

# **Thematic Report**

## **Wellbeing and burnout**

**September 2024**



# Wellbeing and burnout

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## Background

Obstetrics and gynaecology (O&G) is a high-stress field with significant burnout rates. Studies have shown that 43% of O&G trainees and 31% of O&G consultants experience burnout, compared with 21-24% in other specialties<sup>1,2</sup>. Burnout is defined as “a state of exhaustion in which one is cynical about the value of one’s occupation and doubtful of one’s capacity to perform”<sup>3</sup>. It is a syndrome characterised by chronic emotional exhaustion, cynicism (or depersonalisation) and perceived lack of personal accomplishment; it is associated with poorer patient outcomes, reduced willingness to take on more work and greater desire to leave UK practice<sup>4</sup>. In 2020, the General Medical Council (GMC) identified<sup>2</sup> that 12% of O&G trainees leave the specialty within three years of achieving their certificate of completion of training (CCT), the highest of any specialty. Attrition is, therefore, a real challenge for the O&G workforce.

Physical and psychological safety are needed within O&G departments to ensure patient safety and compassionate care are being provided, to improve staff retention and staff satisfaction, to reduce symptoms of burnout and to promote diversity and inclusion within the workplace<sup>5</sup>. The RCOG workforce report in 2022 highlighted the importance of a supportive environment, including supporting training, addressing rota gaps, and providing flexible working opportunities to address the issue of burnout and attrition in O&G<sup>5</sup>. This is in keeping with reports from the BMA and the GMC that improving working conditions including work-life balance, development opportunities and access to basic facilities will aid retention of the medical workforce<sup>6,7</sup>.

For the first time in 2024, the Training Evaluation Form (TEF) survey included questions on rest, burnout and wellbeing. While a multitude of factors contribute to trainee wellbeing, this report summarises O&G trainees experiences and perspectives on rest, burnout and wellbeing alongside working patterns and intention to leave the specialty. We will explore this through the lens of the GMC’s ‘ABC of Doctor’s Core Needs’. The three core needs identified in the ABC model are “Autonomy and Perceived Control”, “Belonging and Perceived Support” and “Competence and Perceived Performance”<sup>8,9</sup>. This framework underscores what doctors need for their wellbeing, motivation and minimisation of workplace stress and burnout<sup>8</sup>, and thus what is needed to support a sustainable and healthy workforce.

The aim of this report is to highlight areas of excellence and opportunities for improvement.



## TEF Questions

- Appendix A shows the list of questions analysed in this report.
- Appendix B shows the list of questions explored through GMC's ABC of Doctor's Core Needs domains.

## Methodology

For each question identified, the responses have been descriptively analysed and, where appropriate, grouped by training year and region. Correlations between relevant variables, such as type of rotas and attrition, are explored. To facilitate statistical comparisons, Likert scale data has been converted to numerical scale data from 1 to 5, with 1 being worst score and 5 being the best score. Where narrative responses are negative, scores were inverted to maintain direction of results. For instance, a 'strongly agree' response to 'The work intensity is too high for my learning needs' would score 1, whereas the same response to the question 'The work intensity is too low for my learning needs would score 5.

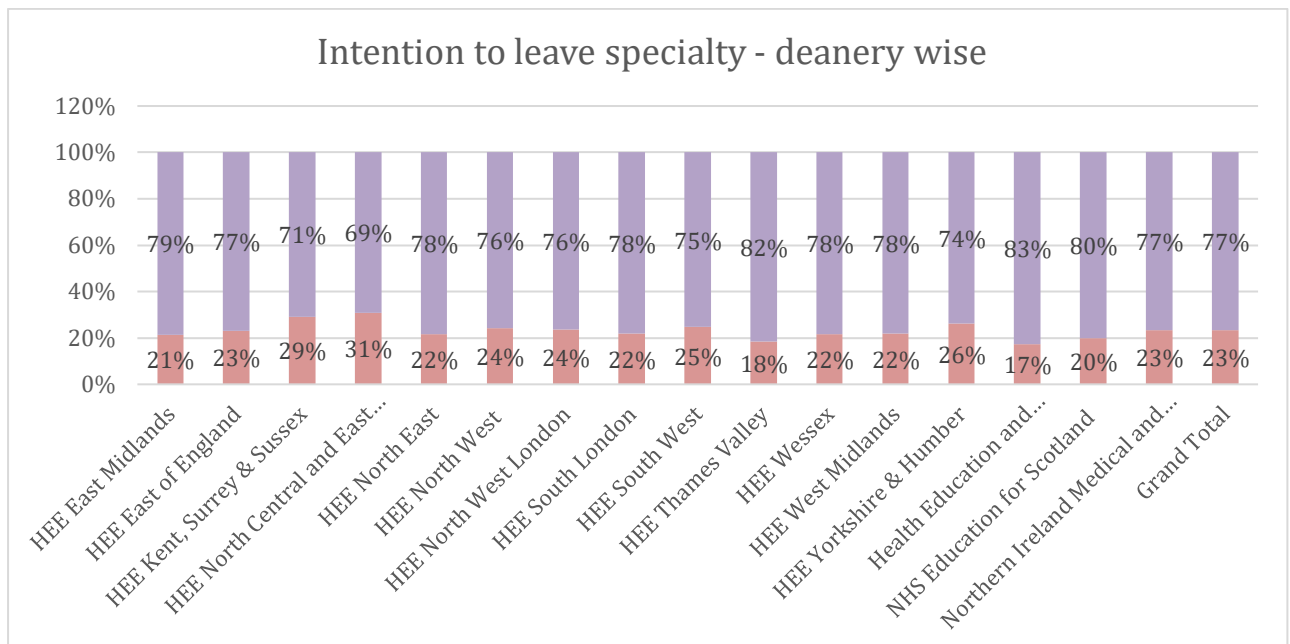
Some responses have been grouped to facilitate comparisons. For instance, attrition has been grouped into 'Yes' if seriously considered leaving daily, weekly or monthly and 'No' if occasionally or never.

When the number of respondents in a group is <3, relevant results and overall totals have been suppressed in order to protect the anonymity of respondents.

## Analysis and discussion

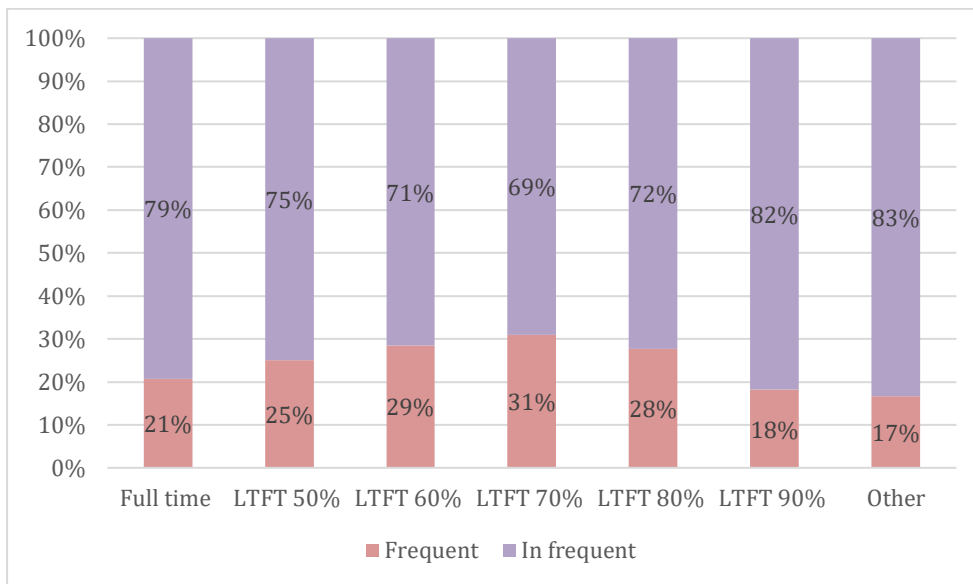
### **Attrition and the intention to leave specialty**

Since starting specialty training, 3% of doctors reported that they are seriously considering leaving O&G daily, 7% seriously consider this weekly and 13% seriously consider it monthly. In contrast, 45% seriously consider it occasionally and 32% of doctors never seriously consider leaving O&G. It is important to note that this question was in relation to seriously considering leaving the specialty, not just the training programme. Of those that reported they are seriously considering leaving O&G daily, this was higher for those in ST1 – 5 than in ST6-7.



