)	**Planning to leave or left training (N = 4)**
Fascinating patients with complex and interesting conditions	89.3% (142)	50% (2)
More opportunity to spend time and get to know patients than in other specialties	82.4% (131)	50% (2)
Clinical diversity of the work	74.2% (118)	25% (1)
Intellectually comprehensive with sufficient academic challenge	74.2% (118)	50% (2)
Holistic bio-psycho-social, 'whole patient' approach	74.2% (118)	0% (0)
Working as part of a team	70.4% (112)	25% (1)
Good quality of supervision	69.2% (110)	25% (1)
Hours and work-life balance	66.7% (106)	50% (2)
Receiving good training	60.4% (96)	0% (0)
Feeling you are 'making a difference' in a significant area of healthcare	51.6% (82)	25% (1)
Good future career opportunities	47.8% (76)	0% (0)
Opportunities for flexible working	45.9% (73)	50% (2)
Access to inspirational role models	37.1% (59)	0% (0)
Exciting potential scientific advances	30.8% (49)	0% (0)
Good opportunity for service development	28.3% (45)	0% (0)
Other	1.9% (3)	0% (0)

Note. *Participants chose all applicable answers.

Trainees were invited to give further details if they had selected the option 'other', and were asked what made them want to continue with psychiatry training if they had doubts but decided to stay. Comments referred to 1) the love for both their job and psychiatry as a subject, as well as 2) experiencing positive interpersonal interactions with patients and colleagues. Notably, trainees also described remaining in training because of 3) job security.

First, the single most described positive of psychiatry training was love for the job and psychiatry as a subject. Trainees were passionate about psychiatry and described finding it an interesting specialty to work in. Trainees described a sense of loyalty to the specialty, and described having a natural affinity for psychiatry, which made the prospect of working in an alternative specialty or profession undesirable.

I am passionate about psychiatry and love learning about it and so can't see myself in another job lacking passion.

Female, UKG, Core trainee

In particular, participants described enjoying the intellectual nature of psychiatry, in spite of the day-to-day challenges of working as a trainee. Trainees enjoyed the emphasis on research, education and academia in psychiatry, with special interest days, the academic programme and protected teaching time being appreciated.

Unsure what else to do… Psychiatry fascinates me and difficult to find something which fascinates me just as much.

Female, UKG, Core trainee

Second, positive interpersonal interactions came from both enjoyment of working with patients and positive experiences of team working. Trainees enjoyed having a sense of purpose, and described that work was rewarding when they felt they had made a positive impact on the lives of their patients.

Some days I feel dejected and wonder about the purpose of my job but other days I get to help a person and that keeps me going.

Male, non-UKG, Core trainee

Finally, the financial and psychological security associated with remaining in training was described at length by trainees. Remaining in training as default most commonly was in the form of the decision to continue until the next clear training milestone, the financial security associated with remaining in training, and the fear of potentially starting their career again.

I am staying currently as I am early in my career and 1 year in to Core training. Currently I intend to complete Core training but don't see myself completing Specialty training.

Female, UKG, Core trainee

Challenges in psychiatry training

Table 17 presents what current trainees find challenging about psychiatry training and what factors trainees who left and made official plans to leave identified as contributing to their decision to leave. The challenges which were most frequently identified by current trainees (more than 30%) were systemic and trust-wide issues (under-resourced, systematic changes, and rota gaps), cultural and societal influences in psychiatry training (level of accountability, stigma), and stress/workload. Among trainees who left and made official plans to leave the main reasons for leaving were their inability to see themselves as consultants in psychiatry. In some instances, this was because they considered themselves to have unsuitable personality traits. This was identified by 75%, 3 trainees.

Table 17. Challenges in psychiatry*.

	Current trainees (N = 159)	**Planning to leave or left training (N = 4)**
Under-resourced in relation to other branches of medicine	66% (105)	0% (0)
Systemic changes and constraints within the NHS (e.g. reforms, target culture, long waiting lists)	66% (105)	25% (1)
Problems and gaps within rotas	50.9% (81)	0% (0)
Psychiatrists held accountable for adverse patient outcomes more than in other specialities	46.5% (74)	50% (2)
High stress and workload, feeling burnt-out	37.7% (60)	25% (1)
Stigma or lack of respect for psychiatrists within medicine	35.8% (57)	50% (2)
I can't see myself coping with or enjoying becoming a consultant psychiatrist	29.6% (47)	75% (3)
Verbal or physical abuse from patients	28.3% (45)	25% (1)
Involvement in a difficult case or event (e.g. patient suicide)	25.8% (41)	0% (0)
Job is too repetitive and/or bureaucratic	23.9% (38)	25% (1)
Cultural or societal stigma about psychiatrists	22.6% (36)	25% (1)
Feel training needs are not being met	15.1% (24)	0% (0)
Poor work/life balance as a trainee	13.8% (22)	25% (1)
Feel work is not valued or making a difference	13.2% (21)	25% (1)
Personal and/or health reasons	11.9% (19)	25% (1)
Number of locum doctors	9.4% (15)	0% (0)
Bullying or undermining from other staff	8.2% (13)	0% (0)
Unsupported work environment/poor relationship with colleagues	8.2% (13)	25% (1)
Interest in another specialty	5% (8)	25% (1)
Psychiatry wasn't what I expected	2.5% (4)	50% (2)
My personality is not suitable for psychiatry	0.6% (1)	75% (3)
Failed to progress/formally asked to leave	0% (0)	0% (0)
Other	6.9% (11)	25% (1)

Note. *Participants chose all applicable answers.

Trainees were invited to elaborate on their answers, or to give further details if they had selected the option 'other'. Comments under the theme 'challenges in psychiatry training' related mainly to 1) systemic and trust-wide issues, as well as to 2) perception of risk at work.

Systemic issues predominantly included comments around under-resourcing. In particular, inadequate rest facilities for on-call shift work, long referral waiting times for community services, and understaffing were all identified as negatively impacting the training experience. Trainees commented on the burden of administration, such as ward round documentation and writing clinic letters. Trainees believe that this took time away from completing clinically important tasks.

Due to health inequity there have been numerous cuts to services over the years causing detrimental effects on the mental health of our patients, and to staff morale.

Female, UKG, Core trainee

I have found the emphasis on teams attaining arbitrary targets (mostly based on duplications of documentation into various places in electronic notes) tedious and a very poor basis for gauging how "successful" an individual clinician or team is. Also it seems to have nothing at all to do with if a patient is improving or not.

Male, UKG, left or planning to leave training

In relation to perceptions of risk, trainees focussed their comments on aggression from patients and their relatives, emotional burden, and lack of senior support. Aggression from patients and relatives was reported to be in the form of both verbal and physical assault. The violent nature of work was identified as a cause of increased emotional burden, as well as feeling undervalued and inadequate as a trainee.

I had 3 serious incidents (2 violent attacks and 1 suicide which I witnessed) very early on in my training as a CT1 and feel they have left me traumatised and on edge.

Female, UKG, Speciality trainee

In light of this, the perceived lack of support was described by trainees as being particularly evident during on-calls, where trainees felt especially vulnerable and the absence of seniors and fellow trainees left them feeling unsafe.

I work very independently in both my day job and on-calls. As a CT1, I feel my work should be more closely supervised as I am still unaware of what I do not know.

Female, UKG, Core trainee

In addition, current trainees were asked specifically about their satisfaction with the transport facilities (e.g. car parking, public transport connections) and workplace amenities (e.g. café, canteen, staff mess). Table 18 shows that more than half of trainees (54%) were satisfied with transport facilities while just approximately one third (35.2%) were satisfied with the workplace amenities.

Table 18. Trainees' satisfaction with transport facilities and amenities at their workplace.

	Strongly disagree/Disagree	**Neither agree nor disagree**	**Agree/Strongly agree**
I am satisfied with the transport facilities at my workplace	35.2% (56)	10.7% (17)	54% (86)
I am satisfied with my workplace amenities	51.6% (82)	13.2% (21)	35.2% (56)

In Survey Part 2, current trainees were also asked about aggression from patients. We have investigated these answers in a descriptive manner here (in addition to further analysis described in the Survey Part 2 section) as trainees mentioned aggression as one of the main challenges (see Table 19). More than a

third of trainees often or frequently experienced verbal and behaviour aggression and were exposed to suicide attempts. Physical violence and sexual intimidation/harassment was less often reported; however, for example, just 34% (54) of trainees did not experience physical violence. 25.7% (41) of trainees experienced a suicide occasionally or more often.

Table 19. Frequency of trainees experiencing aggression at work in the last year.

	Never	Occasionally	Sometimes	Often	Frequently
Verbal and behaviour aggression	4.4% (7)	27.7% (44)	32.7% (52)	17% (27)	18.2% (29)
Physical violence	34% (54)	37.1% (59)	17.6% (28)	6.9% (11)	4.4% (7)
Suicide attempts*	11.9% (19)	30.8% (49)	21.4% (34)	22.6% (36)	12.6% (20)
Suicide	74.2% (118)	21.4% (34)	3.1% (5)	0.6 %(1)	0.6 %(1)
Sexual intimidation/harassment	49.1% (78)	35.8% (57)	10.1% (16)	5% (8)	0% (0)

Note. *n=1 missing.

Leaving training plans and experiences

Trainees who left and made official plans to leave were asked to share what they were currently doing (or considering doing instead of training), and current trainees were asked to share what they were planning to do if they considered leaving their training.

Of those who had not made plans to leave, the desire to work in management and leadership, leave healthcare completely, and remain in clinical work featured prominently. Working in management and leadership was linked to being able to make changes to the NHS at an organisational level, for example, being involved in healthcare policy development.

> *Hopefully remaining in health care, looking for a role where feel I can make a difference on larger scale, looking specifically at improving the huge difficulties and inadequacies of current health care system in delivering good care.*
>
> **Female, UKG, Specialty trainee**

Trainees who had left training and trainees who had made plans to do so intended to remain in clinical work by undertaking psychiatry related work, i.e. work in non-training psychiatry posts. Most commonly, trainees described intending to work in staff grade psychiatry positions, whereas others planned to develop skills within psychiatry, such as psychotherapy. Retraining in an alternative specialty was also identified as a common intention; palliative care, general practice and public health were among the named alternative specialties. Leaving healthcare to work in industries such as law, accounting and business was also described as a desirable alternative to training.

Out of Programme Experience (OOPE)

Current trainees and trainees who made official plans to leave (N = 161) were asked about Out of Programme Experiences (OOPE). The majority of trainees (61.4%, 99) did not take time out of the programme but 11.8% (19) had seriously considered taking time off. A total of 26.7% of trainees (43) had taken time out during

psychiatric training. From these trainees who had taken an OOPE: 7% (3) took time out for 6-12 months, 41.9% (18) for 6-12 months, 32.6% (14) for 1-2 years, 11.6% (5) for 2-3 years, 7% (3) for 3 years or more.

Trainees who had an OOPE were invited to give details about their reasons for wanting to undertake an OOPE and what they felt they gained from the experience in free text answers. Trainees' motivations could be grouped into two distinct categories: for personal reasons and for Curriculum Vitae (CV) building.

Personal reasons were predominantly maternity leave, followed by trainees who wished to experience working abroad. Other personal reasons included time to host life events such as marriage, spend time with family and friends, and caring responsibilities. Trainees also took time out in order to prioritise their own wellbeing such as recovery from burnout or family bereavement.

> *I felt burnt-out and needed to spend time with family and catch up on all my responsibilities that I felt were unfulfilled.*
>
> **Female, non-UKG, Specialty Trainee**

The opportunity for trainees to improve their CV most prominently took the form of wanting to complete fellowships in education or management and leadership. Additionally, participants wanted to use OOPEs to further their education in the form of a PhD, masters or postgraduate certificate. Trainees also took the opportunity to pursue academia and undertake research. A few trainees undertook an OOPE due to exam failure.

In general, the outcomes of the OOPE matched the intended motivations. Additionally, trainees noted a renewed appreciation for psychiatry and increased confidence in their own clinical practice after undertaking an OOPE.

> *[I gained] a huge amount. More experience in clinical work, teaching, academia, management and leadership. The opportunity to travel and work with a diverse population. New friendships and work relationships.*
>
> **Female, UKG, Specialty Trainee**

Voicing concerns

Table 20 shows that most of the current trainees discussed the challenges related to training with their personal and work contacts. However, 11.9% (19) of current trainees chose not to share the challenges they were facing. All trainees who left and made official plans to leave had talked to consultants and educational supervisors about their concerns before leaving the specialty.

Table 20. The type of people that trainees share their concerns/challenges with*.

	Current trainees (N = 159)	**Planning to leave or left training (N = 4)**
Friends outside work	61.6% (98)	50% (2)
Colleague at your level	61% (97)	75% (3)
Consultant	60.4% (96)	100% (4)
Family	59.7% (95)	50% (2)
Educational Supervisor	47.2% (75)	100% (4)
Senior colleague	31.4% (50)	50% (2)
Other healthcare professional	22.6% (36)	0% (0)
Training Programme Director	13.2% (21)	75% (3)
Did not share concerns	11.9% (19)	0% (0)
Careers advisor	5.7% (9)	25% (1)
College tutor	3.1% (5)	25% (1)
Head of School	0.6% (1)	0% (0)
Other	3.8% (6)	0% (0)

Note. *Participants chose all applicable answers.

Trainees were invited to elaborate on their answers, or to give further details if they had selected 'other'. Trainees were also asked to share the nature of the advice they received, and whether they found it to be useful.

Trainees most prominently described choosing to voice concerns to senior psychiatrists, with varying degrees of perceived usefulness. Trusted senior psychiatrists included clinical supervisors, training programme directors, and clinical directors. Many trainees recalled that when voicing concerns to senior members of staff, if they were advised that issues they faced in training were due to wider problems within the NHS, they could be left feeling discouraged about the future. Additionally, trainees reported that the trusted seniors would at times take the opportunity to share their own challenges of practicing as a psychiatrist.

> *[I was told that] difficulties are widespread in the specialty and will get worse in consultant job. Discouraging. Same issues are all over London, so 'at least we're not as bad as the others'.*
>
> **Male, UKG, Specialty trainee**

Trainees usually felt that the outcome of voicing their concerns was helpful, even when practical solutions or advice were not actually offered to them. Examples included appreciating having time to reflect on the situation with a senior, reassurance that their concerns were valid and an increased understanding of wider issues effecting the NHS, which helped trainees to contextualise their own experiences.

Perceptions of the role of the Colleges, Deaneries and supervisors

Trainees were asked what the role of the College, Deanery and supervisors should be in supporting trainees who are considering leaving. The single most described factor was for the College, Deaneries and supervisors to explore trainees' reasons for wanting to leave. Trainees also desired practical solutions to encourage trainees to stay and the need to address systemic issues also featured prominently.

Trainees described wanting to be asked about the challenges they experienced in training and, in particular, trainees stated that they wanted earlier support offered to those who were experiencing difficulties. Trainees linked the supervisors and the College having interest in their training experience (through investment in their educational and professional development) to feeling more valued in the workplace. Additionally, trainees wanted better pastoral support, and felt they would benefit from being offered personal therapy as part of their training.

> *Find out reasons for wanting to leave and see if there are any strategies to minimise/remove them.*
>
> **Female, UKG, left or planning to leave training**

> *As a trainee looking in, it is a faceless impenetrable overly bureaucratic organisation/system that is very happy to lose good doctors, throwing away the money it has already invested in people, because it can't be bothered to do anything different. This sadly creates a huge amount of resentment, as well as gives off a message that it neither cares nor values the work force.*
>
> **Female, UKG, Specialty trainee**

> *Pay for individual therapy... it is cost prohibitive for many struggling trainees…*
>
> **Female, UKG, Specialty trainee**

Trainees wanted practical solutions to their issues, as opposed to shared sympathy. Trainees viewed their training to be inflexible. Greater access to less than full-time (LTFT) training was the most favoured solution trainees wanted to be implemented, with the current system for LTFT training being viewed as inaccessible for those who did not have specific caring responsibilities. Trainees also wanted OOPEs to be encouraged more widely and felt that these were also not currently accessible enough to all trainees. Trainees described wanting greater control over their on-call commitments, and felt it was better for trainees to have reduced on-calls if that was what it took to keep them in training.