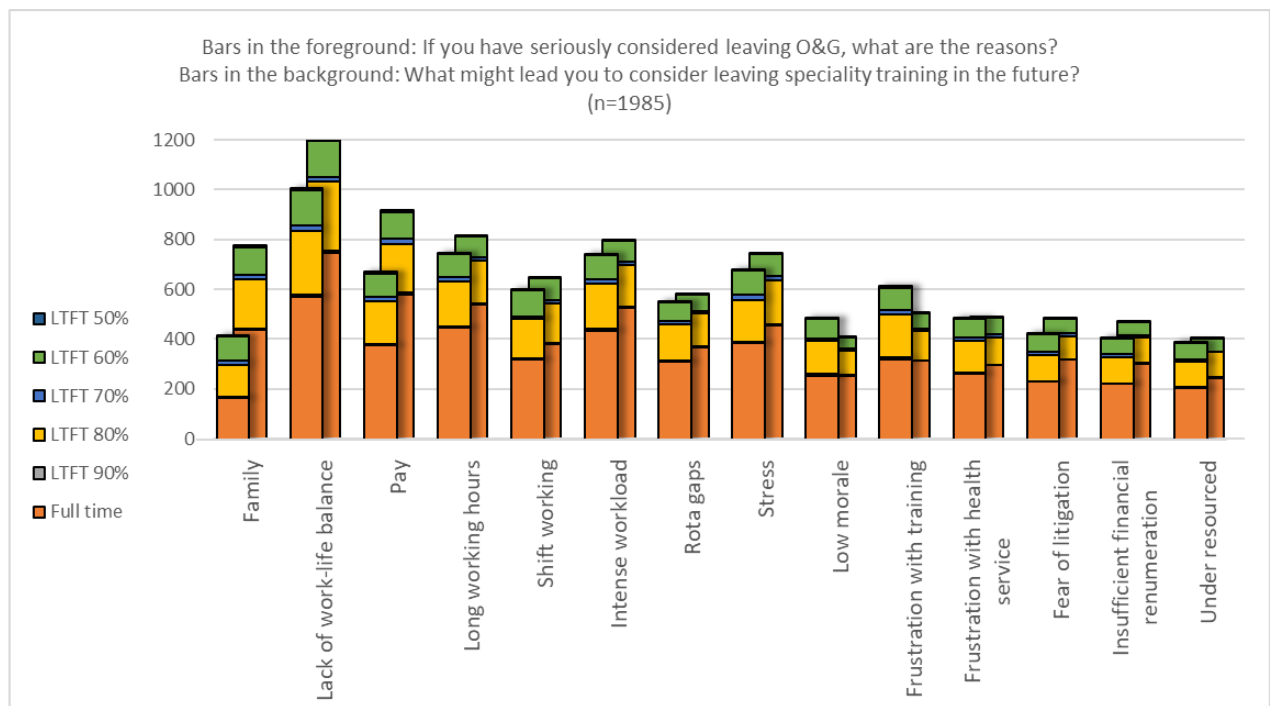
**Figure 1. Intention to leave specialty - Deanery wise.** The red bars represent the proportion of trainees who seriously considered leaving O&G monthly, weekly or daily.

Paradoxically, the proportion of trainees seriously considering leaving O&G is higher for doctors working LTFT than for those working full-time (FT) (see figure 2 below; table 1 and figures A and B in Appendix C). This is likely because lack of work-life balance, a common reason for choosing to work LTFT, is also the most cited reason for considering leaving O&G. While going LTFT might be seen by some as the first step to leaving O&G, having the flexibility to work LTFT provides doctors with greater autonomy over their working hours and improves workforce retention. As such, this finding is likely a marker of dissatisfaction with training and working conditions, rather than a sign that those working LTFT are less committed to the specialty or more likely to leave the specialty.



**Figure 2. LTFT and intention to leave.** The red bars represent the proportion of trainees who seriously considered leaving O&G monthly or more.

Across all respondents, the reasons most cited for seriously considering leaving specialty training were lack of work-life balance (cited by 51%), long working hours (38%), intense workload (38%), stress (34%) and pay (34%). Note that trainees could select all reasons that applied.



**Figure 3. Intention to leave - Reasons**



In trainees who have seriously considered leaving O&G, the most common reason cited is the lack of work-life balance (50%). Meanwhile, 60% of all trainees cite lack of work-life balance as a reason that they might consider leaving O&G in the future. This 10% difference appears to come from those currently working full time; this suggests that we should look to improve work-life balance if we want to reduce attrition in those who are working full time. It is possible that improved access to LTFT training (via the Category 1 route) will help to reduce attrition.

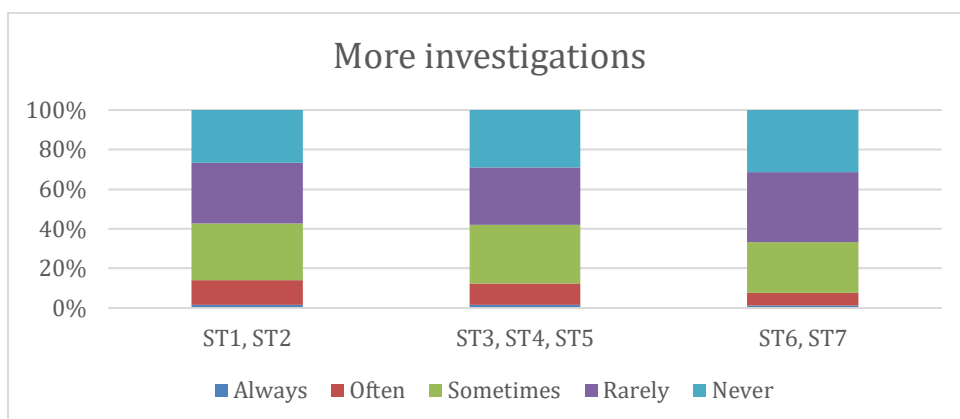
It is worth noting that while only 20% of all trainees who have seriously considered leaving O&G have cited 'Family' as the reason, this doubles when we consider that 40% of all trainees consider that 'Family' will be a reason for considering leaving the specialty in the future. It may be worth exploring how O&G might become more 'family-friendly' as a specialty – perhaps with flexible hours, such as late starts to accommodate drop-offs at nursery/school; or more flexibility around carers' leave for when children fall ill as well as increased clarity about how this might contribute to an extension to training time.

### **Burnout and defensive medical practice**

In a 2019 survey of over 3000 O&G doctors, Bourne et al<sup>1</sup> found that those with burnout were 4 times more likely to engage in defensive medical practice (DMP). DMP is defined as the modification of standard practice to reduce the likelihood of litigation, complaints or criticism<sup>10</sup>.

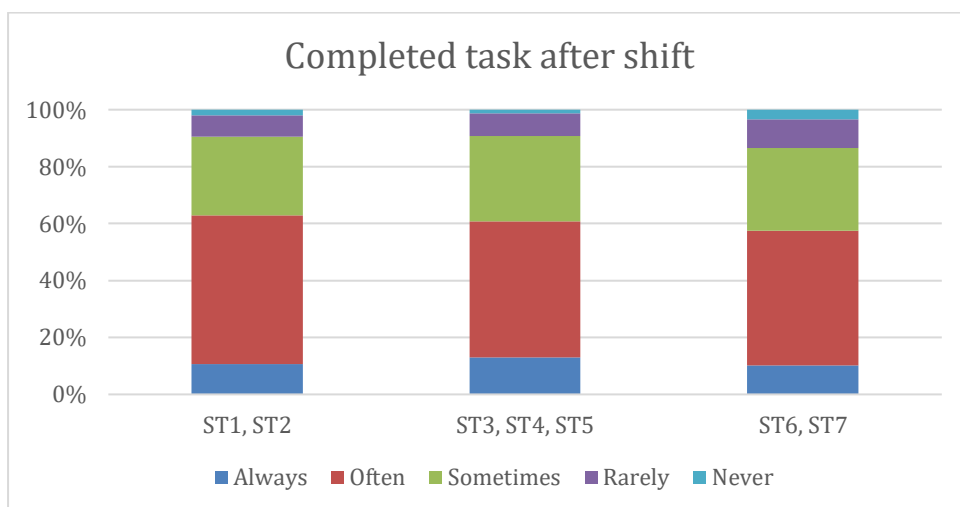
Whilst burnout was not specifically measured in the 2024 TEF survey, questions on defensive medical practice (DMP) were adapted from Bourne et al's survey questionnaire<sup>1</sup>.

12% of respondents either 'always' or 'often' conducted more investigations than warranted by the patient's condition, within the last three months, for fear of possible consequences such as complaints, disciplinary actions by managers, being sued, or publicity in the media. This was more common for trainees in the earlier stages of their training, with 13% of ST1-2s engaging in this type of practice 'often', followed by 11% of ST3-5s and 6% in ST6-7 (see Figure 4, below). This suggests that as experience develops, defensive medical practice decreases.



**Figure 4. Defensive Medical Practice: Over-investigating across stages of training.**

Nearly half of trainees (49%) reported 'often' having to stay after the end of a shift to complete a task or document notes ('always', 12% and 'never', 2%). Reported figures were similar across all the specialty training programme stages, as shown in the graph below (Figure 5).



**Figure 5. Extended Stay practices across stages of training.**

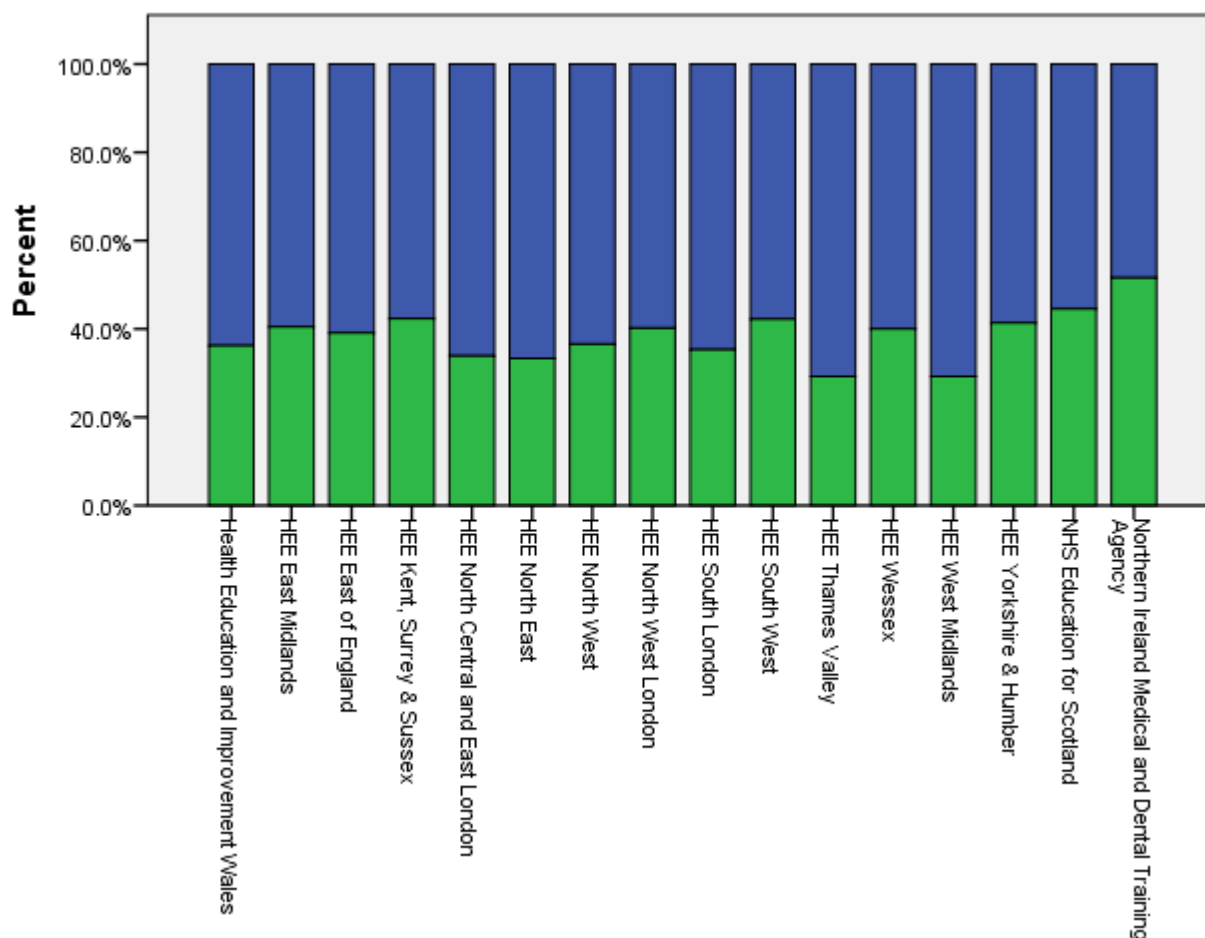
#### Wellbeing and work-related sickness:

A quarter of respondents (25%) reported that they have experienced mental health problems (such as anxiety disorders, depression etc.) in the last twelve months (12% preferred not to say). This was highest in the ST3-5 group (28%), although similar levels were reported at ST1-2 (23%) and ST6-7 (22%).

The majority of respondents (92%) have not experienced a work-related injury in the last 12 months. Of those that have, needle stick injury was the most common (n = 44), followed by

back pain (n = 17). Other injuries were noted including shoulder pain, wrist injury and muscle sprain, although these were reported by >6 responses per injury.

The graph below (Figure 6) shows the proportion of trainees with or without wellbeing concerns (physical and/or mental) by deanery.



- Green- Proportion of trainees who responded yes to either physical or mental health problems in the past 12 months.
- Blue – Proportion of trainees who responded no to either physical or mental health problems in the past 12 months.

**Figure 6. Deanery wise distribution of reported physical/mental health problems.**

Only a small percentage of doctors in training (8%) reported starting prescribed medication in the last 6 months based on any work-related injury, physical or mental health concerns. 16% reported having had time off work for work-related injuries, physical or mental health concerns or additional life stressors. Of those who had taken time off, 76% of respondents





reported feeling supported to have this time off. In the last six months, 76% of respondents had 0-5 days off in the last six months. This was marginally highest in the ST6-7 group. 38% of respondents did not think that their working pattern had contributed to the days absent due to sickness/health concerns. There were a range of factors that respondents reported for contributing to number of days absent due to sickness/health concerns. Of the answers provided, 19% said they were due to personal circumstances and 10% said workplace environment. Other common self-submitted responses included COVID, pregnancy and child illness.