> *More options for training e.g. less than full-time including in order to combine psychiatry with other interests, and not just for caring responsibilities. I have found being LTFT after having children has given me a better balance between work and other aspects of life, however this option is only available for quite limited reasons currently.*
>
> **Female, UKG, Core trainee**

> *Support in taking OOPE. Often just a break from the treadmill is helpful. Rules at the moment regarding 6 months' notice are off putting and don't reflect reality of posts being advertised etc.*
>
> **Female, UKG, Specialty trainee**

Trainees accepted that systemic and trust-wide issues were more difficult for the Colleges and Deaneries to address, however, they felt that improved rota planning and doctors' facilities were realistic and would improve the overall training experience. This extended to applying for both annual and study leave, with the study leave process being identified as difficult financially and logistically.

HR [departments] still need to improve, we need to receive rotas on time… it's not acceptable that they are always late.

Female, UKG, Specialty trainee

Free parking for night staff.

Female, UKG, Specialty trainee

Survey Part 2

This section consists of two sub-sections: a description of trainees' intentions to leave and burnout levels and an overview of factors predicting psychiatry trainees' intentions to leave. Note that only current trainees (N = 159) completed Survey Part 2.

Is there a problem? Trainees' intentions to leave and burnout

A total of 22% (35)[14] of trainees agreed or strongly agreed that they were thinking a lot about leaving the profession, but trainees were less likely to think about leaving psychiatry training as soon as possible (4.4%, 7) or actively be looking for another job outside of psychiatry (8.2%, 13). Table 21 provides more details on trainees' intentions to leave.

Table 21. Trainees' answers to the questions on intentions to leave.

	Strongly disagree/Disagree	**Neither agree nor disagree**	**Agree/Strongly agree**
I think a lot about leaving the profession	66% (105)	11.3% (18)	22% (35)
I will leave psychiatry as soon as possible	83.6% (133)	11.3% (18)	4.4% (7)
I am actively looking for another job outside of psychiatry	83.6% (133)	7.5% (12)	8.2% (13)

To provide a description of the variations in burnout amongst the sample, trainee scores were compared to cut-off values provided by Schaufeli et al. (2019). A total of 12% (19)[14] of trainees were classified as having low burnout levels and 63.5% (101) as having average levels (based on the Burnout Assessment Tool; (Schaufeli et al., 2019)). A total of 23.3% (37) of trainees were experiencing high levels and 0.6% (1) a very high level of burnout.

Predicting trainees' intentions to leave training

Table 22 shows the correlation matrix, mean scores and accompanying standard deviations for all the constructs measured in Survey Part 2. The results indicate that trainees with stronger intentions to leave psychiatry training were experiencing lower occupational commitment (r = -0.604), less work engagement (r = -0.477), and higher levels of burnout (r = 0.389). These trainees were also working in more demanding (r = 0.290) workplaces with less resources (r = -0.191). They were also less able to psychologically detach themselves from work during their free time (r = -0.261).

[14] 1 missing.

Table 22. Correlation matrix of survey measures based on the responses of 159 current trainees.

Scale	*M* (SD)	INT	AOC	ENG	Burnout	Job demands	Emotional demands	Job efforts	Aggression	Job resources	Support	Autonomy	Task significance
INT	1.86 (0.96)	1											
AOC	5.80 (0.89)	**-.604****	1										
ENG	3.56 (0.83)	**-.477****	**.569****	1									
Burnout	2.13 (0.45)	**.389****	**-.451****	**-.431****	1								
Job demands	2.77 (0.52)	**.290****	**-.312****	**-.160***	.**480****	1							
Emotional demands	3.38 (0.73)	**.262****	**-.237****	**-.157***	**.489****	**.817****	1						
Job efforts	2.67 (0.60)	**.288****	**-.210****	-.089	**.292****	**.695****	**.358****	1					
Aggression	2.25 (0.69)	.136	**-.262****	-.122	**.316****	**.797****	**.485****	**.322****	1				
Job resources	3.61 (0.59)	-.**191***	**.324****	**.373****	**-.339****	**-.175***	-.102	-.133	-.**172***	1			
Support	3.81 (0.99)	-.108	**.181***	**.178***	**-.161***	.005	.018	-.053	.039	.**760****	1		
Autonomy	3.21 (0.84)	-.**207****	**.286****	**.321****	**-.342****	**-.280****	**-.165***	**-.237****	**-.253****	**.758****	**.279****	1	
Task significance	3.81 (0.61)	-.093	**.243****	**.359****	**-.242****	-.130	-.096	.019	-.**211****	**.638****	**.212****	**.376****	1
Recovery experiences	2.94 (0.81)	-.**261****	**.242****	**.316****	**-.447****	**-.323****	**-.266****	**-.207****	**-.258****	**.241****	.097	.**301****	.119

Note. INT – Intentions to leave; AOC – Affective occupational commitment; ENG – Engagement.
$^{**}p < 0.01$; $^{*}p < 0.05$

We performed structural equation modelling to test a model predicting trainees' intentions to leave (presented in Figure 14). The fit indices for our model showed a comparative fit index (CFI) of 0.93 (acceptable), a Tucker-Lewis index (TLI) of 0.89 (acceptable), a standardized root mean square residual (SRMR) of 0.072 (good) and a root mean square error of approximation (RMSEA) of 0.072 (acceptable).[15] Combining these fit indices we consider the fit of the model sufficient, strengthening the credibility of findings.

Table 23 and Figure 14 show the strengths of the relationships between constructs of interest through presenting the regression coefficients as well as their significance as determined by the structural equation modelling. The results show that trainees' intentions to leave psychiatry training were stronger when they were less committed to their occupation (β = -0.47, $p < 0.001$) and were less engaged in their work (β = -0.16, $p = 0.042$). There was no significant direct effect of burnout on trainees' intentions to leave (β = 0.12, $p = 0.082$). Work engagement (β = 0.48, $p < .001$) and burnout (β = -0.21, $p = 0.002$) levels significantly predicted trainees' commitment levels, meaning that trainees experiencing stronger work engagement and lower burnout levels were more committed to their occupation (being a psychiatrist). Trainees were more engaged at work when they were experiencing better job resources (β = 0.62, $p = 0.001$). Moreover, trainees who had less job resources (β = -0.33, $p = 0.009$), high job demands (β = 0.45, $p < 0.001$) and were less able to psychologically detach from work in their free time (β = -0.17, $p = 0.021$) experienced higher levels of burnout. Trainees experiencing high job demands were less able to psychologically detach from work in their free time (β = -0.40, $p < 0.001$).

Table 23. Regression coefficients and test statistics for the relationships between the constructs used in the structural equation modelling.

Outcome	Predictor	Unstandardized Coefficient (b)	Standardised Coefficient (β)*	Z value	*P*
Intentions to leave	Affective commitment	-0.53	-0.47	-6.1	**<0.001**
	Engagement	-0.18	-0.16	-2.0	**0.042**
	Burnout	0.26	0.12	1.7	0.082
Affective commitment	Engagement	0.50	0.48	7.0	**<.001**
	Burnout	-0.41	-0.21	-3.0	**0.002**
Engagement	Job resources	1.45	0.62	3.3	**0.001**
Burnout	Job resources	-0.41	-0.33	-2.6	**0.009**
	Job demands	0.34	0.45	4.0	**<0.001**
	Recovery experiences	-0.09	-0.17	-2.3	**0.021**
Recovery experiences	Job demands	-0.57	-0.40	-4.0	**<0.001**

Note. *Completely standardised solution in which both the observed and latent variables are standardised.

[15] The pre-determined cut-off values for these fit indices were CFI and TLI >0.95, SRMR<0.08, and RMSEA <0.06 for good fit between the model and the data; and CFI and TLI >0.90, SRMR <0.12, and RMSEA <0.10 for acceptable fit (Brown, 2015).

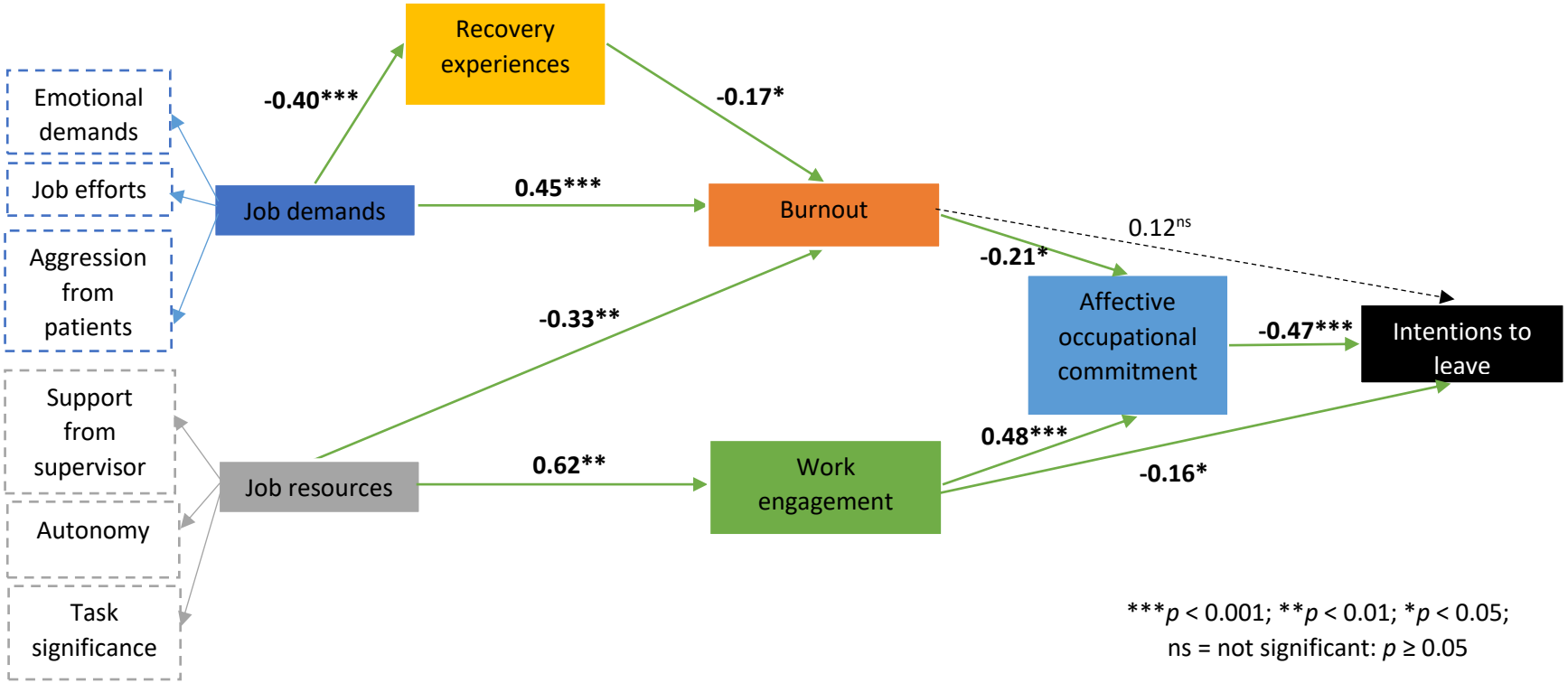

Figure 14. Visual representation of the tested theoretical model and the relationships between the constructs.

We also tested the mediating effect of recovery experiences (psychological detachment from work) for the relationship between each individual job demand and burnout. Both linear multiple regression and Sobel's test confirmed partial mediation of recovery experiences on the relationship between trainees' all job demands and burnout: emotional demands (Z = 3.0; p = 0.003), job efforts (Z = 2.4; p = 0.015), and aggression (Z = 3.0; p = 0.003). This means that these three work demands will have less of a negative effect on trainees' burnout levels if they are able to psychologically detach from work in their free time. Partial mediation means that recovery experience (psychological detachment) does not cancel the impact of job demands on burnout completely, i.e. high job demands still have a negative impact on burnout; however, this effect is less strong when trainees psychologically detach from work after work.

Furthermore, we tested the mediating effect of occupational commitment for the relationship between burnout and trainees' intentions to leave as well as for the relationship between work engagement and trainees' intentions to leave. The relationship between burnout and trainees' intentions was fully mediated by occupational commitment (Z = 5.2; p < 0.001). This means that the effect of burnout on trainees' intentions to leave manifests solely through trainees' occupational commitment. In other words: trainees who experience more signs of burnout are less committed to their profession and in turn more likely to have intentions to leave their training. The relationship between work engagement and trainees' intentions to leave was partially mediated by occupational commitment (Z = -6.4; p < 0.001). This means that work engagement affects intentions to leave directly (higher engagement results in reduced intentions to leave) but also through commitment to the occupation (higher engagement increases commitment and in turn reduces intentions to leave). =

Key findings

From the analyses of Survey Part 1 and Survey Part 2 several key findings can be derived (Box 4).

Box 3. Key findings from the analysis of the survey.

- Under-resourcing of the NHS is perceived to have a very large impact on the training experience. Although trainees are aware that they are on a training programme, their experience of 'training' is essentially synonymous with their experience of working as a doctor in an under-resourced healthcare system. Trainees identified different cultures and social norms in psychiatry compared to other specialties (e.g. stigma) and stress/workload (e.g. 23.9% of trainees had high/very high level of burnout) as the main challenges in psychiatry training. When discussing challenges trainees also mentioned the perception of risk (e.g. aggression from patients) with 35.2% (56) of trainees experiencing verbal and behaviour aggression often or frequently and feeing particularly vulnerable during on-calls.
- 22% of trainees agreed or strongly agreed that they were thinking a lot about leaving the profession. When thinking about leaving, trainees consider a wide variety of alternatives with non-training psychiatry posts being most frequently mentioned. Trainees also desired to work in management and leadership or to retrain in another specialty.

Box 4. Key findings from the analysis of the survey - Continued

- 26.7% of trainees (43) had taken time out during psychiatric training for personal reasons (maternity leave, recovery from burnout, etc.) and for CV building (education, research, etc.). OOPEs helped to uncover a new appreciation for psychiatry and increased confidence in their own clinical practice.
- Most trainees voiced their concerns about their training to work and personal contacts. 11.9% (19) of current trainees chose not to talk with anybody about the challenges they are facing. Trainees felt that voicing concerns was helpful.
- Trainees suggested that the Colleges, Deaneries and supervisors recognise the critical importance of exploring trainees' reasons for wanting to leave. Although sympathy and constructive discussions provided immediate comfort, trainees wanted changes to be made to their situation. They wanted practical solutions implemented to encourage trainees to stay (e.g. more flexibility with LTFT, increased accessibility of OOPEs), and systemic and trust-wide issues to be addressed (e.g. receiving rotas in a timely manner).
- Trainees enjoyed numerous aspects of their training, including patient contact (e.g. complexity of conditions), the nature of work (e.g. intellectually comprehensive), and training arrangements (e.g. supervision). Trainees remain in spite of all the challenges they have described because they are deeply committed to the specialty, subject, and patients. However, trainees also described remaining in training as a safe default option due to job security and fear of starting again.
- The statistically tested model showed that the work demands and resources that trainees experience in their workplace have a significant impact on trainees' wellbeing (i.e. their work engagement and burnout levels).
    - A combination of high *emotional demands* (e.g. emotionally draining work, dealing with people whose problems affect one emotionally, or with people who have unrealistic expectations), *efforts* (e.g. high workload, interruptions, or disruptions while working), and *aggression from patients* (e.g. violence, suicide, sexual intimidation) increased burnout;
    - A combination of *support from the supervisor* (e.g. advice, feedback, sympathy), *autonomy* (e.g. deciding when to take a break, what work to carry out and in what way, plan one's own work), and *task significance* (e.g. job itself is important in the broader scheme of things; work is likely to significantly affect the lives of other people.) increased work engagement and reduced burnout.
- Trainees' wellbeing is important for workforce planning because trainees' wellbeing significantly predicts their commitment to psychiatry training and, in turn, this is strongly indicative of their intentions to leave training.
- The work demands of trainees that apply recovery experiences (are able to psychologically detach from work in their free time) will have less of a negative effect on trainees' risk of burnout compared to trainees that do not employ these recovery experiences.