## Physical needs

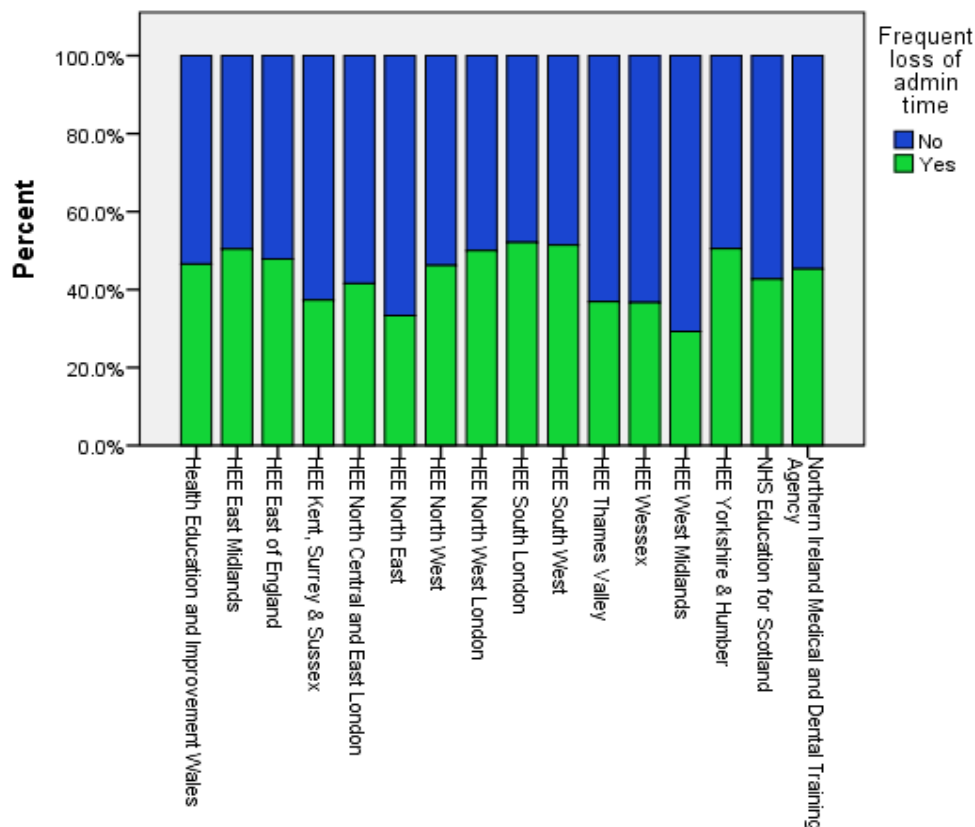
### Working patterns, rotas and work conditions

It is important that rota designs consider rest periods and recovery time, as fatigue can negatively impact both the individual doctor as well as patient safety. In addition to meeting the service needs, rotas must also consider the workforce by addressing work intensity, leave entitlements, training and professional development as well as meeting the needs of those with protected characteristics, individuals working LTFT and being cognisant of work/life balance.<sup>11</sup>

42% of trainees use their own personal time on weekends to update their ePortfolio and/or study for exams. Over half of respondents (55%) have zero non-clinical sessions in their average working week for audit, admin, projects, and private study time. Of those with scheduled non-clinical sessions, 30% 'often' and 31% 'sometimes' have to cover service clinical work during these "admin/private study" sessions, showing that these sessions are not adequately protected.

We further categorise responses as positive and negative, with 'often' and 'always' covering service during admin time being negative. The graph below (Figure 7) shows the proportion of trainees having negative responses in each deanery.

Figure 7. Proportion of trainees having had frequent loss of admin time, deanery wise.

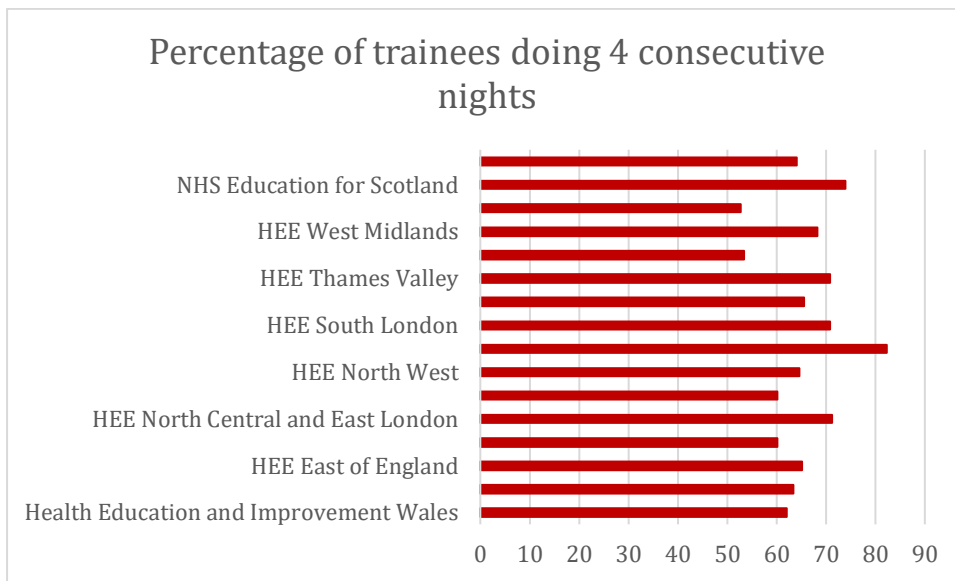


### 1.9.1 Deanery / HEE region

Exception reports can be submitted for any variation from the planned working hours or training opportunities scheduled in the rota.<sup>12</sup> Interestingly, a high proportion of respondents (84%) had not submitted any exception reports in the last six months.

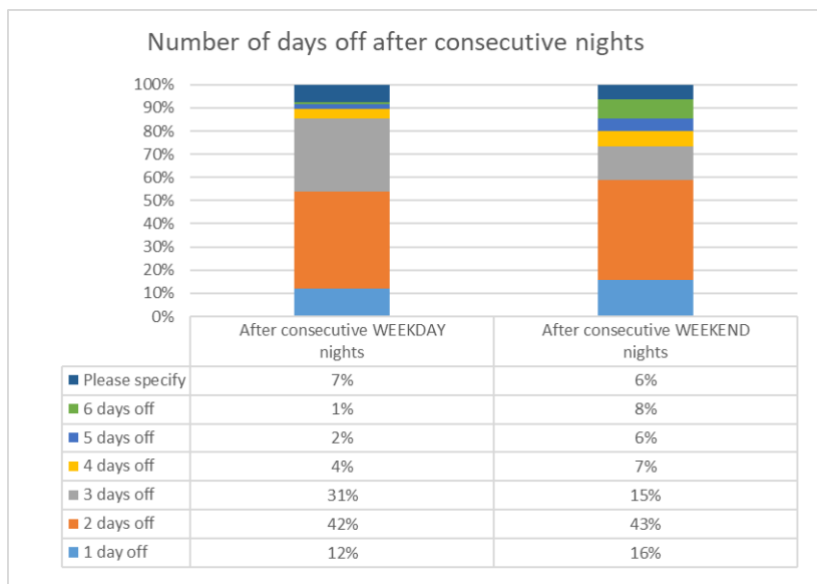
The terms and conditions of the 2016 doctors in training contract (England) states that work schedules should have a maximum of four consecutive night shifts with a minimum 46 hours rest after a run of either three or four consecutive night shifts.<sup>13</sup> The majority of respondents reported working four consecutive **weekday** nights (66%).