Research Objective 3: Examine, qualitatively, how and why these (and other) factors contribute to attrition or retention.

In this section, we present the key findings from interviews with a diverse group of trainees who were either currently in training or had left/were planning to leave. Their experiences, priorities and attitudes help build a detailed understanding about how and why the factors identified in the survey, as well as others, contribute to attrition or retention in psychiatry training (Research Objective 3).

Methodology

Sample and recruitment

Trainees currently active in a London training programme were invited to participate in a one-to-one interview via an email distributed by London Deaneries, via social media platforms, and through a reminder following their completion of the survey between August and October 2019. Trainees who had left a London training programme were recruited through social media platforms and snowball sampling.

We aimed to recruit a similar number of trainees from each of the three groups: current Core trainees; current Specialty trainees; and trainees who had left or were planning to leave training. We classified trainees in the following situations in the 'planning to leave or left training' category:

- Those still in training who 'agreed' or 'strongly agreed' that they intended to leave training as soon as possible (as described in the intentions to leave questionnaire; see Survey Part 2 section, Research Objective 2);
- Those who were still in training and had made firm plans to leave the programme;
- Those who were out of programme and had maintained their training number but currently had no concrete plans to return;
- Those who had surrendered their training number.

We aimed for a wide variety of views within our participant group. Those wishing to participate were asked to complete a socio-demographic questionnaire so that these details could be captured and a balanced and varied group could be developed.

Interviews were conducted in a narrative style in which trainees were encouraged to tell their 'stories' freely, with the interviewer asking broad open-ended questions and providing prompts to gain more detail or guide the conversation (e.g. how and when did you come to the decision to specialise in psychiatry?). The interview guide is included as Appendix B. This approach particularly encouraged seminal and impactful moments in trainees' experiences to come to light and be discussed in their own words.

Data analysis

Interview audio-recordings were transcribed verbatim, corrected for accuracy, anonymised and uploaded into NVivo12 data analysis software. Template analysis (King, Horrocks, & Brooks, 2018) was

used to code all data, develop themes, and create a final template, which formed the basis and structure of the write up. The first three transcripts (11%) were coded by two researchers (KA & OA), the differences in coding were discussed, and an initial template was jointly developed. This template was then used by each researcher to independently code three transcripts each. The researchers then met to critically discuss coding and changes to the template. This process was repeated, until all transcripts had been coded. The researchers then discussed and agreed on a final template, which was applied to all transcripts to ensure that earlier transcripts were coded consistently with later ones, and that the template was representative of all data.

Results

This section will discuss socio-demographic characteristics of participants and present findings grouped into the following topics: attitudes to the training programme, managing challenges, and the impact of the wider medical and training culture.

Socio-demographic characteristics

A total of 28 one-to-one interviews were conducted, including trainees in each category: Core trainees (ten); Specialty trainees (ten); and those planning to leave or left training (eight). Interview participants possessed diverse characteristics (see

Table *24*). More participants were female than male (67.9% and 32.1% respectively), with this imbalance being largest within the 'left or planning to leave' category (87.5% female; 12.5% male). Overall, the majority of trainees were ethnically white (67.9%) and had gained their primary medical qualification in the UK (UKG) (75%). However, minority ethnic participants and those who had gained their primary qualification abroad (non-UKG) were included in each category (Core, Specialty, planning to leave/left). More participants who were planning to leave or had left training had dependents (37.5%) in comparison to those continuing in Core (10%) or Specialty (10%) training. Participants were, or had been, in training across the London training regions, with greater numbers coming from the North Central (32.1%) and South East (28.6%) regions.

Table 24. Participant socio-demographic characteristics

Variables		**Core trainees (n = 10)**	**Specialty trainees (n = 10)**	**Planning to leave or left training (n=8)**	**Total (n=28)**
Gender					
	Male	30% (3)	50% (5)	12.5% (1)	32.1% (9)
	Female	70% (7)	50% (5)	87.5% (7)	67.9% (19)
Ethnicity					
	White	60% (6)	70% (7)	75% (6)	67.9% (19)
	BME	40% (4)	30% (3)	12.5% (1)	28.6% (8)
	Missing	0% (0)	0% (0)	12.5% (1)	3.6% (1)
Dependents					
	No	90% (9)	90% (9)	50% (4)	78.6% (22)

	Yes	10% (1)	10% (1)	37.5% (3)	17.9% (5)
	Missing	0% (0)	0% (0)	12.5% (1)	3.6% (1)
PMQ region					
	UKG	70% (7)	80% (8)	75% (6)	75% (21)
	Non-UKG	30% (3)	20% (2)	12.5% (1)	21.4% (6)
	Missing	0% (0)	0% (0)	12.5% (1)	3.6% (1)
Training Region					
	South West	10% (1)	30% (3)	0% (0)	14.3% (4)
	South East	30 % (3)	10% (1)	50% (4)	28.6% (8)
	North East	10% (1)	20% (2)	0% (0)	10.7% (3)
	North West	30% (3)	0% (0)	12.5% (1)	14.3% (4)
	North Central	20% (2)	40% (4)	37.5% (3)	32.1% (9)
	Missing	0% (0)	0% (0)	12.5% (1)	3.6% (1)

Note. PMQ – primary medical qualification; BME – black minority ethnic group.

Attitudes to the training programme

In this section, we describe trainees' attitudes to the training programme, including teaching and training opportunities and relationships with seniors. We then describe trainees' reasons for taking time out of their programme and explore what impact breaks can have on their desire to continue with, or leave, training.

Teaching and training opportunities

Trainees generally talked very positively about the training and teaching opportunities in Core and Specialty training. Protected time built into their rotas for these activities was particularly appreciated. Dedicated supervision time, both formal and informal, was also highly valued (see below).

> *So the training itself is great, like I actually didn't think it was going to be this good… in terms of how much time we get off for things like the [MRCPsych teaching days]… the academic programme at our own sites, supervision with the clinical supervisors, then teaching by registrars and other senior doctors, time off to go to events and conferences – you just have to ask for it and they'll give it to you.*
>
> **Participant 5, male, UKG, Core trainee**

Trainees perceived that their learning was generally valued highly in psychiatry, and more so than in other specialities. They spoke of a culture amongst seniors that promoted an openness to learning, which appeared to encourage and support trainees to seek out opportunities.

> *…no consultant would dare suggest that you should not attend teaching on a Wednesday and come to the job, sort of thing, so yes, it's felt like it's been important, my learning has been important.*
>
> **Participant 8, female, UKG, Core trainee**

Teaching days were also valued as these brought larger groups of trainees together, inviting opportunities for them to compare experiences and socialise. Trainees reported that a sense of belonging and comradery with others in psychiatry helped them progress through and enjoy the training programme. Emotional support provided by the programme in the form of Balint groups was reported to be useful and a necessary outlet for emotional strain given the nature of the work.

Trainees valued and appreciated the dedicated hour of weekly supervision, especially for reflection and reassurance. However, they found regular clinical supervision on the wards invaluable to keep up with the learning curve. If this was lacking due to understaffing, pressures of service provision or because the supervisor was not on the ward rota at the same time as the trainee, trainees could grow frustrated and dissatisfied with a lack of learning in their placement.

Relationships with seniors

Relationships with seniors acting in both official and informal supervision roles were very heavily referred to and substantially impacted on trainee experience. Advice from trusted seniors, especially educational supervisors with whom trainees had built a longer-term relationship, could be very influential, for example, in encouraging trainees to continue with training if they were considering leaving.

Trainees reported that the majority of their supervision experiences had been positive. As a whole, seniors in psychiatry were understood to be more supportive, constructive and approachable than in other specialties. Seniors who had a positive impact were described as inspiring role models, and an approachable source of clinical learning and emotional reassurance. Trainees took it to heart if their supervisors took an interest in their individual interests and needs, made them feel valued, or indicated that they were valuable to the team. They particularly appreciated when seniors acted decisively on their behalf, for example, to change a situation that the trainee found distressing or if they sought out development opportunities for them.

> *Two or three days after starting I was summoned up to… he [is] clinical director for the trust now, someone very senior. I was just thinking 'Oh my God, something awful's happened, what have I done?' And actually the first thing he said was 'Right, so I'm going to be your supervisor for the next couple of months, [I] wanted to set aside some time to talk to you, let me know when it's convenient, we'll go through how we manage this. And you know if you need me my door's open.' So you know the fact that somebody, in my mind very high up and very removed, actually was that approachable and that open was very helpful.*
>
> **Participant 14, male, UKG, Speciality trainee**

In contrast, critical and disapproving seniors who did not provide positive or affirming feedback could be very damaging to trainees' confidence and self-belief, causing anxiety and exacerbating a feeling of being out of their depth. Trainees found it difficult to approach critical seniors for advice or with concerns. Similarly, burnout or disillusioned supervisors were hard to approach with issues even if their relationship to trainees was otherwise good.

> *…the dynamic between [myself and my supervisor] was quite difficult and I think probably because she was also not well, but I was also feeling quite like I was doing all of this work but she would still criticise me… that kind of chimed in to my own issues, and kind of just made me*

doubt myself. And it kind of manifested in this sort of, I guess having now read about burnout and how it looks different in different people, I think I really did experience that kind of really horrible kind of cognitive sort of anxiousness about decisions, and like kind of everything took longer and I doubted every single thing I'd done.

Participant 26, female, non-UKG, Speciality trainee

Taking time out of programme

Trainees' reasons for taking breaks in training were individual and context-dependent; however, they could be grouped into one of three broad categories: to seek escape from the inflexibility of training; to proactively develop skills within and/or outside clinical medicine; or to reactively avoid their current situation.

Trainees reported that they found the training programme inflexible, and that this negatively impacted their ability to manage the balance between professional and personal life. For example, some trainees viewed it as necessary to take time out of training to spend time with family and friends, manage childcare, or to plan a life event. Trainees who had caring responsibilities or were pregnant particularly perceived the rigidity of training as representative of a lack of consideration towards trainees' needs.

Trainees thus reported a break allowed them time for personal or wider development. Others took a break to proactively dedicate time to professional interests outside of clinical psychiatry or to develop their careers in a different direction. Gaining postgraduate qualifications, research, and medical education experiences helped trainees to improve their CVs without the pressures of training. This was seen as particularly valuable if trainees wished to pursue these interests as a consultant.

I think I'll probably continue wanting to spend periods abroad, you know, maybe during higher training, after training. As a consultant I think that's something that I've always wanted to do since, since I took a gap year I guess before university, yeah I guess I feel like that's something I'll always want to do, to try and be useful somewhere in the world where there's so much less than there is here in terms of mental health care.

Participant 8, female, UKG, Core trainee

Females reported taking time out of programme for maternity leave and subsequently feeling the need to work LTFT. These factors contributed to them progressing more slowly through training than their male counterparts. Although our interview sample does not allow generalizability or for us to study this particular aspect in detail, we suggest that reasons related to maternity are not the only factor that cause females to progress more slowly through training. For example, issues related to an increased sense of vulnerability, greater calls on them from 'home' or to fit with partners' careers, and an increased unwillingness to vocalise needs may have also play a part. In addition, female trainees took breaks for a similarly wide range of reasons to males.

Trainees also reported taking breaks to gain more experience and improve their clinical skills before progressing. These trainees usually had experienced negative or uninspiring placements and seemed to feel the training programme had not prepared them adequately to progress clinically without additional experience.

Overall, these trainees highly appreciated the opportunity to take a break in training and reported that they gained a sense of perspective and time to make decisions about their career moving forward. A desire and need for time out of programme was regularly expressed, with one trainee describing breaks as necessary to 'get through' training successfully.

Some trainees also described taking a break because of a desire to change their current situation, most commonly to have time away from clinical work. These trainees wanted time to reflect and recuperate from the physical and psychological challenges of psychiatry training, and reported that time out of programme was an acceptable way to do this. Breaks also temporarily removed the pressures of training requirements such as portfolio and membership exams.

> *For example I'm on nights this weekend, but that does mean that, you know, where all your friends are going out or whatever and you can't, you wouldn't be able to join them and then for the rest of the week you're like you're waking up in the morning when everyone else is going to work and it kind of just feels very out of it, and I think doing that consecutively for sort of six, seven years is a little bit overwhelming. I think I was like oh I just need a break from like being on this schedule all the time.*
>
> **Participant 9, female, UKG, Core trainee**

For those who were unsure about continuing in psychiatry, taking a break – particularly between Core and Specialty training – was positioned as a key way to gain time to reflect and make decisions before either committing to the programme or deciding to leave.

> *I had two maternity leaves… and after that I had an accident, so I had about 6 months of sick leave and then I took a year out of training to recuperate and get my thoughts together [about] whether I want to continue on at work.*
>
> **Participant 13, female, non-UKG, planning to leave or left training**

> *I got everything ready and I got an interview because it's centralised, and then I just felt I didn't have enough energy, I was quite unmotivated to – which is very, very unlike [me] – I've never been like that in my life, and I just thought I'm going to pull out of the interview because I don't feel like I know what I want to do. So I cancelled the interview and just thought I'm going to have to find a job that I'll do for a year or two while I make my mind up.*
>
> **Participant 17, female, UKG, planning to leave or left training**

Moreover, the process of returning to training could be perceived as logistically difficult due to a lack of information and advice, particularly if the trainee was applying to specialty training following an extended break. Those who had worked in non-training posts found a drop in salary upon returning to training was a deterrent. For trainees who had taken a break to escape a negative training environment or recover from burnout or a traumatic incident, time away could also trigger a dread of returning which grew over time. This could deter trainees from returning, or push them to return before they were ready.

> *…every time I thought about going back to work at that time each day it would get worse. And my worry was that if I left it any longer I knew I wouldn't have gone back. So I said okay you've*

had a month and that is enough, go back to work, get on with it, see how you go. So I possibly went back too early, but I made that decision to just nip it in the bud and just try and get back to work and not let it drag on any longer.

Participant 21, female, UKG, Specialty trainee

[Interviewer: And what is it that's really putting you off applying?] Oh there's a few things. So going back to doing nights and on-call. So where I am for on-calls… you had to do the adult rota. And I've been out of adult now for so long, and I really don't feel safe doing an adult rota. The geography of the deaneries are massive, so I don't even know where I'd try and live with all that travel. I would have to go down on my pay quite significantly, because they don't pay – so even though I've got that extra experience I'd still have a massive pay cut – so there's no temptation to do that. Another thing for me is just that feeling that you're then tied down to something for a three years, and if you want to take a step out, or it's too much, it feels like you're not allowed, [but] once you drop your number it's very hard to get back in, it just feels like a big commitment.

Participant 18, female, UKG, planning on leaving or left training

Finally, if the circumstances that were causing the trainee distress changed (e.g. they changed placement, were taken off on-calls, or gained a new supervisor), some trainees could change their minds about leaving quite rapidly as the joy of psychiatry returned.

I decided to leave in April, so I gave in my notice and decided that I just was not, not only was I going to give up psychiatry, but I was going to give up being a doctor altogether – which was unfathomable to me, I can't believe I'm saying it now. And then what happened was I left the post I was with and I took, I had the annual leave and I just went covering for a bit. And then I had a change in personal circumstances, so I wasn't able to have the luxury of not working for a while, like I needed to be in work. So I changed my post and I had a sort of graded return to work. And now I am, I wouldn't say I'm 100% back to where I was before, but I'm about 75% back to having the determination of 'yes, I'm going to get to be a consultant and I'm going to stick with psychiatry' which is progress, but I usually run at about 100% because I'm usually very passionate about psychiatry, I absolutely love it. So as it stands I'm just I'm seeing how things go.