The graph below (Figure 8) shows the percentage of trainees doing 4 or more consecutive nights, deanery wise.

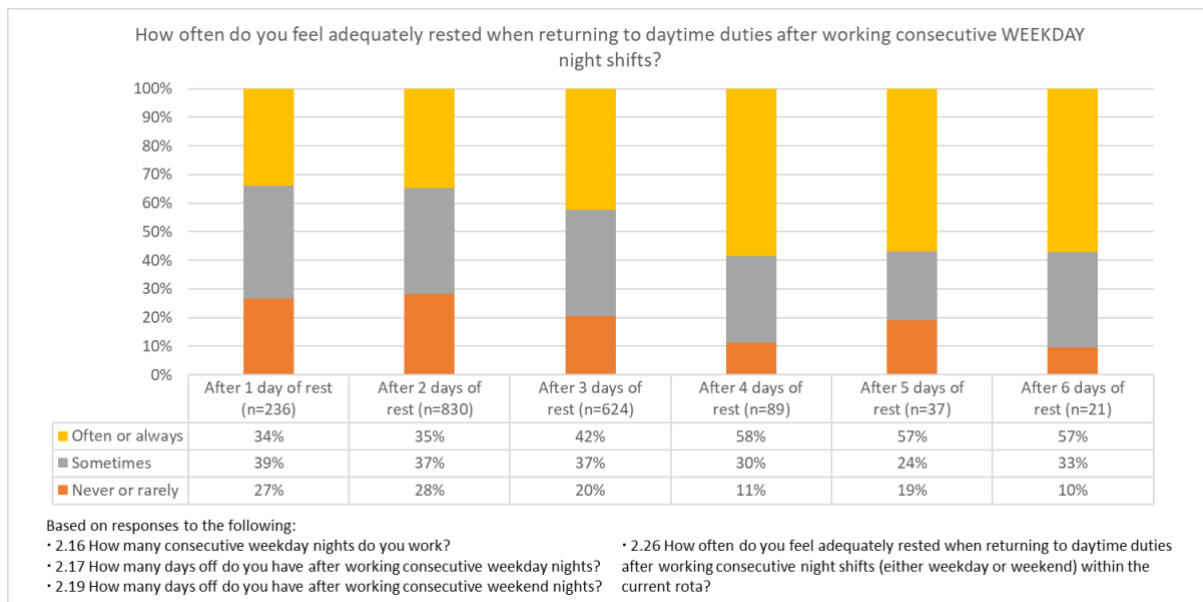


**Figure 8. Percentage of trainees doing 4 consecutive nights, deanery wise**

Figure 9 (below) illustrates that most trainees reported having 2 days off after working consecutive **weekday** nights and consecutive **weekend** nights (42% and 43% respectively). However, it should be noted that 6-7% of trainees opted to specify using free text instead of selecting a discrete answer; this suggests that there is a degree of variation in how this question was interpreted.

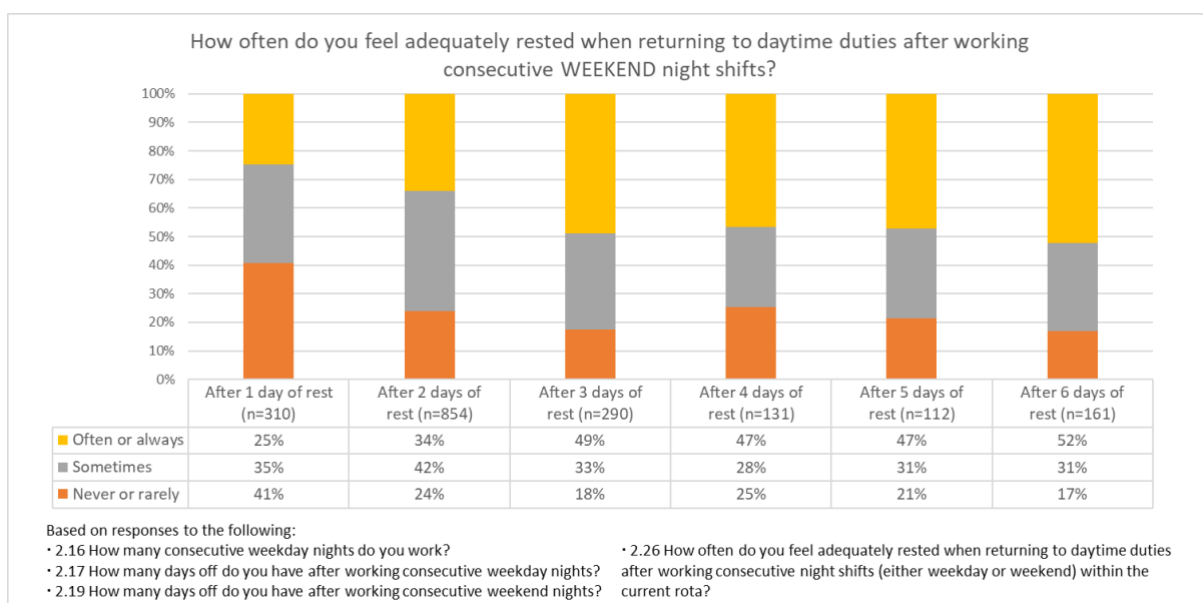


**Figure 9. Percentage of days off after consecutive weekday and weekend nights.**



**Figure 10. Percentage of how rested doctors in training feel by number of days of rest after weekday night shifts.**

The graph above (figure 10) shows that 58% of trainees who have had 4 days off following consecutive **weekday** nights feel “often or always” adequately rested upon returning to daytime duties; compared to only 35% of trainees who have had only 2 days off following consecutive **weekday** nights. However, it is not clear if Saturdays and Sundays (after consecutive **weekday** nights) are being counted by trainees as a ‘day off’ or excluded from the count on the basis that these two days comprise their usual non-working weekend and so not viewed as a ‘day off’ to recover from working nights.