Participant 21, female, UKG, Specialty trainee

Managing challenges

In this section, we describe aspects of training that trainees found challenging and explore the strategies trainees used to overcome these. Challenges include coping in an under-resourced work environment, balancing the emotional strain of psychiatry work and the perceived risk, managing responsibilities and handling patients' physical health needs, and the experience of on-calls. We also explore how, why, and under which circumstances trainees seemed unable to cope with these challenges, and therefore how these contributed to a state in which trainees seemed at higher risk of leaving the programme.

Systemic and trust-wide issues

Trainees perceived the NHS system to be an under-resourced and challenging work environment. Although NHS resources and facilities were acknowledged as outside the control of the training programme, the impact of these factors on the training experience are briefly described here for context.

Although trainees found some training locations had good facilities for both staff and patients, they found other locations very poor. Trainees described wards and clinics which were in dreary, dark and cramped environments, which trainees felt were neither suitably therapeutic or comfortable for patients, nor pleasant for staff. Out-dated and missing equipment frustrated care. Teams were commonly understaffed or experienced a rapid staff turnover. Factors such as these caused trainees to feel guilt to patients for their inability to provide high quality care.

> *I think when you are working long hours and sometimes it is the small things that add up. You know no one is going to leave [training] because they don't get a bed when they want to have a rest, but it's that cumulative effect of not, you know, working endlessly in facilities which are not designed, and offices that are far too hot or cold, windows that don't open, don't shut.*
>
> **Participant 20, female, UKG, Core trainee**

These conditions exacerbated several challenges already facing trainees, and these are discussed in the sections below. More generally, however, trainees perceived some environments as 'high-risk', which contributed to a culture of defensiveness, whereby trainees felt they should take extra precautions to lessen the perceived likelihood that they might be blamed for adverse patient outcomes. These precautions potentially increased their workload and slowed their decision-making. Trainees also reported a culture of disengagement, feelings of resentment and not being valued triggered by system pressures that prevented them from taking leave, linked to heavy on-call rotas, and being unable to complete training requirements.

> *[When] you're working, you're functioning, you're productive [then] your job wants you. But the moment you start asking for things, or even using up your study budget or study leave, or your annual leave, or even asking for sick leave, sick pay – things start shaking up.*
>
> **Participant 13, female, non-UKG, planning to leave or left training**

Moreover, because of the temporary nature of the placement some trainees simply continued without seeking to improve the overall situation, knowing it would only be for a finite period.

> *I mean that's the thing about being a trainee as well, like you're only there for a certain amount of time, which is sort of a blessing and a curse because I think you sort of, you never fully invest in it. And if it's good you sort of are sad because you know it's going to end, and if it's bad well you just get through it because it's going to end. As a trainee you sort of let things [go] because like 'Oh it's only 3 months left' – just you know get through it.*
>
> **Participant 26, female, non-UKG, Specialty trainee**

Overall, poor work conditions and heavy service pressures could cause trainees to feel disillusioned with the future and value of psychiatry within the NHS system. Trainees who felt this way could be seen as less committed to the profession and potentially at higher risk of leaving the programme.

Emotional burden

The emotional burden of working as a psychiatry trainee was described in two forms: 1) the cumulative stress of clinical work with emotionally distressing psychiatric conditions in an under-resourced speciality; and 2) the acute emotional burden following a specific traumatic incident.

Trainees reported that the nature of psychiatric work took a psychological toll, as it required them to repeatedly connect with patients who were very vulnerable or unwell. Although it was acknowledged this emotional burden is not unique to psychiatry, participants reported the impact was unexpected and perhaps more severe than in other specialties, where doctors can remain more emotionally distant from patients. This routine emotional pressure was exacerbated by feelings of helplessness and guilt to patients, often related to the perceived under-resourcing of the speciality and related therapies and services.

This cumulative emotional burden presented itself as burnout, as well as a growing dissatisfaction and disillusionment with psychiatry provision in its current form. Participants also reported it negatively impacting their personal lives through emotional exhaustion, an increasing inability to switch-off and mothers reporting concern that it impacted quality time with their families.

> *But on a personal level I think, you know, less-so now but more-so when I first started training – it does take a toll on you, you do think about it later. You know, you do worry when you get home, you know, and everyone has different defence mechanisms of how to suppress that or how to you know debrief that later you know with their family or during supervision or whatnot, you know.*
>
> **Participant 6, male, non-UKG, Core trainee**

Trainees reported that talking to other psychiatrists about these issues was important in helping them process and manage this emotional load. Weekly supervision meetings and Balint groups were reported as useful for this, but trainees relied predominantly on informal discussions with peers. Without peers available, or without the opportunity to meet with them informally due to service pressures, trainees reported substantial difficulties in managing the day-to-day pressures of challenging placements.

Trainees discussed their feelings with friends and family, but commonly felt that those outside psychiatry could not fully understand their concerns/experiences, or that they did not want to consistently burden others with their upset. There was also a perception that the daily emotional burden was to be endured and even some struggling trainees did not recognise this as worthy of being specifically addressed. Instead, unhappy trainees could question their ability to cope as a psychiatrist and thought of leaving the profession.

> *I haven't been able to find a platform where you can just discuss those [inaudible] dilemmas, although we have a Balint group where you can go and do that, but I hardly managed to find time for my clinical day-to-day activities to go and attend it. So I guess I haven't been able to*

find the support. Although they're all advertised on the Royal College website and GMC etc. that you have got this confidential helpline etc. but I don't think this day-to-day emotional burden that comes with the patient care is severe enough to access that helpline. But at the same time it isn't small enough that you can just brush it under the carpet.

Participant 13, female, non-UKG, planning to leave or left training

Trainees who had experienced a traumatic event or emotionally difficult case could suffer from the effects of emotional burden more acutely. For example, some reported anxiety, nightmares, the inability to switch-off, and increasing dread around certain aspects of psychiatry training. This was exacerbated by worries around speaking up about the incident and acknowledging their true feelings. Some trainees thus appeared to be repressing the effect of the experience rather than accepting and processing it. Balint groups were seen as positive, but not sufficient to deal with the effects of a serious incident. When accessed, personal therapy was reported as more effective.

I almost felt like it was like a secret, kind of and then the advice I got from my friends and colleagues like weren't at all involved were, you know, one of them was like keep quiet, like don't say anything, like you don't want to be involved. And another friend was like oh you know it happens, you know you'll be fine you know, so it's like I didn't even know kind of how to respond except all I knew was like inside I felt like really upset by it as you can imagine, but so but again it's like so I dealt with it kind of myself. I wished there was some kind of, I mean there was Balint, it just didn't feel like enough.

Participant 22, female, UKG, planning to leave or left training

Trainees expressed the hope that a break in training or a change in placement might alleviate their worries, and although this did help some trainees, those troubled by traumatic incidents appeared to remain troubled by their experiences unless they confronted and processed them.

Perceived safety

Trainees understood that, as in other areas of medicine, patients could be verbally and physically aggressive and there was a risk of assault. This was largely accepted as an unpleasant but inevitable part of medical practice, and manageable as long as trainees felt the environment and team was sufficiently able to deal with any incidents.

…once a patient grabbed me round the wrist but apart from that I've never actually kind of, you know. Some other people I know have been actually kind of assaulted by patients. So I suppose you know, well I feel like that could happen in A&E in a way… I mean I don't enjoy that part of the job, but I don't find it's regular.

Participant 20, female, UKG, Core trainee

When trainees felt unsafe at work, however, their perceptions changed substantially, and the risk of assault became a strong source of anxiety and stress. An unsafe feeling was often reported as due to a poor working environment and low levels of staffing, which resulted in a higher incidence risk and severity of assault on staff. The risk for female trainees, particularly on all-male units and doing solo

home visits was perceived to be higher, and particularly trainees who had been pregnant reported situations in which they felt frightened and anxious about their safety.

> *And I think when you're working in under-resourced environments like that ward and you're not set up to deal with violence and when it inevitably happens in the psychiatric kind of context, as I say it's waiting for the next serious incident, and in fact that's a real drain and a real stress.*
>
> **Participant 11, male, UKG, Specialty trainee**

Assaults varied substantially in severity; however, the trainee's own perception of their vulnerability prior to an assault appeared to have a substantial impact on how they reacted to an assault. If they generally felt confident and safe at work, it appeared to have little lasting effect; however, if they felt burnout, anxious or out of their depth in the placement, the effect could contribute to their decision to discontinue or pause training.

Trainees felt that teams' and Trusts' responses to assaults varied. Pregnant trainees found their seniors or trust management were generally supportive if they voiced safety concerns, and their circumstances were quickly changed or they were signed off following an incident. Some trainees reported that there was a lack of leadership in managing expectations, raising awareness and preparing trainees for both minor and major risks to safety, as the topic was not openly discussed.

Handling responsibility

Trainees reported that they enjoyed managing the responsibility associated with working as a trainee, as long as they felt adequately trained and the level of responsibility was appropriate. They described the importance of making clinical decisions in an environment that felt safe and supportive, which included working as part of a team and where trainees could seek advice.

> *But I'm not really worried about taking on extra clinical responsibility, in fact I think that's what we've been trained for. So I kind of feel prepared for it actually. And if there's something that I'm stuck with then, you know, yes I can get a second opinion or I can refer someone to a more specialist service, or you know I can seek some help from my colleagues, whether it's another psychiatrist who I speak to sort of relatively informally, or whether it's a psychologist who I refer someone to or whatever.*
>
> **Participant 25, male, UKG, Specialty trainee**

A new placement could be a steep learning curve; however, as long as trainees received adequate supervision their confidence in the placement grew. Yet others found that they were immediately expected to perform psychiatry-related tasks outside of their level of competence and training. These situations caused anxiety over their level of responsibility and could be very stressful for trainees.

Trainees could also find the adjustment to a flatter hierarchy and multidisciplinary team working in psychiatry challenging, as they found this could lead to a blurring of boundaries of responsibility in relation to patient care.

The burden of responsibility was expressed in many forms, including having to make ethically and legally robust decisions, particularly during on-calls, when fewer team members were readily available. Trainees linked their sense of responsibility to the perception that psychiatrists were at higher risk of being blamed for adverse patient outcomes, in comparison to other specialities. This was subsequently linked to an increased perception of risk related to regulatory sanctioning and appearing in the coroner's court. There was a presumption that these experiences were a near-inevitability of being a psychiatrist. For trainees who had not experienced this personally, witnessing colleagues going through the process shaped their perceptions of responsibility as burdensome.

> *Yeah I haven't, touch wood, had to go to coroners yet myself, so I think for me it's just more the constantness, the atmosphere that you work in that you know people who have, or you know people who are worried about it or have had really difficult times explaining – not because they've done wrong, but you know have just had a grilling because someone's died. Every time someone's died you can feel the anxiety within the wards, with the team that you're working for, or you see you know what the consultant has had to deal with – and you know, yeah, so it just seeps into you this kind of thing that you will be blamed if something goes wrong.*
>
> **Participant 15, female, UKG, planning to leave or left training**

Trainees reported stress and anxiety caused by the daily responsibility for clinical decision making in a feeling of uncertainty. Particularly if they lacked seniors around them, some reported that as the doctor the final responsibility for the patient rested with them, even if the decision or treatment had been actioned by the larger team.

For some trainees the perception of becoming a consultant, and having ultimate responsibility, was therefore daunting and unappealing. Trainees described needing more time to prepare for the role than training allowed, with skills such as making difficult decisions and management and leadership needing extra preparation time. Trainees reported that taking breaks to delay becoming a consultant was a reasonable solution to gaining more clinical experience and confidence before progressing.

> *I'm pretty tepid about being a consultant actually… I kind of want my clinical work to only take up probably, you know, in a working week sort of two or three days, and devote the rest of it to something else. I'm a bit worried about, yeah I sort of worry a little bit about the responsibility suddenly having to do an awful lot of stuff that I've perhaps not been training to do. I don't know, I worry much more about clinical competence than I do anything else, and I wonder whether my training has been the best preparation for consultant work.*
>
> **Participant 11, male, UKG, Specialty trainee**

In spite of their anxieties, most trainees believed they would complete their training and practice as consultants when the time felt right. However, a substantial number of trainees described a desire to work less than full-time as a consultant, in order to pursue non-clinical interests and receive respite from the challenges of clinical work.

Handling patients' physical health needs

Trainees commonly also reported anxiety about their level of preparedness to address patients' physical health needs. The physical aspects of care were routinely given to junior trainees. If their seniors did not also expose them to psychiatric clinical practice, this could cause frustration about a lack of learning regarding the psychiatric aspect. Moreover, as psychiatry training progressed trainees perceived themselves to be increasingly unskilled in managing physical illnesses in their patients.

> *I guess as the years go by you resent that even more and more, and for me that was because you felt more and more incapable and more and more unskilled. And I don't think it is psychiatrists resenting doing physical health, for me it's mad that I did it, because I feel unskilled, and you know borderline incompetent – it's four years ago since I did an ECG or something, you know – you need to perform in a role and I'm going to be judged against these criteria, when I don't feel I do this regularly enough to make a sound confident decision.*
>
> **Participant 15, female, UKG, planning to leave or left training**

Other trainees reported substantial anxiety about providing physical care within a mental health context, where nursing staff were untrained for physical health, and resources were frequently unavailable or unfamiliar. This put an extra burden of responsibility on to trainees and heightened their perception of the risk of adverse incidents.

> *…patients have been seriously unwell, they've died, and the recognition, the timely response, these facilities available in a mental health unit to manage for example cardiac arrest and medical emergencies – we have learnt from experience is often lacking. And I say it's upsetting because when those kind of things happen it's almost like you are the only person who has to really advocate for that patient and [who] calls first and makes sure they get access to the physical side of things.*
>
> **Participant 21, female, UKG, Specialty trainee**

Trainees acknowledged the systemic issues related to under-resourcing and a disparity of funding between physical and mental health services. They reported a lack of communication about how and where to access physical health equipment and procedures when starting placements, as well as a silo-thinking culture which did not account for the prevalence and potential severity of psychiatric patients also experiencing physical illness.

On-calls

On-calls brought together a number of the factors that caused trainees to feel vulnerable. Service pressure, under-resourcing, and increased responsibility with a lack of senior or peer support were all described as factors that made for a challenging training experience.

Trainees described feelings of isolation, fear, and an increased level of responsibility for patients whilst on-call, which led to a heightened sense of vulnerability. Trainees felt that the lack of senior presence on-site during on-calls made the experience of working out of hours more challenging. They described being aware that they could theoretically call seniors if they needed support, but felt there was pressure to avoid doing so if possible.

I can count on one hand the number of times a consultant's rung to check how I am at the beginning of the shift. I know consultants who email and sort of say 'This is my mobile number, call me if need be' but I think I've maybe had a couple of consultants, you know a couple who've called me, but there are a couple where there is a definite barrier between consultant and trainee, which is not necessarily helpful.

Participant 14, male, UKG, Specialty trainee

Trainees described feeling anxious before, during and after on-calls. Although many on-calls were busy, being able to rest during downtime was difficult because of inadequate or lacking facilities and an inability to switch-off and relax due to the anticipation of a difficult case or feelings of isolation.

Overall, trainees recognised that on-calls were a difficult but important part of the training experience, which could largely be endured. However, there were some aspects which they found made on-calls unbearable such as working in an environment where they felt unsafe. For some participants, the anticipation of on-call work made the prospect of returning to training more difficult.

The on-calls fill me with dread. The idea of having to go back to so many years of nights, the way that – I mean that's a huge, huge thing that puts me off going back. They make me feel sick, the idea of them.

Participant 27, female, UKG, planning to leave or left training

The impact of medical and training culture

Trainees are positioned at the intersection of multiple professional groupings and therefore belong to a number of overlapping professional cultures. For example, they belong to a medical culture, influencing what they believe it means 'to be a doctor' in the broadest sense. Simultaneously, they are exposed to UK medical training culture, which shapes their impression of what it means to be a 'good trainee' within an NHS system and training programme. Our participants were also learning the culture of medical training specifically in psychiatry and the implications for 'how things are done' within this particular specialty.

Group culture has a strong influence on its members' beliefs, priorities, and actions. Cultural beliefs, for example, about what a trainee should or should not do in a given situation, came across strongly in participants' accounts. In this section we will describe two aspects in which wider medical and training culture appeared to play a particularly strong role in shaping trainee decisions: firstly, in their willingness to vocalise their needs and ask for exceptions or help when encountering difficulties; and secondly, in their attitudes to progression through training, in terms of setting expectations of the 'right way' to train, as well as the work ethic and practices of a 'good trainee'.

Hesitance to vocalise needs

Although many trainees were attracted to psychiatry in part because the work-life balance was perceived to be preferable than in other specialities, they still experienced a workplace culture which was not always conducive to prioritising the balance between life and work. This included: a culture

in which working overtime was not only felt to be necessary, but also valued by seniors; an obligation to fill rota gaps; and an assumption that full-time training was the right way to train and that less-than-full-time caused inconvenience for rotas and ward teams. These pressures were particularly felt by trainees with young families.

> *I work with [a consultant] now, who I actually really like, but he, I don't think he really understands what it's like to have children. I think he's someone that values people who work really hard and you know stay late and put in extra effort, which I totally understand, but then I think he perceives part time as an easy option.*
>
> **Participant 22, female, UKG, planning to leave or left training**

Similarly, although trainees perceived psychiatry training to be less hierarchical than other specialities, they reported an awareness of a power imbalance whereby they were partially reliant on their seniors' good opinion for access to future opportunities. Furthermore, as a group they were keen to make a good impression, reluctant to be seen to 'make a fuss' and to preserve an image of competence.

> *I wanted to make a decision on my own and not say well I'll speak to them about it, because you want to show that you're competent and knowledgeable and you can handle things on your own.*
>
> **Participant 2, female, UKG, Core trainee**

Trainee work culture thus influenced their willingness to voice their needs and to highlight if they were struggling. This was exacerbated by work environments pressurised by understaffing and other resourcing issues. Trainees' accounts implied guilt for asking for exceptions to training, for example, reducing on-calls or being moved to another placement, even if their current situation was causing them substantial distress and was unbearable in the longer term. Others were anxious that honestly revealing their distress would cause others to doubt their capability to be a doctor, which was a threat to their identity and confidence and led them to cover their anxiety.

> *I felt bad for saying 'oh actually that last placement really was knocking my confidence big time, and really can we sort of' so I thought I'll just do it for another sort of few months, I'm not going to sort of make a fuss. So I went back and it was, it was almost damaging actually, I definitely was thinking about giving up at that stage.*
>
> **Participant 23, female, UKG, Core trainee**

Moreover, the culture in teams was sometimes to turn a blind eye to trainee worries in an effort to retain them.

> *I think that's also sort of to do with how stressed everyone is and how busy they are, that actually you don't really want to find out that someone's not coping cos you're probably just going to have to cover them when they go off on sick leave. I don't know, but I do feel like there's been quite a number of sort of people that have been unwell and it hasn't, yeah I don't know if it's been handled all that well by colleagues, but also I guess more informally as well just in teams.*
>
> **Participant 26, female, non-UKG, Specialty trainee**

As a result, trainees were often already seriously considering, or had made a decision to leave training, before they had a serious conversation with a senior in the training programme about their concerns or distress. Therefore, when trainees approached seniors with concerns, it was important that these were seen as serious and legitimate, even if it was the first time these had been raised.

Attitudes to progression

Trainees perceived the progression through the training programme to be treadmill-like, and expressed a feeling of desire, as well as internal pressure, to continue to meet training milestones. Some trainees who were finding training was negatively affecting them, still reported a desire to continue, with breaks in training as a means to endure. Even those on extended breaks could still perceive returning to training as the default option. Trainees implied that if they did not complete training they would have 'failed' and potentially 'wasted time' on this career. The perception that consultancy was the end goal was thus very pervasive.

Trainees' attitudes to progression were thus strongly shaped by their perception of the working lives of consultants and senior trainees they worked with. Seniors who were satisfied and fulfilled in their job inspired trainees to continue training in the hope that their experiences would continue to be positive or improve once reaching consultancy. This was particularly the case if trainees found positive role models within their preferred subspecialty, leading to enjoyable placements and a sense of purpose and direction for their future career.

> *Um, so that was one of the first times when, like, my views changed and I think another time was my last consultant was in the liaison service and he is someone who is really, really kind of [has] a holistic approach. He is an older adult consultant and, but he is just a bit untraditional… he did lots of psychotherapy training and has a special interest in that. He also has a special interest in teaching and etc. And we would talk about issues specifically with a legal framework, because that's a bit important when you're working on the cusp between the medical and the physical bit and some difficult cases.*
>
> **Participant 3, male, non-UKG, Core trainee**

In contrast, if trainees had worked with seniors who were disillusioned and burnt-out, this appeared to strong influence trainees' attitudes to the future.

> *When you work for someone who is negative and pessimistic about the system and who has been treated really unfairly by the system – and I liked him a lot, and he was so hurt by his job – you're like 'That's just not on is it?' Even just thinking about it now, that's what psychiatry can do, it can serve people so badly, and people don't feel supported.*
>
> **Participant 15, female, UKG, planning to leave or left training**

Furthermore, trainees described the pressure to stay in training to be influenced by the need to pass membership exams, meet portfolio requirements and also complete training rapidly, in order for the experience to be completed as soon as possible and to become a consultant.

I guess earlier on in my career I was really ambitious and I sacrificed a lot. Like when my kids were tiny, like doing exams when they were really tiny – because I wanted to plough on and get to become a consultant.

Participant 27, female, UKG, planning to leave or left training

The pressure to progress appeared to be largely self-imposed, related to a feeling of 'how training should be done'. Trainees expressed that they wished to feel they were progressing towards the end of training and getting closer to the goal of consultant. The perception of 'a long time left' in training weighed heavily on some trainees, especially those in LTFT posts. Although some saw taking OOPEs as delaying progression, this was not always the case: the renewed sense of control over their time and the feeling of 'doing something productive' during an OOPE appeared to negate this effect.

As such, extending time before consultancy *per se* (e.g. by taking breaks) was not generally perceived as burdensome or negative; however, extending the number of years *within training* could be. This was commonly related to trying to avoid the restrictive structure, pressures, requirements and exams which were required whilst *in* the programme. Trainees thus found it more acceptable to push through the programme at full-time pace and take breaks (e.g. 6 years in programme, 2 years of break) than do their training LTFT (e.g. 10 years in programme).

Trainees implied that achieving the MRCPsych and subsequently leaving training during the break between Core and Specialty training was more acceptable than leaving midway through either, as it was perceived more as 'choosing to leave' than 'failing to complete'. In this 'natural break' it was accepted a trainee might decide that they did not wish to continue, having met this milestone; whereas if they left in the middle of either the core or higher years they felt it more implied that they were failing to complete that step of training, and unable to cope.

Leaving training and a change of career or circumstances was described as extremely difficult and required bravery.

Key findings

The key findings from this chapter are summarized in Box 5.

Box 5. Key Findings from the interviews.

- Trainees were generally very positive about the dedicated time and priority that was given to their training and teaching days, as well as weekly supervision sessions.
- Supervision experiences strongly impacted trainees' confidence, both positively and negatively. Seniors were the major source of clinical reassurance and without support, trainees felt out of their depth. Trainees found it difficult to approach critical or distant supervisors with concerns.
- Time out of programme allowed trainees to escape a placement they found distressing or to recuperate from the strains of clinical work or a traumatic experience. Some desired to avoid the inflexibility of training to have life events, time with family, or more control over their schedules. Others took breaks to develop their professional skills within and outside psychiatry.
- Reasons related to maternity leave and caring responsibilities may cause females' slower progression through training in comparison to males. We suggest however, that this is unlikely to be the only cause.
- Trainees perceived the NHS to be an under-resourced and challenging environment. This could lead to frustrations and guilt related to the delivery of patient care, a culture of defensiveness, and feelings of resentment, particularly if service pressures prevented them from taking leave, being obliged to take heavy on-call rotas, or miss out on training opportunities.
- The cumulative stress of daily clinical work and/or impact of a traumatic experience created an emotional burden on trainees. This was expressed as anxiety, burnout and disillusionment with psychiatry provision. Peer support was very important to help trainees process this burden.
- Assault by patients was expected and could be managed, but if a trainee was in a state of heightened vulnerability (anxious, burnout or feeling unsafe) even minor incidents could trigger a strongly negative reaction. Feeling unsafe was seen as unbearable by trainees.
- Trainees enjoyed being given responsibility and autonomy, when they saw these as appropriate. However, if trainees felt out of their depth or unsupported, responsibilities could trigger anxiety. Trainees perceived that psychiatrists were more commonly blamed for adverse patient outcomes than doctors in other specialties.
- Some trainees wished to take breaks to further develop their clinical skills or delay becoming a consultant. Others perceived full-time clinical work as consultant too stressful to be attractive.
- Trainees felt particularly underprepared to deal with patients' physical health needs, and reported a lack of resources and training amongst trainees and wider teams.
- On-calls were a focal point for factors that caused trainees to feel vulnerable in training: under-resourcing, a lack of senior and peer support, difficult decisions, and an unsafe atmosphere.
- Trainee culture discouraged them from asking for exceptions, vocalising their concerns or distress, or making 'a fuss'. Trainees were thus often already seriously considering leaving, or had made a decision to leave, before they had a serious conversation about this with a senior.
- Trainees felt strong pressure to continue with training and achieve consultancy as their end goal. Trainees' perceptions of their seniors' working lives strongly influenced their motivation to continue on to consultancy, and whether they wished to delay this with breaks.

Discussion

The discussion section will synthesise the findings from the different parts of our research (the LRMP and UKMED data, quantitative and qualitative survey data, and interview results) to provide a holistic view of trainees' career choices during their psychiatry training. This chapter will first present an overview of psychiatry trainees' progression through training by discussing attrition in psychiatry training and addressing the most common career paths of psychiatry trainees, by integrating the findings from the LRMP, UKMED data and interviews. The chapter will then focus on explaining the factors that impact trainees' decision to stay or leave their training by integrating the survey and interview data. The discussion will conclude with strengths, limitations, and future directions for research, and implications for practice.

Attrition in psychiatry training: defining the new 'expected' path through training

Attrition, in the context of psychiatry training, could be understood as the loss of a trainee because of educational or personal reasons. In other words, attrition occurs when trainees start their training but then give up their post and leave definitively by surrendering their training number. Researching attrition in theory therefore sounds simple enough, but in practice proves to be challenging. The key challenge is that it is difficult to pinpoint whether trainees who drop out of training for a period of time actually leave training for good.

From our interviews it is apparent that a trainee's decision to leave is rarely followed by an action (definitive leave), but rather it initiates a process (work towards leaving). This process might start with the trainee taking breaks, which is understood to be an accepted way to cope with the pressures of training. The normality of taking such breaks means that trainees who were seriously considering or ultimately intended to leave training often initially declared themselves on a break. For some trainees, this created a limbo state in which returning to training was rationalised as the logical and sensible option but was extremely difficult for them to action for emotional and/or financial reasons. These trainees tended to be out of training but active in psychiatry-related areas, for example in locum, staff-grade or medical education posts, but were unsure about long-term plans. In contrast, some of the trainees who had previously made concrete plans to leave training had their opinion towards the future changed within a short period, if the circumstances which were previously causing them distress suddenly altered and enjoyment returned. These trainees were able to return to psychiatry training, meaning they would not contribute to attrition.

An implication from trainees taking career breaks is that it will take psychiatry trainees longer to complete their training. Indeed, the LRMP data shows that the majority of trainees do require longer than normally expected to become a registered consultant in psychiatry, with UKGs taking approximately 11 years from graduation to registration and some of them reaching consultant level over 20 years after graduation.

Understanding that trainees may take longer to complete their training than initially expected has significant implications for the analysis of attrition. Specifically, our aim to explore attrition longitudinally using our main secondary data source (the UKMED) becomes challenging because we cannot be sure to observe true attrition (not taking a break but actually leaving training definitively) in seven years of available data within UKMED. Because of these difficulties, we took an alternative

approach and focused on the way in which psychiatry trainees progress through their training in general rather than on true attrition. In doing so, we considered trainees that progressed through psychiatry training in six years to be trainees that followed the so-called 'expected' way of progressing and classified all other trainees as following a path of delayed progression.

When investigating the UKMED with the aim to identify trainees' (un)expected progression, our analysis shows that on average only 14.7% of the trainees manage to complete their psychiatry training within six years. Reassuringly the UKMED shows this 14.7% (on average 75 trainees) is only a small part of the on average 473 trainees that are at ST6 each year. This implies, therefore, that the large majority of trainees do not complete their psychiatry training within six years. These results alone call for a paradigm shift on how we view psychiatry training; we need to redefine 'the expected' path through training.

A longitudinal follow up of psychiatry trainees in the UKMED shows that non-progression occurs at every stage of training, but most often specifically at the transition from Core training to Specialty training. Only about half of the trainees that are progressing through Core training in three years progress to Specialty training the next year. Although failing exams at the end of Core training seemed a plausible explanation for this phenomenon, data from the UKMED shows that failing the CASC exam does not fully explain trainees' non-progression. Instead, the lack of a requirement to seek permission for an OOPE at this point facilitated the decision to take time out for numerous reasons, for example deciding to use the opportunity: to locum; undertake research; travel or work abroad; build their CV; spend time with family/friends; or take a SAS post. Moreover, trainees stated that leaving training during the break between Core and Specialty training was perceived as more acceptable because they had reached this key milestone and then chosen to leave, rather than leaving midway which could be perceived as failing to continue.

We also found that expected and delayed progression differs between groups of trainees, such as males and females or UKGs and non-UKGs. These differences suggest that various groups are faced with unique challenges during psychiatry training and that these group-specific challenges may cause them to progress through training differently. Although reasons related to maternity leave and caring responsibilities may cause females' slower progression through training in comparison to males, participants' accounts however, suggest that this is unlikely to be the only cause. We tentatively suggest that differing pressures on females, an increased perception of vulnerability and less willingness to vocalise needs potentially also play a role.

From the study results, it is evident that 'expected' progression should be redefined in psychiatry training, and consequently 'attrition' is difficult to measure. This has implications for the accurate prediction of the workforce. Most trainees are not progressing through psychiatry training in six years and trainees often stated that their decision to leave training was often not yet fully finalised or accepted, even for those who could not envisage themselves returning after a year or more out of training. Although a small number of participants had moved on to other careers and decided to surrender their training number (which can be classified as true attrition), most participants who had made concrete plans to leave training did not intend to do this in the immediate future, and some of the ones who had 'left' were not ready to give up their training number just yet. This means that, rather than considering a six years psychiatry training trajectory to be expected, it can be considered to be expected to finish training in a longer time span and to follow a training trajectory interspersed with breaks and time out of training.

A holistic view on trainees' progression through psychiatry training

Key findings from the survey and interviews sections are presented in Figure 15. This figure shows that trainees' perceptions of their training, and consequently their decisions to leave or stay in the training programme, depend on work and personal factors, as well as trainees' health and wellbeing, and their commitment to being a psychiatrist. This section summarises each of these aspects.

Work and personal factors

Trainees' mentioned numerous factors to be both enjoyable as well as challenging in training. The key factors are discussed below: their system and trust-wide environment, risks at work, support (including after voicing concerns), feeling valued, performing duties beyond their level, perceived stigma, and personal factors.