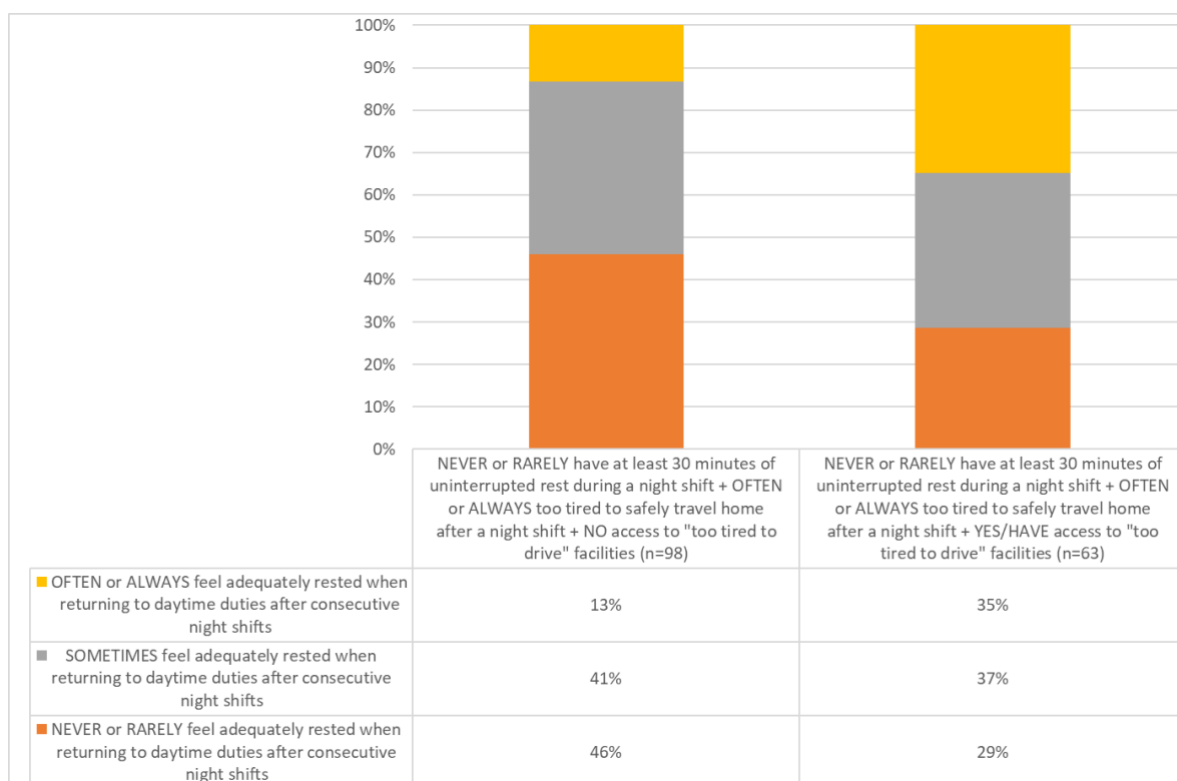


**Figure 11. Percentage of how rested doctors in training feel by number of days of rest after weekend night shifts.**

Following consecutive **weekend** nights, 47% of trainees report being “often or always” adequately rested upon returning to daytime duties after 4 days off; compared with 34% of trainees being “often or always” adequately rested upon return to daytime duties after 2 days off (see Figure 11).

As expected, the more days off following consecutive night shifts, the more rested upon returning to daytime duties.

Interestingly, trainees who did have access to “too tired to drive” facilities were more likely to feel often or always adequately rested when returning to daytime duties after consecutive night shifts, compared to trainees who did not (35% vs 13%). (Figure 12)



**Figure 12. Access to “too tired to drive” facilities and how adequately rested doctors feel when returning to daytime duties after consecutive night shifts.**

### On-call frequency

The on-call frequency is determined by the number of Whole Time Equivalent (WTE) doctors on the respondent’s tier of rota. For example, if the respondent is working on a rolling rota

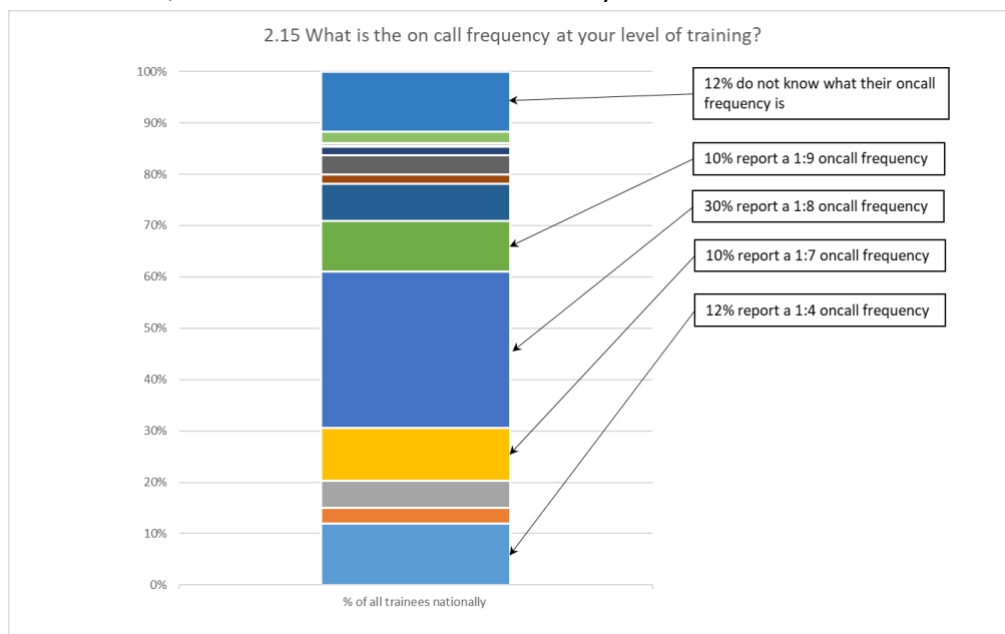
that requires 8 full time doctors to staff it, then the on-call frequency should be reported as 1 in 8.

There are 19 possible responses to the question “What is the on-call frequency at your level of training?”:

- 1 in 4
- 1 in 5
- 1 in 6
- 1 in 7
- 1 in 8
- 1 in 9
- 1 in 10
- 1 in 11
- 1 in 12
- 1 in 13
- 1 in 14
- 1 in 15
- 1 in 16
- 1 in 17
- 1 in 18
- 1 in 19
- 1 in 20
- Please specify:
- Don't know

As illustrated in Figure 13, the most common on-call frequency was reported as 1 in 8. This accounts for 602 trainees, and 30% of all trainees nationally.

**Figure 13.**  
**% of**  
**trainees**  
**reporting**  
**the on-call**  
**frequency**  
**at their**  
**level of**  
**training.**



However, this result should be interpreted with caution as there are discrepancies in reporting where trainees of the same level working at the same Trust do not all report having the same on-call frequency. At only 22% of Trusts, do all ST1-2s agree as to what their on-call frequency is; this occurs in 16% of Trusts at the ST3-5 level, and 37% of Trusts in the ST6-7 level (see Figures C, D and E in appendix C).

A more accurate way to capture this information would be to directly gain this from rota coordinators at each Trust, rather than rely on trainee self-reporting. The rota coordinators would also have a better understanding as to the size of rota gaps.

Closely linked to working patterns, is the importance of good working conditions which are needed to ensure that doctors' physical needs are met.

The Association of Anaesthetists outlines that the gold standard or best practice is for organisations to have an adequate number of rooms immediately available during a shift that are quiet, dark, private, and include a bed.<sup>14</sup> However, nationally, just over a third (36%) of all trainees report that they do not have access to a private area with bedding or a comfortable chair to use for rest during a night shift (see graph below, Figure 14).



**Figure 14. Percentage of trainees that reported they either have or do not have accessible and adequate rest facilities by ST Year.**

Where such facilities do exist, trainees are more likely to get at least 30 minutes of uninterrupted rest during a night shift. 20% of those with access to rest facilities report “often” or “always” getting their 30 minutes rest - compared to only 8% if there were no rest facilities available. Overall, however, 51% of all trainees report never or rarely getting 30 minutes of uninterrupted rest during the night shift (see Figure F and G in Appendix C).

Interestingly, ST2 trainees are more likely to “never or rarely” get 30 minutes of uninterrupted rest during a night shift, compared to ST1 trainees (62% vs 47%). One might have expected that the increased experience as an SHO would mean better work efficiency and a higher likelihood of getting uninterrupted rest during a night shift. Based on the TEF data, we are unable to explain this. However, anecdotally, it may be that ST2 trainees are getting less rest as they attempt to



'step-up' on Labour Ward at night time or to get more instrumental delivery experience (see Figure G in Appendix C). Notably, the doctors in training contract (2016) terms and conditions outline that whilst doctors working night shifts must have 'access to a space in which to take a meal and other rest breaks, ideally in an area away from patients, employers are not required to provide a bedroom for doctors who are rostered to work a night shift'.<sup>13</sup> Overall perceived levels of rest across all grades is shown in Figure H (Appendix C).