Trainees highlighted that their training experiences were inevitably impacted by under-resourcing and service pressures within ***the NHS environment***. For example, some missed teaching days because of understaffing or felt their learning was side-lined due to the demands of service provision. Trainees mentioned several ***trust-wide*** challenges that interfered with their training experience: admin tasks, not receiving rotas in a timely manner, and the study leave process being difficult financially and logistically. In addition, just 35.2% of trainees were satisfied with the workplace amenities (e.g. café, canteen). Poor work facilities (e.g. dreary, dark and cramped environments, out-dated and missing equipment) could lead to trainees feeling frustrated and guilty for their inability to provide high quality care.

Trainees also found work ***emotionally demanding*** because of the cumulative stress of clinical work with emotionally distressing psychiatric conditions and traumatic events/difficult cases. Trainees felt that their work is more emotionally demanding that in other specialties because they were repeatedly connecting with very vulnerable or unwell patients. Nevertheless, the daily emotional burden was often not recognised as worthy of being specifically addressed even by struggling trainees.

Trainees were also often exposed to aggression at work or adverse patient outcomes, e.g. 35.2% of trainees often or frequently experienced verbal and behaviour aggression from patients, and 25.7% of trainees experienced completed suicides at least once a year. Trainees reported that such events caused anxiety, nightmares, the inability to switch-off and increasing dread around certain aspects of psychiatry training.

Trainees, however, reported that verbal and physical assault was an inevitable aspect of medical practice, but this was manageable as long as the team and environment were sufficiently set up to deal with incidents safely as they arose. However, when trainees felt ***unsafe*** in their placement, the anticipation of assault became a strong source of anxiety and stress, often to unbearable levels. For trainees who felt confident at work, an assault often had little effect; however, trainees who were vulnerable (e.g. burnout, anxious, pregnant) could have a very strong negative reaction to even a minor incident.

When under pressure, trainees looked primarily to their peers and seniors for advice and reassurance. A sense of belongingness, mutual understanding and ***support*** amongst psychiatrists was commonly reported. Approachable seniors were an important source of clinical learning and emotional reassurance. Trainees appreciated seniors who took an interest in their individual interests and needs.

In contrast, critical seniors who did not provide positive feedback, may increase anxiety and damage trainees' confidence and self-belief.

An absence of seniors and fellow trainees, particularly during on-calls, left some trainees feeling vulnerable and unsafe. Trainees who had experienced a traumatic event in training also felt the need to talk about it, but without colleagues' support were often unable to process and recover from their experience. Trainees reported Balint groups as useful for coping with the day-to-day emotional rigours of psychiatric work. Trainees also highlighted that without peers available they experience substantial difficulties in managing the day-to-day pressures of challenging placements. When dealing with a serious incident, however, peer support or Balint groups were often perceived as insufficient. Personal therapy was perceived as more effective for overcoming specific traumatic experiences or substantial emotional burden.

When asked about ***voicing their concerns*** regarding training, 11.9% of current trainees decided not to voice their concerns, but the majority talked to their work and personal contacts. Trainees felt the usefulness of voicing concerns varied. However, most felt that the outcome of doing so was helpful, even if practical solutions were not given. Trainees appreciated seniors dedicating time to discussing their issues, which communicated an acknowledgement of their concerns and helped to contextualise their own experiences through a better understanding of wider system issues. Trainees found it hard to vocalise their concerns to supervisors who were perceived to be burnt-out or disillusioned themselves, even if the trainee-supervisor relationship was otherwise positive.

Receiving support from seniors was reported to be a sign of ***being valued***. Two levels of being valued were expressed by trainees as important: at a personal level and at a professional level. At a personal level, trainees felt unappreciated if seniors showed a lack of interest in their priorities, challenges and concerns, or if there was a lack of investment in their educational and professional development. In contrast, trainees described their work as rewarding when they felt they had made a positive impact on patients, added value to their team, or were acknowledged for their contribution.

At a professional level, trainees perceived that some non-psychiatry colleagues within the medical profession did not hold psychiatry in such high regard as other specialties, which could be challenging. They also perceived societal stigma towards psychiatry, and felt that they were held accountable for adverse patient outcomes to a greater extent than doctors in other specialities, which exposed them to higher levels of blame. This was linked to an increased perception of litigation, regulatory sanctioning and appearances in the coroner's court. These experiences were perceived as a near-inevitability for a psychiatrist and induced anxiety and a weight of responsibility on trainees.

Generally, trainee attitudes were overwhelmingly positive regarding the training programme's provision of teaching, training, supervision, and reflective support. Protected time for these activities was very much appreciated, as was a culture that prioritised their learning as valuable. Trainees enjoyed taking on the ***responsibility*** associated with working as a trainee, as long as they felt it was appropriate. However, when trainees were asked to perform duties outside of their level of competence and training, they find this very stressful and could experience negative reactions, inducing anxiety. Such duties included being required to perform tasks or take on cases outside their competence and training level, or specific to physical health needs, where trainees often felt under-skilled.

Despite comradery, approachable seniors and a sense of belonging with other psychiatrists who provided trainees with support and reassurance, wider medical and training ***culture*** dictated what is acceptable/expected from trainees. For example, trainees felt that raising concerns can be seen as 'making a fuss'. Such a culture encouraged struggling or unhappy trainees to preserve an image of competence and discouraged them from fully vocalising their needs or distress. Some trainees also reported a stigma towards psychiatrists acknowledging their own poor mental health. As a result, they could be reluctant to accept this as an issue and/or access sources of support, even if these were confidential or specifically aimed at doctors.

The wider medical and training culture also affected the perception of an 'acceptable' way of training and what it means to be a 'good trainee'. For example, there was an assumption that full-time training was the right way of training while LTFT was perceived as inconvenient. Trainees also felt pressure to continue to meet training milestones, and not completing their training was perceived as failing.

Personal factors, such as personality and coping strategies, also impacted trainees' career choices and training experiences. In the survey, when former trainees were asked why they decided to leave training, some felt that their personality was not suitable for psychiatry.

Personal attitudes can also have an impact on how trainees deal with the work challenges. When faced with challenging work conditions and feeling unsatisfied or untenable, some trainees proactively attempted to improve these, for example by: petitioning for facilities such as lockers, a bed for overnight shifts, peer-to-peer training for physical health care, or pushing for higher staff numbers. These initiatives could be successful but were often frustrated by a lack of trust support and resources. Some trainees also continued without seeking to improve the overall situation because of the perceived temporary nature of the placement.

Statistical analysis of the survey quantitative data also showed that personal strategies to cope with demanding work can be beneficial. For example, psychological detachment (e.g. not thinking about work and distancing oneself from work during time after work) is an important factor that reduces the negative effect of the demands of the job (emotional demands, aggression from patients, and job efforts) on trainees' wellbeing.

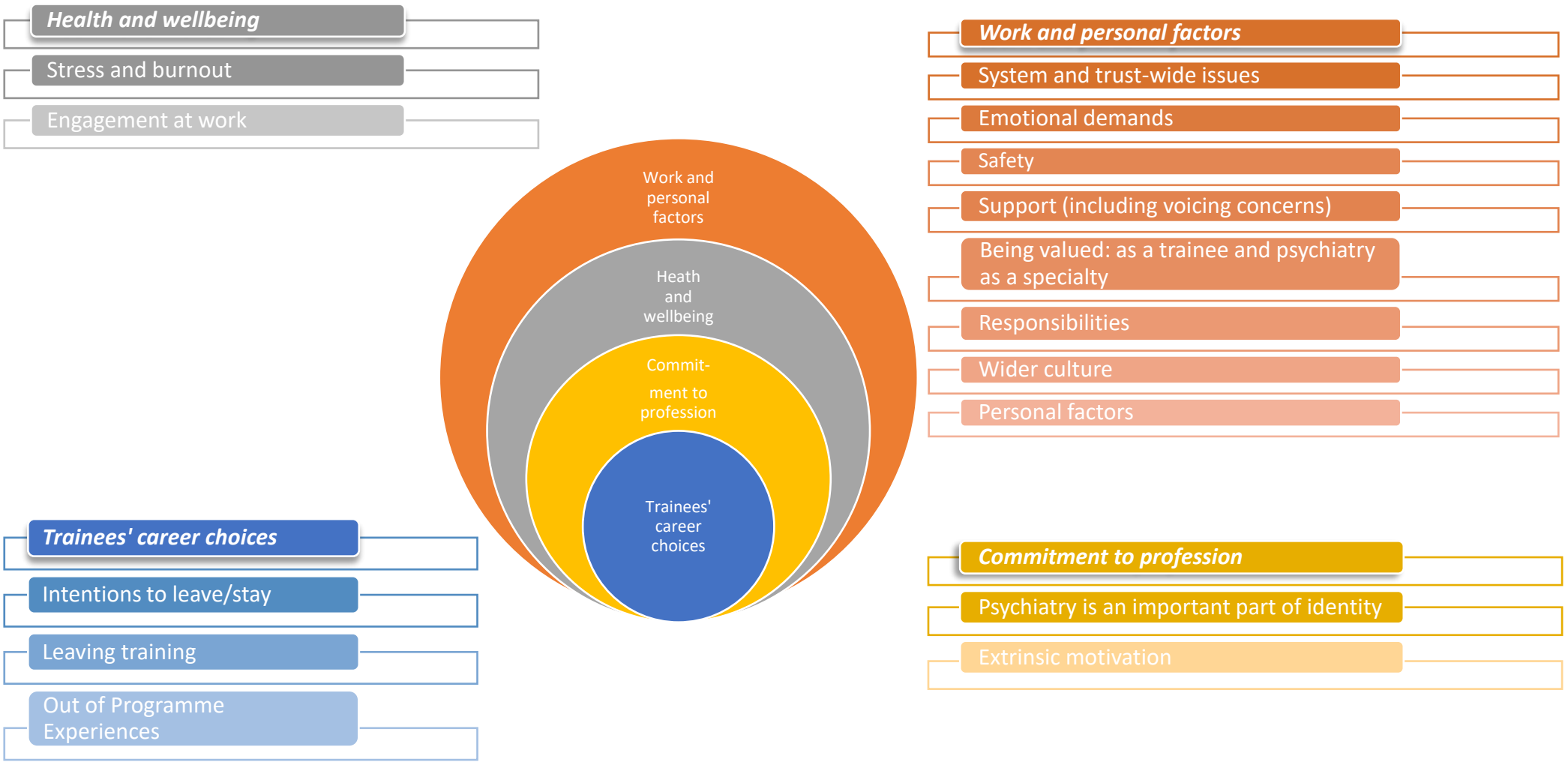

Figure 15. The summary of key findings of trainees' career choices.

Wellbeing and health

The psychological impact of day-to-day cases and responsibilities as a psychiatrist created a cumulative emotional burden on trainees, which was substantially exacerbated by under-resourced and under-staffed environments in both their own workplace, as well as in other mental health services. A total of 23.9% of trainees reported experiencing high or very high levels of ***burnout***. Most trainees (63.5%) were experiencing burnout at moderate level, but only 12% reported low levels. High stress and burnout were identified as challenging by 37.7% of trainees and in the statistical model it showed a significant link to trainees' commitment to their occupation and, in turn, intentions to leave training.

Trainees' accounts indicated there to be a perceived inability to provide patients with high quality care, a feeling that trainees were not valued by the healthcare system, and a belief that stressful aspects of the job would not improve. This contributed to trainees becoming anxious, burnt-out, disillusioned, and dissatisfied. Trainees with inappropriately high responsibilities, unresolved emotional burden or who felt physically unsafe, became particularly vulnerable, stressed, and unhappy in their placements. Trainees with caring responsibilities, or who were coping with personal or family illness or crisis, could be more acutely affected. These trainees seriously considered leaving training, sometimes over a protracted period.

Consultants', who are trainees' role models, wellbeing may also affect trainees' decisions regarding their progression. Trainees saw some aspects of the consultant role as positive, however, they could also be discouraged by the levels of stress, responsibility and burnout in those they observed around them. Such perceptions may result in trainees deciding to work in non-training or non-consultant posts instead.

The positive side of health and wellbeing should not be ignored. ***Work engagement***, which is described as high energy, strong involvement at work, and engrossment in one's work, had a direct impact on one's commitment to work and their intentions to leave: trainees who were more engaged at work were less likely to report an intention to leave their training and were also more committed to their work which, again, made them less likely to leave. Trainees who felt their learning in psychiatry was improving, who felt valued and respected, and who were in placements where the training conditions were being met, were generally strongly engaged within the training programme. These trainees could clearly envisage their future progression to consultancy.

Commitment to the profession

A strong commitment to psychiatry is crucial because it encouraged trainees to remain in their training despite the challenges. This is because they are deeply committed to the specialty, subject, and patients. Trainees who felt that being a psychiatrist was important to their ***self-identity*** and were proud and enthusiastic about psychiatry were less likely to intend to leave psychiatry training. Trainees reported that a sense of belonging and comradery with others in psychiatry helped them progress through and enjoy the training programme. Seniors who were satisfied and fulfilled in their roles inspired trainees and allowed them to clearly picture themselves working in psychiatry in the future. In contrast, trainees who worked under heavy service pressures and in a poor work environment felt less committed to their profession and less positive about their future in psychiatry.

Nevertheless, some trainees mentioned remaining in training as a default option, even those who were on extended breaks with no clear plans to return. Such a commitment is less associated with being enthusiastic about psychiatry, but related to ***extrinsic motivators***, e.g. continuing because of financial security, the fear of starting a new career or a desire to remain until the next clear training milestone, for example, gaining the

MRCPsych qualification before leaving. Consultancy was clearly positioned as the 'end goal' of training, and trainees implied that if they did not achieve this they would have 'failed' and potentially 'wasted time' on this career.

Trainees' career choices

Trainees felt the learning opportunities the training programme offered, the collegial atmosphere, a love of the subject, and meaningful interactions with patients were substantial factors for them ***to stay in psychiatry.*** They did not see these advantages as available in the same way in other specialities. When asked what trainees enjoyed about psychiatry training, trainees picked numerous aspects, including patient related aspects (e.g. complexity of conditions, clinical diversity), nature of work (e.g. intellectual nature, teamwork), and training arrangements (e.g. supervision, working hours). Those who developed a particular interest in a subspecialty were especially motivated to pursue and specialise in this.

However, not all trainees considered staying in training. From all current trainees who took part in our survey 22% indicated that they often thought about ***leaving the profession***, but only 8.2% said that they were actively looking for another job outside of psychiatry. Even fewer trainees (4.4%) stated they wanted to leave psychiatry training as soon as possible. The final decision to leave training was very difficult for some trainees to make (see 'Attrition in psychiatry training' section above). Those who decided to leave appeared to be those who had been operating in a state of vulnerability, usually for some time – feeling anxious, burnt-out, unsafe – and then experienced an incident, which was 'the final straw'. In isolation, the incident itself might not be objectively serious but pushed them to take time out of programme as soon as possible and eventually leave.

Trainees considered a variety of options as an alternative to psychiatry training, in which non-training psychiatry posts were most often mentioned, for example, Specialty and Associate Specialist (SAS) posts or locum work in the UK and abroad. Others deliberated working in trust management/leadership, different specialties or medical education posts. Some found careers outside of healthcare in a variety of industries.

Those who were in between the decision of staying or leaving, or just wanted to proactively pursue interests outside direct clinical practice or to escape situations which were negatively affecting their wellbeing, chose to take ***time out of programme***. Trainees believed these to be essential to persevere and eventually successfully complete the training programme. Trainees were interested in a wide range of areas outside of the clinical application of psychiatry (e.g. research, wellbeing therapies, legal issues, medical education) and wished to have time to pursue these, as well as build up skills in these areas so that they were able to argue for less-than-full-time clinical practice as a consultant. Others wished for time out of training to gain more control over their time, to spend time with family or personal events, or to seek out new experiences. Recuperating during time out was perceived to give trainees strength to re-enter and cope with the intensity of training. Therefore, trainees suggested increasing accessibility of OOPEs and LTFT for wider group of trainees. However, returning could be difficult due to experiencing a reduced salary on return, challenging logistically due to a lack of information and advice, or emotional reasons as the dread of returning had grown during time out. Others felt that OOPEs helped them regain an appreciation for psychiatry and helped increase their confidence.

Strengths and considerations/future directions

The major strength of this study its mixed method approach combining two secondary data sources, an empirical survey study providing qualitative and quantitative data, and an interview study. Triangulation of multiple data sources provides more comprehensive and credible data, which add to the rigour, breadth and understanding of our results and conclusions on psychiatry trainees' career choices.

When reviewing the methodology used to answer the first research objective, we can identify the combination of the GMC's LRMP and UKMED as a major strength. The LRMP is a unique dataset, both because of its completeness and its historical reach: it contains key data on all doctors registered in the UK, including high quality information on the numbers of doctors becoming consultants in psychiatry since 1996. The LRMP also provides a useful picture of one of the most important features of psychiatry training – entering the PSpR – but it is limited on information on the process and the route through which this occurs (training paths). Furthermore, considering the identified delays in trainees' progression to become a consultant psychiatrist, those who graduated more recently are not yet visible in the LRMP. Finally, there is little information in the LRMP on demography, nor is there information on previous educational performance, all of which might give more recent and in-depth information on trends in entry to psychiatry, which makes it impossible to assess the most recent trends.

This is where the UKMED, with information on trainees' career paths, complements the LRMP and provides an opportunity for the longitudinal investigation of trainees' progression from the start to completion of their training. However, the UKMED provides limited insight in trainees' reasons for not progressing due to the restricted quality of such data. Furthermore, the UKMED is available from 2012 (academic year 2011/2012) onwards only. Considering that psychiatry training takes a minimum of six years (three Core training + three Specialty training), there are just two cohorts available for which we were able to follow up trainees from the start to completion of their training (the trainees starting Core psychiatry training in 2011/2012 and 2012/2013).

We recommend that future longitudinal research on trainees' progression should also perform a comparative analysis with multiple other specialties to assess whether the progression of trainees' differs across specialties and delve deeper into following up trainees that do not progress in an expected way.

When reviewing the methodology used to answer the second research objective, we can identify the chosen mixed-method approach as a major strength. This approach guaranteed the credibility of the results stemming from the first part of the survey in two ways: (1) the data was elicited by embedding previously validated constructs into the survey and the reliability of the used constructs was confirmed for this project specifically, and (2) the insights that were acquired by examining the quantitative data were confirmed and further explored by analysing qualitative data. This triangulation of data not only allowed us to give more depth to data that was derived from the questionnaire, but it also enabled participants to elaborate on topics not covered by the questionnaire. This meant that we allowed a thorough data collection to coexist with a participant driven data collection to enrich and complete our understanding of trainees' views on their progression through training.

A limitation of the chosen approach to reach the second research objective is that the survey was completed by a relatively small sample size of current trainees and just four former trainees. A small sample size might pose threats to the validity and generalisability of the results. Although the risk of invalid results is mitigated by the chosen mixed-methods approach and triangulation of data, the generalisability issues that may stem from a small sample size are harder to pinpoint. Another threat to generalisability is the fact that the

questionnaire was only administered amongst current and former trainees in London. The London-only location exposed trainees to environmental pressures, which they perceived to be unique or more prevalent in this context: for example, working with diverse cultures and in a relatively fast-paced environment. Although some findings may be transferrable to other contexts (e.g. trainees' emotional burden or work culture), urban centres and rural locations outside London may experience different environmental pressures and therefore findings cannot be generalised to these locations.

A next step would therefore be to verify the results on a wider-scale and to gain a more in-depth understanding on how to help trainees during crucial stages in their training. We would specifically recommend a national study which encompasses all UK regions, as well as future studies which focus more specifically on the experiences of trainees who have left. For example, analysing exit-interviews with psychiatry trainees leaving training might be highly useful to uncover their motivations and considerations.

When reviewing the methodology used to reach the third research objective, we can consider the diversity of the sample a strength. Participants were diverse in terms of their career choices (e.g. leaving, OOPE), gender, training level, country of primary medical qualification, and whether they had caring responsibilities. Those planning to leave or having left training, were acknowledged as a harder group to recruit resulting in eight participants in this category rather than ten, as in the Core and Specialty training categories. Moreover, in this category all but one participant was female. The voices of leavers are thus less varied within our participant group in comparison to those who leave London training overall. Moreover, as this part of the study was also conducted in the London-region only, the same limitations about transferability of the results apply as for the methodology chosen to answer Research Objective 2.

Future research could focus in particular on which interventions are effective when trainees are considering leaving and we suggest realistic evaluation approaches might be a useful methodology for this. Another suggestion would be to conduct in-depth interviews amongst trainees from different specialties to elicit previously unconsidered or assumed aspects that may also contribute to our understanding of trainees' career choices.

Implications and conclusions

Psychiatry workforce planning

This report reveals that a training trajectory of six years is an exception rather than common practice in psychiatry training, with the large majority of trainees taking longer to complete their training. Trainees' speed of progression should be taken into account when planning the psychiatry workforce, in order to more accurately estimate how many trainees from each cohort will progress to consultancy each year, and where shortfalls might occur.

Moreover, as many trainees want opportunities for LTFT clinical work, both during training and when envisaging their consultancy, the training programme should plan their workforce numbers with an awareness that LTFT working is desirable and prevalent across a wide range of trainees. A reluctance to offer LTFT may cause frustration and resentment, and cause trainees to see a future in psychiatry as unattractive or untenable.

Differences in progression paths are evident between groups of doctors, for example, between male and female doctors and between UKGs and non-UKGs. The training programme may therefore wish to put in place particular measures of support for these groups. To be most effective, these interventions should be developed in conjunction with members of these groups and be context sensitive. Although it is out of the scope of this report to recommend specific interventions, it highlights areas in which work might begin, for example, to support those returning from time out of programme.

Our report reveals the individually tailored paths trainees take through training, often with one or more breaks for personal reasons or professional development. Although our report finds patterns and themes which suggest why certain groups of trainees may continue, take a break, or leave training at given point or after a particular experience, these reasons remain largely individualised. Moreover, the impact of the break – whether it helps the trainee recover from training, or makes them more hesitant to return – also varies from person to person. As a result, the support and options each trainee requires when making decisions about progression is likely to be highly individualised.

Therefore, we recommend that psychiatry training is perceived as a more flexible trajectory during which trainees are permitted, and perhaps even encouraged, to take career breaks. Our analysis shows time out of programme can create space for personal and professional development and help trainees to find a renewed appreciation for psychiatry and increased confidence in their practice. Trainees seemed to already consider taking breaks as the norm, and perceived these as a relief from the rigours of training, and a way to retain themselves in the training programme in the long run.

It is important to note, however, that if trainees had taken time out to escape a difficult situation or to recover from a distressing incident or burnout, it could be very emotionally difficult for them to return as their reservations and fear of returning may have grown during their break. Others, who had gained considerable experience in non-training posts, voiced financial concerns about returning. Again, this report cannot recommend specific interventions, however, some trainees indicated that they felt isolated before their return, and would have benefitted from others in the programme reaching out to them, as well as more accessible information about applying for Specialty training, about the regions, and options for flexible working. Discussions with these trainees about what support they feel might be appropriate and helpful would be a recommended first step in designing interventions to recover these trainees back into training.

Improvements to training

Generally, trainees were positive about the teaching and training opportunities offered by the training programme, valued the protected time for these activities and an overall culture that prioritised their learning. In this respect, we would recommend that the level of opportunities and support in the training programme is maintained, and further efforts are made to ensure that all trainees can access these, as some reported missing out due to service provision pressures and under-staffing.

Systemic and trust-wide issues, such as understaffing and under-resourcing, were reported as major challenges in training and these substantially exacerbated other challenges such as learning to manage psychological challenges, maintaining healthy levels of responsibility, and feeling valued. Trainees understood that many of these issues were outside the control of the training programme; however, smaller structural changes, such as receiving rotas in a timely manner and having more control over the allocation of placements, might reduce levels of dissatisfaction within what can be controlled.

Moreover, trainees were generally motivated and keen to act proactively to make positive changes to facilities and training in their workplace; however, these efforts could be frustrated by processes or lack of response in the trust. Supporting trainees to help themselves, for example, by highlighting existing processes or resources, or advice on navigating trust protocols and procedures may help both empower them and improve their situations. Again, doing this in conjunction with trainees is most likely to achieve optimal and tailored results.

Dissatisfaction due to feeling psychologically or physically vulnerable was reported in particular in relation to on-calls. Some trainees reported this directly contributed to their decision to leave training. Currently, distressed trainees seem to be removed from the on-call rota, which temporarily alleviates their situation, but allows for no lasting change. We suggest the training programme reconsiders the current format of on-calls and discusses possible changes with trainees and supervisors, understanding trainees' concerns as legitimate and actionable.

Finally, despite all the challenges they experienced, the majority of trainees stayed in psychiatry training because there were numerous aspects they were passionate about, found interesting and rewarding about working and training in psychiatry. Strategically highlighting these aspects throughout training and allowing trainees time to reflect on the enjoyable aspects may increase their motivation and resilience during harder times.

Enhancing trainees' wellbeing

Trainees' wellbeing is an important factor contributing substantially to their decisions to stay or leave psychiatry training. Enhancing trainees' wellbeing by minimising burnout and improving their work engagement should support trainees in their commitment to training and the profession, and subsequently help retain them within the programme. Bearing in mind the restricted influence of the programme to tackle wider systemic NHS issues affecting trainees, we suggest wellbeing may be improved by reorienting the workplace culture and implementing some practical steps as described below.

Trainees' stated that dealing with aggression from patients is one of the main challenges in psychiatry training. Trainees' specifically talked about the stress and emotional exhaustion that they experience when

having to deal with varying forms of aggression, such as verbal and behavioural aggression, sexual intimidation, and harassment. Considering the large impact of aggression at the workplace on trainees' wellbeing, we suggest it is crucial for training programmes to recognise that trainees are dealing with this on a regular basis and offer clear avenues to access support (e.g. a helpline, regular discussions, or training). Trainees felt that generally team and trust responses to assault were supportive and relatively rapid, although this could be very varied. Moreover, trainees reported a lack of leadership from the training programme in managing expectations about assault and preparing trainees for both minor as well as major incidents. What support or initiative would be optimal is best decided in each specific context and in collaboration with all stakeholders involved in training – especially with the trainees themselves.

Trainees reported a stigma in psychiatry about psychiatrists themselves being affected by poor mental health. This was combined with a wider medical and training culture, which encouraged trainees to see suffering as a rite of passage and to endure circumstances without 'making a fuss'. As a result, trainees reported being reluctant to ask seniors for help, fearful of the consequences of revealing their true level of distress, or to access support services such as personal therapy. Some also reported that they did not see their day-to-day emotional burden or the obvious cumulative psychological impact on them as serious enough to warrant direct address; rather this was accepted as an inevitable and unchangeable aspect of training. Culture is often slow to change, but psychiatry should be well placed to engage with and explore how best to tackle stigma about mental health in doctors, and to place wellbeing at the forefront of issues within training. Once again, we suggest this to be a community effort that draws on voices and experiences of those throughout the speciality to identify key issues and interventions for change.

In combination with a culture that supports trainees see their wellbeing concerns as legitimate, and to voice these, opportunities should be created which actively encourage them to do so. A total of 22% of current trainees agreed they had thought about leaving, however, not all trainees with concerns reported talking to seniors about their concerns (e.g. 47.2% talked to their educational supervisor). As a result, their reasons may currently not be officially or unofficially known. Trainees suggested that conducting exit interviews with those leaving the training programme would provide key information that would help to identify the challenges trainees are experiencing and inform change. The training programme may want to consider a more proactive approach in which trainees are not only encouraged to be forthcoming with concerns, but are actively asked about their ongoing wellbeing on a regular basis. Overall, trainees wished to be seen and to have their wellbeing concerns acknowledged.

Awareness of doctors' poor wellbeing is increasingly acknowledged, and various institutions offer support, from online resources to personal therapy. However, participants in this study were often unaware of these services. We suggest the training programme investigate trainees' awareness of various sources of support further, and if seen as beneficial collate and advertise information on these resources to trainees, encouraging them to see 'people like them' use and benefit from these services. A targeted needs assessment would also help advise whether further-reaching support might be possible and beneficial, such as coaching sessions or personal therapy built into the programme as occurs in other countries.

Finally, increasing trainees' intrinsic motivation for psychiatry could significantly increase their work engagement. Our study showed that the work environment is crucial for trainees' wellbeing, and that job resources such as autonomy and good supervision could help to reduce the negative effect of demanding environments. It is important that the training programme strives for excellence in these aspects, so that more trainees are able to maintain the love of psychiatry and enjoy the positives of training which attracted them to the programme initially.

References

Armat, M. R., Assarroudi, A., Rad, M., Sharifi, H., & Heydari, A. (2018). Inductive and deductive: Ambiguous labels in qualitative content analysis. *The Qualitative Report, 23*(1), 219-221.

Barras, C., & Harris, J. (2012). Psychiatry recruited you, but will it retain you? Survey of trainees' opinions. *The Psychiatrist, 36*(2), 71-77. doi:10.1192/pb.bp.111.034413

Brown, T. A. (2015). *Confirmatory factor analysis for applied research*: Guilford publications.

Choudry, A., & Farooq, S. (2017). Systematic review into factors associated with the recruitment crisis in psychiatry in the UK: students', trainees' and consultants' views. *BJPsych bulletin, 41*(6), 345-352. doi:10.1192/pb.bp.116.055269

Cohen, A. (1998). An examination of the relationship between work commitment and work outcomes among hospital nurses. *Scandinavian Journal of Management, 14*(1-2), 1-17.

De Jonge, J., Dormann, C., Van Vegchel, N., Von Nordheim, T., Dollard, M., Cotton, S., & Van den Tooren, M. (2007). The DISC Questionnaire, English version 2.1. *Eindhoven: Eindhoven University of Technology*.

Dobbie, S., & Wickham, H. (2018). *Psychiatry core trainee attitudes towards higher training in South East London*. London School of Psychiatry. Personal communication (e-mail).

Gafson, I., Currie, J., O'Dwyer, S., Woolf, K., & Griffin, A. (2007). Attitudes towards attrition among UK trainees in obstetrics and gynaecology. *76*(6), 344–348.

Goldacre, M. J., Fazel, S., Smith, F., & Lambert, T. (2013). Choice and rejection of psychiatry as a career: surveys of UK medical graduates from 1974 to 2009. *The British journal of psychiatry : the journal of mental science, 202*(3), 228-234. doi:10.1192/bjp.bp.112.111153

Haynes, C. E., Wall, T. D., Bolden, R. I., Stride, C., & Rick, J. E. (1999). Measures of perceived work characteristics for health services research: Test of a measurement model and normative data. *British Journal of Health Psychology, 4*(3), 257-275.

King, N., Horrocks, C., & Brooks, J. (2018). *Interviews in qualitative research*: SAGE Publications Limited.

Lambert, T. W., Turner, G., Fazel, S., & Goldacre, M. J. (2006). Reasons why some UK medical graduates who initially choose psychiatry do not pursue it as a long-term career. *36*(5), 679-684.

Meyer, J. P., & Allen, N. J. (1991). i Smith, CA (1993). Commitment to organizations and occupations: Extension and test of a three-component conceptualization. *Journal of applied psychology, 78*(4), 538-551.

Morgeson, F. P., & Humphrey, S. E. (2006). The Work Design Questionnaire (WDQ): developing and validating a comprehensive measure for assessing job design and the nature of work. *Journal of applied psychology, 91*(6), 1321.