The 2024 TEF survey also included questions on trainees' commute home following a night shift. The Association of Anaesthetists note that cognitive function is impaired after 16-18 hours of wakefulness, and also highlights that 20 hours of wakefulness can cause impaired performance equivalent to being over the UK legal driving limit for alcohol.<sup>14</sup> 71% of TEF respondents reported that they drive home after a shift. 18% of respondents reported that they 'often' feel too tired to safely travel home after a night shift. 51% of respondents do not know if they have access to "too tired to drive" facilities after a shift if they need them. Notably, in the 2016 contract (England), it stipulates that if a doctor expresses they are too tired to travel home following a night, long, or late shift, the employer shall where possible provide an appropriate rest facility where the doctor can sleep.<sup>13</sup>

## The ABC Model

As illustrated above, the 2024 TEF survey responses demonstrate the challenges facing the O&G workforce. Intention to leave, defensive medical practice behaviours, and physical/mental health concerns are outcomes of poor wellbeing.

To be able to provide safe and compassionate patient care, O&G doctors need a work environment in which they feel physically and psychologically safe. This is also linked to improved staff retention and staff satisfaction, more effective team working and a reduction in the symptoms of burnout<sup>5</sup>.

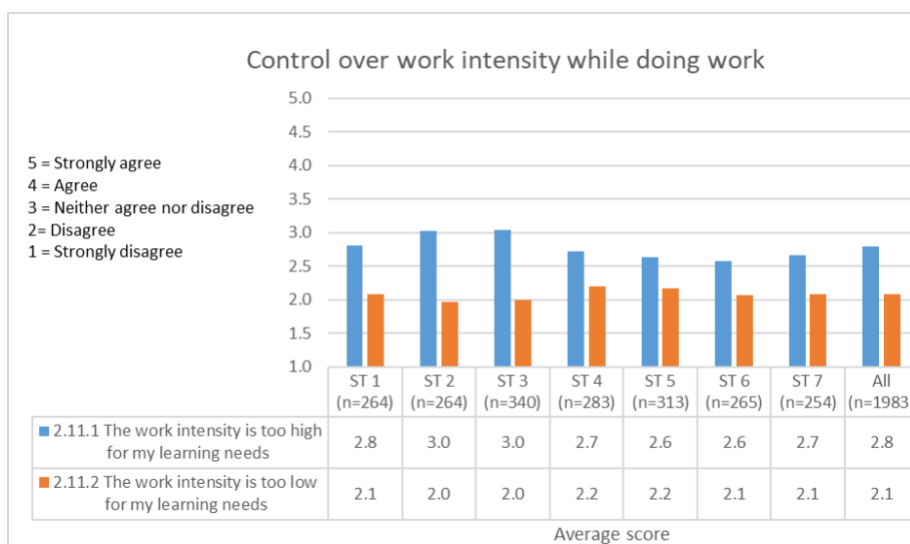
In 2019, West and Coia were commissioned by the GMC to investigate the factors which impact on the mental health and wellbeing of medical students and doctors<sup>9</sup>. They applied the Autonomy, Belonging and Competence (ABC) model to the UK medical workforce, setting out workplace recommendations for how these three core needs can be met in doctors, and thus how doctors' wellbeing and motivation can be improved. If we want to reduce poor wellbeing, then we need to improve doctors' Autonomy, Belonging and Competence. As such, we will use this ABC framework to discuss findings regarding wellbeing and burnout.



## Autonomy (A of GMC's ABC needs)

For the autonomy need to be met, doctors must feel that they have control over their work lives, and that they can act consistently with their work and life values<sup>9</sup>. This includes being able to control work intensity while doing work and having decision latitude or decision-making authority over how work is done.

On average, O&G trainees disagree that their work intensity is too low for their learning needs. Meanwhile, they neither agree nor disagree that their work intensity is too high for their learning needs (see Figure 15, below).



**Figure 15. Work intensity by ST Year**

There is a small but significant negative correlation between the two statements (Pearson correlation -0.246; n=1985; p<0.001). As both of these statements are the exact opposite of each other, we would have expected that this correlation to be stronger and closer to -1.

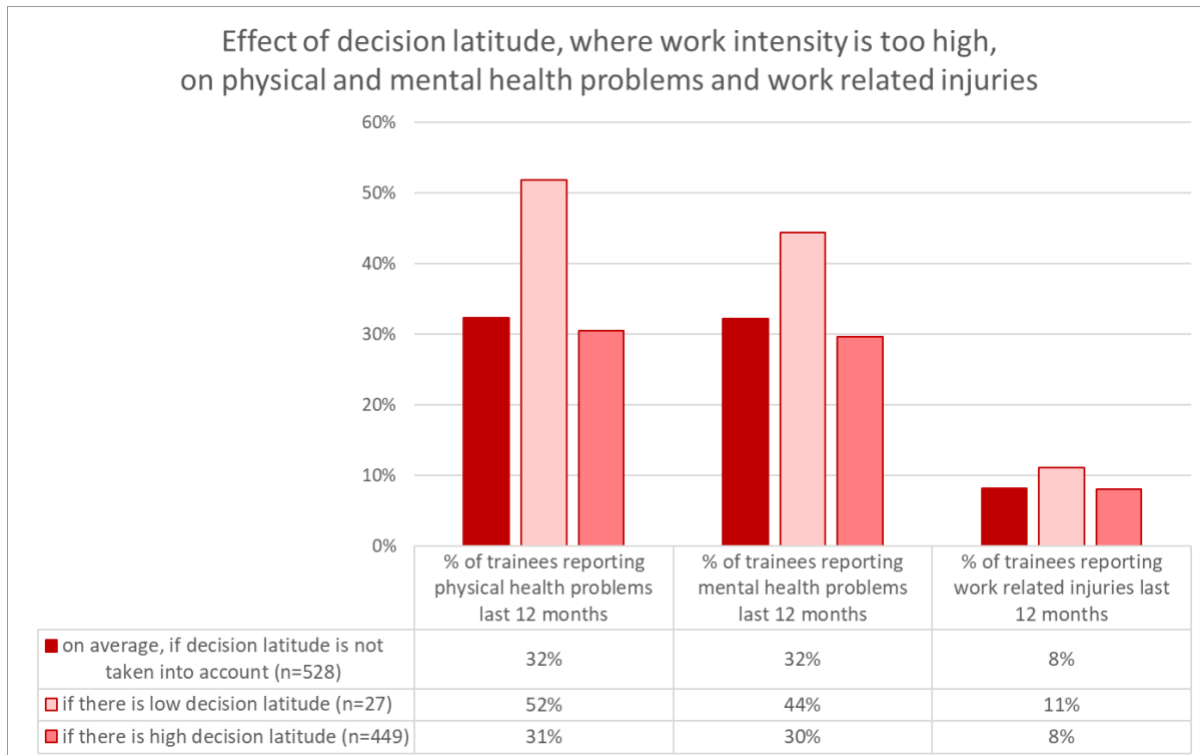
Without comparing this data against objective data such as number of deliveries/operations/clinics per year, size of rota gaps, on call frequency and rest patterns at each trust, we cannot know whether the work environment of one trainee is truly more work-intense than that of another trainee, or whether it is just perceived as such. However, if we make the argument that all trainees at the same Trust share the same work environment, then we can assume that work intensity is objectively the same for all trainees at the same Trust. When the

same data is aggregated by Trust, there remains a negative correlation of a larger magnitude (Pearson correlation -0.483, n=150, p<0.001), but this is also not close to -1.