NHS. (2017). National Psychiatry Recruitment - Fill Rates & Competition Ratios. Retrieved from https://www.nwpgmd.nhs.uk/national_Psychiatry_Recruitment_Comp_Ratios_Fill_Rates

O'Driscoll, M. P., Brough, P., & Kalliath, T. J. (2004). Work/family conflict, psychological well-being, satisfaction and social support: A longitudinal study in New Zealand. *Equal opportunities international, 23*(1/2), 36=56. doi:https://doi.org/10.1108/02610150410787846

Oud, N. (2001). POPAS Ervaringen van psychiatrische hulpverleners met agressief gedrag. 1-15.

RCPSYCH. (2019). *Census 2019: Workforce figures for consultant psychiatrists, specialty doctor psychiatrists and Physician Associates in Mental Health*. Retrieved from https://www.rcpsych.ac.uk/docs/default-source/improving-care/workforce/census-2019-editmar20.pdf?sfvrsn=17d88821_2

RCPSYCH. (2020). Choose Psychiatry. Retrieved from https://www.rcpsych.ac.uk/become-a-psychiatrist/choose-psychiatry

Sarfraz, M. A., Merrony, I., & Atkins, C. (2016). A survey of foundation doctors' attitudes towards psychiatry before and after their first clinical working year. *British Journal of Medical Practitioners, 9*.

Schaufeli, W. B., & Bakker, A. B. (2003). UWES–Utrecht work engagement scale: test manual. *Unpublished Manuscript: Department of Psychology, Utrecht University, 8*.

Schaufeli, W. B., De Witte, H., & Desart, S. (2019). *Unpublished Manuscript: Manual Burnout Assessment Tool (BAT)*.

Siegrist, J., Li, J., & Montano, D. (2014). Psychometric properties of the effort-reward imbalance questionnaire. *Germany: Duesseldorf University*.

Sonnentag, S., & Fritz, C. (2007). The Recovery Experience Questionnaire: development and validation of a measure for assessing recuperation and unwinding from work. *Journal of occupational health psychology, 12*(3), 204.

Appendix A. Survey Part 1.

1. What do (did) you enjoy about your psychiatry training? (please tick all that apply)

	Intellectually comprehensive with sufficient academic challenge
	Fascinating patients with complex and interesting conditions
	Clinical diversity of the work
	Holistic bio-psycho-social, 'whole patient' approach
	More opportunity to spend time and get to know patients than in other specialties
	Receiving good training
	Working as part of a team
	Feeling you are 'making a difference' in a significant area of healthcare
	Good future career opportunities
	Hours and work-life balance
	Opportunities for flexible working
	Access to inspirational role models
	Good quality of supervision
	Good opportunity for service development
	Exciting potential scientific advances
	Other _____

2. If you have had doubts but have chosen to stay, what has made you want to continue with psychiatry training?

3. What factors contributed to your decision to leave?/ What do you find challenging about psychiatry training? (please tick all that apply)

	High stress and workload, feeling burnt-out
	I can't see myself coping with or enjoying becoming a consultant psychiatrist
	Problems and gaps within rotas
	Feel training needs are not being met
	Personal and/or health reasons
	Involvement in a difficult case or event (e.g. patient suicide)
	Verbal or physical abuse from patients
	Under-resourced in relation to other branches of medicine
	Systemic changes and constraints within the NHS (e.g. reforms, target culture, long waiting lists)
	Stigma or lack of respect for psychiatrists within medicine
	Cultural or societal stigma about psychiatrists
	Psychiatrists held accountable for adverse patient outcomes more than in other specialities
	My personality is not suitable for psychiatry
	Bullying or undermining from other staff

	Failed to progress/formally asked to leave
	Feel work is not valued or making a difference
	Job is too repetitive and/or bureaucratic
	Poor work/life balance as a trainee
	Psychiatry wasn't what I expected
	Number of locum doctors
	Unsupported work environment/poor relationship with colleagues
	Interest in another specialty
	Other _____

3.a. If you would like to expand on your answers, please do so here:

4. Thinking about your current working environment, please indicate the extent to which you agree with each statement:

	Strongly disagree	**Disagree**	**Neither agree or disagree**	**Agree**	**Strongly agree**
1. I am satisfied with the transport facilities at my workplace (e.g. car parking, public transport connections)					
2. I am satisfied with my workplace amenities (e.g. café, canteen, staff mess)					

5. What are you doing now (considering doing) instead? / If you considered leaving the speciality, what were you planning on doing instead?

6. Have you taken time out of programme during your psychiatry training?

a) Yes
b) No
c) No, but I seriously considered it
d) No, because it wasn't approved by my trainer(s)

7. *If Y to above:* **How long were you out of programme?**

a) 6 months or less
b) 6-12 months

c) 1-2 years
d) 2-3 years
e) 3 years or more

8. *If Y to above:* **Why did you take time out of programme?**

9. *If Y to above:* **What did you gain from your time out of programme?**

10. Before leaving the speciality, did you voice your concerns to any of the following people?/ Have you voiced your concerns/discussed these challenges with any of the following people?

	No
	Consultant
	Educational Supervisor
	College tutor
	Head of School
	Training programme Director
	Colleague at your level
	Senior colleague
	Other healthcare professional
	Friends outside work
	Family
	Careers advisor
	Other _____

10.a. If yes, what was the advice from those you liaised with and was it useful?

11. What do you think the Deanery/College/supervisors could do to support trainees who are considering leaving?

Appendix B. Interview Guide

Aims of study

This study aims to develop a detailed understanding of the positive and negative elements of being a psychiatry trainee. The findings are intended to go on to provide the team at the Royal College of Psychiatry (RCPsych) greater insight into how best to design and implement high quality psychiatry training, as well as how best to enhance the experience of being a trainee.

To that end, we want to hear your views and experience of psychiatry training in London. Yours and others' collated and anonymised views and experiences will be fed back to RCPsych in the form of a report.

Process

- So, over the next hour or so, I'm going to be asking you a series of questions that will hopefully spark some interesting conversations.
    - I'd like to audio record this interview and take some notes to help me accurately remember what was said.
    - What you say will be kept confidential – we won't share details of it with anyone outside of the research team.
    - And just to say at this point that there are no right or wrong answers, I just want to hear all of your opinions and experiences.
- The recording of our discussion will be transcribed and anonymised.
- These anonymised transcripts will then be analysed by the research team at the Research Department of Medical Education.
- We may publish small sections of what you say in our report. But we will only publish these in a way that means that it impossible for anybody to identify you as the person making the statement.
- If at any time you want to stop or needs to leave, that's fine

Any questions about any of that?

Interviews with trainees in Core training

NB: NEED TO TRY AND UNPACK ALL ANSWERS/INTERESTING POINTS MADE – e.g "why do you think that was?"; "what was it about that, that made you feel X"

NARRATIVE INTERVIEW

Now I'd like to talk a little about your experiences of psychiatry training. Can you think back to when you decided to specialise in psychiatry, and just talk me through your experiences from then to now?

NB: narrative interview is them telling a story virtually uninterrupted. The aim is to get them to talk you through their whole experience and you drill into/unpack significant points as they emerge. ***It's not a Q&A session.***

Particular events to explore in narrative:

a) When they decided to specialise in psychiatry
   i) (including how/why made that decision)
b) The night before first day of training
   i) How they were feeling
   ii) What they knew in terms of what was going to happen
c) What emerges as seminal moments in training from them (these will be events/moments they pinpoint - e.g. moving to take up a training post, exams, experiences of violence and aggression, placements, on-call rotas)

Try to unpack what is what about their interaction with an event/person/experience that is shaping their recollection with it:

- Was it positive/negative
- How did it make them feel
- How did they feel others viewed them

'TOP UP' QUESTIONS IF NOT COVERED IN NARRATIVE

1) What were your expectations of psychiatry training?
   a) Prompt: had you heard anything about what it was going to be like from anyone?

2) How do your experiences of training compare with your expectations of it?
   a) Prompt: What was what you expected/ what was not what you expected?
   b) NB: unpack how they feel about that (e.g. pleasant surprise or off-putting one, confidence boost?)

3) In your opinion, what does a 'good' psychiatry trainee look like and what does a 'bad' one look like?
   a) How would you classify yourself?
   b) NB: unpack how/why answers about themselves and about the abstract identity constructs being presented

4) What is the most important thing that you think should be included in psychiatry training? *NB: this can be something that already is, or something that they think is missing.*
   a) NB: unpack how/why think this

   i) *When relevant, include discussion of relationship between what's being said and working environment factors – i.e. distance from home. Commute length. Working hours & work/life balance.*
b) Do you think there is anything missing from psychiatry training?
c) Do you think training to be a psychiatrist could be improved?
   i) *NB: unpack: how/why their yes/no answers*

5) How are you feeling about the next steps of becoming a psychiatrist?
   a) *NB: unpack how/why feeling this*
      i) *Especially if participant is anxious/has reservations, what could be done to ease this (if anything)*

6) What do you think about psychiatry as a specialty?
   a) *NB: unpack how/why think what they say*
   b) Is this different to how you felt about it before you started training?

7) What are your plans after completing Core training?
   a) *Unpack those that are wanting to continue into higher (what is about psychiatry training that they enjoy and want to continue)*
   b) *Unpack those that are uncertain/aren't thinking about progressing at all/straight away – find out what could sway their decision? Why they are unsure?*

8) Have you experienced violence or aggression in your training?
   a) *Unpack responses*
      i) *Focus on how significant this experience was for them*
      ii) *If they haven't experienced it directly, explore how anecdotal experiences have shaped their experience of training (e.g. afraid? More cautious?)*

Is there anything that you wish to add?

9) Do you know of anyone who has left psychiatry training? [If Y, explain we are really keen to interview leavers and ask them if they would be kind enough to pass on our details to the person who has left).
10) If Y, ask them their views on why they think they left training

THANK AND CLOSE.

Interviews with trainees in Specialty training

NB: NEED TO TRY AND UNPACK ALL ANSWERS/INTERESTING POINTS MADE – e.g "why do you think that was?"; "what was it about that, that made you feel X"

NARRATIVE INTERVIEW

Now I'd like to talk a little about your experiences of psychiatry training. Can you think back to when you decided to specialise in psychiatry, and just talk me through your experiences from then to now?

NB: narrative interview is them telling a story virtually uninterrupted. The aim is to get them to talk you through their whole experience and you drill into/unpack significant points as they emerge. ***It's not a Q&A session.***

Particular events to explore in narrative:

a) When they decided to specialise in psychiatry
   i) (including how/why made that decision)
b) The night before first day of training
   i) How they were feeling
   ii) What they knew in terms of what was going to happen
c) What emerges as seminal moments in training from them (these will be events/moments they pinpoint - e.g. moving to take up a training post, exams, experiences of violence and aggression, placements, on-call rotas)
d) When/how they made decisions about sub-specialty
   i) Unpack why they dismissed some & how narrowed down what they wanted
   ii) What influenced decision making here
e) How they found the application process for Specialty training

Try to unpack what is what about their interaction with an event/person/experience that is shaping their recollection with it:

- Was it positive/negative
- How did it make them feel
- How did they feel others viewed them

TOP UP' QUESTIONS IF NOT COVERED IN NARRATIVE

1) What were your expectations of psychiatry training?
   a) Had you heard anything about what it was going to be like from anyone?

2) How do your experiences of training compare with your expectations of it?
   a) Prompt: What was what you expected/ what was not what you expected?
   b) NB: unpack how they feel about that (e.g. pleasant surprise or off-putting one, confidence boost?)

3) In your opinion, what does a 'good' psychiatry trainee look like and what does a 'bad' one look like?
   a) How would you classify yourself?
   b) NB: unpack how/why answers about themselves and about the abstract identity constructs being presented

4) What is the most important thing that you think should be included in psychiatry training? *NB: this can be something that already is, or something that they think is missing.*
    a) *Unpack how/why think this*
        i) *When relevant, include discussion of relationship between what's being said and working environment factors – i.e. distance from home. Commute length. Working hours & work/life balance.*
    b) Do you think there is anything missing from psychiatry training?
        i) Unpack: how/why their yes/no answers
    c) Do you think training to be a psychiatrist could be improved?
        i) Unpack: how/why their yes/no answers

5) How are you feeling about the next steps of becoming a psychiatrist?
    a) Unpack how/why feeling this
        i) Especially if participant is anxious/has reservations, what could be done to ease this (if anything)

6) What do you think about psychiatry as a specialty?
    a) Unpack how/why think what they say
    b) Is this different to how you felt about it before you started training?
        i) Unpack what's changed/why hasn't

7) What are your plans after completing training?
    a) Unpack those that are wanting to continue (what is about psychiatry training that they enjoy and want to continue)
    b) Unpack those that are uncertain/aren't thinking about practice straight away – find out what could sway their decision? Why they are unsure?

8) Have you experienced violence or aggression in your training?
    a) Unpack responses
        i) Focus on how significant this experience was for them & if they haven't experienced it directly, explore how anecdotal experiences have shaped their experience of training (e.g. afraid? More cautious?)

9) Do you know of anyone who has left psychiatry training? [If Y, explain we are really keen to interview leavers and ask them if they would be kind enough to pass on our details to the person who has left).
10) If Y, ask them their views on why they think they left training

Is there anything that you wish to add?

THANK AND CLOSE.

Interviews with trainees who have left training

NB: NEED TO TRY AND UNPACK ALL ANSWERS/INTERESTING POINTS MADE – e.g "why do you think that was?"; "what was it about that, that made you feel X"

NARRATIVE INTERVIEW

I'd like to talk a little about your experiences of psychiatry training. Can you think back to when you decided to specialise in psychiatry, and just talk me through your experiences from then to now?

NB: narrative interview is them telling a story virtually uninterrupted. The aim is to get them to talk you through their whole experience and you drill into/unpack significant points as they emerge. ***It's not a Q&A session.***

Particular events to explore in narrative:

d) When they decided to specialise in psychiatry
   i) (including how/why made that decision)
e) The night before first day of training
   i) How they were feeling
   ii) What they knew in terms of what was going to happen
f) What emerges as seminal moments in training from them (these will be events/moments they pinpoint - e.g. moving to take up a training post, exams, experiences of violence and aggression, placements, on-call rotas)
g) When they decided to leave
   i) How/why the made that decision
   ii) Could anything have been done to change it?

Try to unpack what is what about their interaction with an event/person/experience that is shaping their recollection with it:

- Was it positive/negative
- How did it make them feel
- How did they feel others viewed them

'TOP UP' QUESTIONS IF NOT COVERED IN NARRATIVE

1) What were your expectations of psychiatry training?
   a) Had you heard anything about what it was going to be like from anyone?

2) How do your experiences of training compare with your expectations of it?
   a) What was what you expected/ what was not what you expected?
   b) Unpack how they feel about that (e.g. pleasant surprise, or off-putting one)

3) In your opinion, what does a 'good' psychiatry trainee look like and what does a 'bad' one look like?
   a) How would you classify yourself?
   b) Unpack how/why answers about themselves and about the abstract identity constructs being presented

4) What is the most important thing that you think should be included in psychiatry training? *NB: this can be something that already is, or something that they think is missing.*

   a) *Unpack how/why think this*
      i) *include discussion of relationship between what's being said and working environment factors – i.e. distance from home. Commute length. Working hours & work/life balance.*
   b) Do you think there is anything missing from psychiatry training?
   c) do you think training to be a psychiatrist could be improved?
      i) *Unpack: how/why their yes/no answers*

5) Did you ever experience violence or aggression in your training?
   a) *Unpack responses*
      i) *Focus on how significant this experience was for them & decision to leave*
      ii) *If they haven't experienced it directly, explore how anecdotal experiences have shaped their experience of training (e.g. afraid? More cautious?)*

6) What do you think about psychiatry as a specialty?
   a) *Unpack how/why think what they say*
   b) Is this different to how you felt about it before you started training?

7) What are your plans now?
   a) *Unpack those that are/aren't thinking about another specialty or changing careers totally*
   b) *Unpack those that are uncertain – find out what could sway their decision? Why they are unsure?*

Is there anything that you wish to add?

THANK AND CLOSE.