	2.11.2 The work intensity is too <b>low</b> for my learning needs - STRONGLY DISAGREE or DISAGREE	2.11.2 The work intensity is too <b>low</b> for my learning needs - NEITHER AGREE NOR DISAGREE	2.11.2 The work intensity is too <b>low</b> for my learning needs- STRONGLY AGREE or AGREE	Total trainees
2.11.1 The work intensity is too <b>high</b> for my learning needs - STRONGLY DISAGREE or DISAGREE	793	112	98	1003
2.11.1 The work intensity is too <b>high</b> for my learning needs - NEITHER AGREE NOR DISAGREE	211	185	22	418
2.11.1 The work intensity is too <b>high</b> for my learning needs - STRONGLY AGREE or AGREE	528	28	8	564
Total trainees	1532	325	128	1985

**Table 2. Correlation between Work Intensity being too high and being too low for learning needs.**

To make sense of the data, we have taken that work intensity is ‘too high’ when trainees both STRONGLY AGREE or AGREE with statement 2.11.1 (work intensity is too high for my learning needs) and STRONGLY DISAGREE or DISAGREE with statement 2.11.2 (work intensity is too low for my learning needs); n=528 (see table above). We have also taken that the work intensity is ‘just right’ when trainees STRONGLY DISAGREE or DISAGREE to both statements 2.11.1 and 2.11.2; n=793. We then considered decision latitude, defined as a combination of decision-making authority and opportunity to use/develop own skills on the job<sup>15</sup>, as a construct that is captured by statement 16.1.1, “I was given sufficient independence and clinical responsibility appropriate to my level of training (i.e. given the opportunity to practice independently)”. If there was a strong disagreement with the statement 16.1.1, then we deemed it low decision latitude. If there was a strong agreement with statement 16.1.1, then we deemed it to be high decision latitude. The figure below shows how such decision latitude plays against the trainees’ physical and mental health problems, and work related injuries. (Figure 16, below)

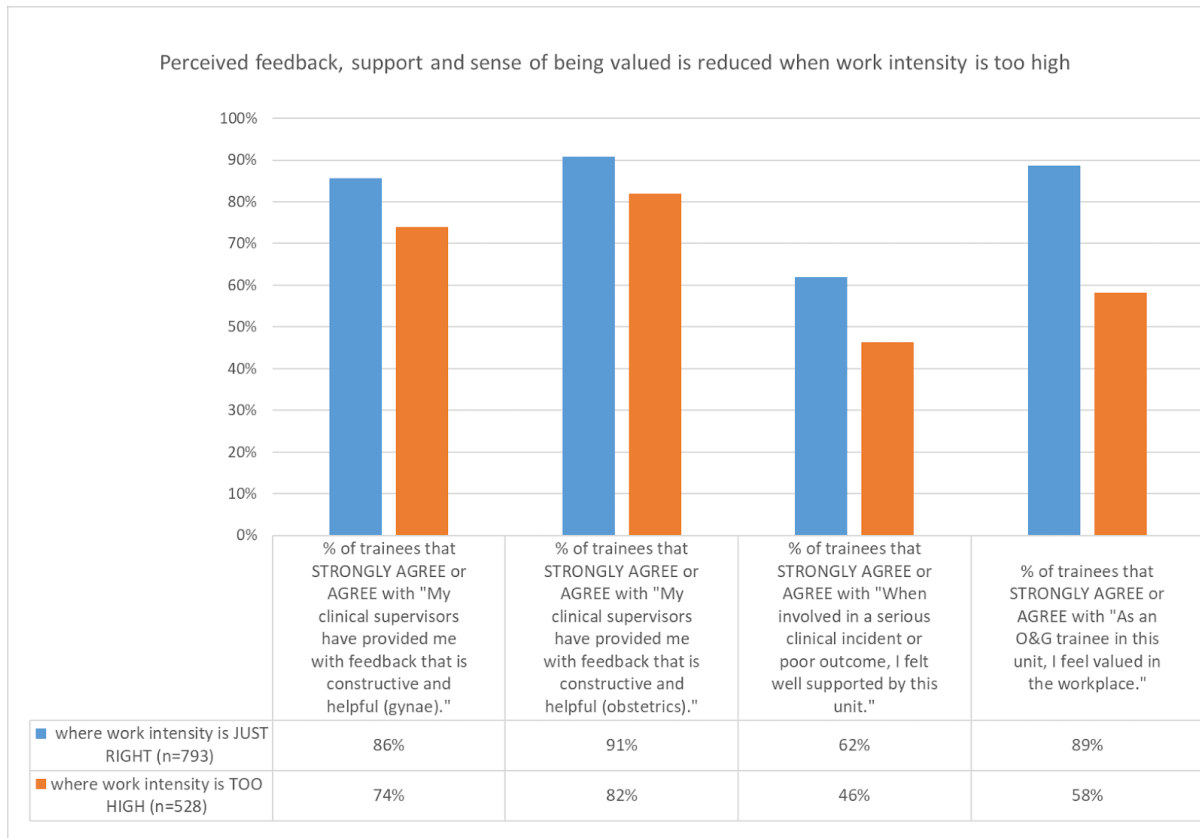


**Figure 16. Effect of decision latitude, where work intensity is too high, on physical and mental health concerns and work related injuries.**

When work intensity is too high, it appears that trainees are more likely to report physical and mental health problems and work related injuries if there is low decision latitude compared to high decision latitude (52% vs 31%; 44% vs 30%; 11% vs 8%). However, it should also be noted that there is a difference in sample size of those reporting low decision latitude vs those reporting high decision latitude (27 vs 449) and this result might be skewed.

### **Belonging (B of GMC's ABC Needs)**

Another influential need to ensure doctors' maintain motivation and positive wellbeing is the need for belonging. To have a sense of belonging, it is important for doctors to gain constructive and helpful feedback, be supported when things go wrong and to feel valued.



**Figure 17. Perceived feedback, support and sense of being valued in relation to work intensity**

The TEF responses show that the trainees' perception of constructive feedback, support following a poor outcome, and the sense of feeling valued in the workplace is reduced when work intensity was perceived as being too high (Figure 17, above).

However, it could be that trainee perception of work intensity being too high is caused by having reduced feedback. In other words, feeling that there is too much work to do because you lack enough feedback that you have 'done enough'. Feedback from others around us helps us to decide whether we need to work harder to improve our performance, or whether we need to work 'less hard' on a particular task so that we can conserve our resources for other more important tasks. Senior support, either by way of role modelling or actively discussing how tasks are to be prioritised at night time, can help juniors to understand when they can take 'safely' take a break and rest while on night duty. Trainees who perceived less support after serious incidents/poor outcomes also reported engaging in defensive medical practices and physical/mental health problems, slightly more than those who felt well supported. (Figure I and J)

## Competence (C of GMC's ABC Needs)

Competence refers to the psychological need to feel effective in one's work. In the context of doctors in training this can be the performance of patient safety tasks. It should be emphasised here that this does not only involve being able to achieve the training competencies (OSATs, CBDs, etc.) but also relates to how effectively doctors are able to perform within their roles and responsibilities. For example, being able to handover successfully before leaving work and knowing that patients will be safe in one's absence. 87% of trainees strongly agree or agree that handover arrangements always ensure continuity of care for patients between shifts. While this is a very reassuring and positive result, we should also consider that 90% of trainees would also sometimes, often, or always stay after their shift has ended to complete a task or document in notes. (Table 3)

		2.34 Handover arrangements in this post always ensure continuity of care for patients between shifts (n=1984)			
		Strongly disagree or disagree	Neither agree nor disagree	Strongly agree or agree	
21.1.6 How often have you had to stay after shift ended to complete a task or document in notes? (n=1984)	Never or rarely	7	12	188	207 (10% of all trainees respond Never or Rarely)
	Sometimes	27	25	524	576 (29% of all trainees respond Sometimes)
	Often or always	89	95	1017	1201 (61% of all trainees respond Often or Always)
		123 (6% of all trainees Strongly Disagree or Disagree)	132 (7% of all trainees Neither Agree nor Disagree)	1729 (87% of all trainees Strongly Agree or Agree)	

**Table 3. Correlation between handover arrangements and staying back after shift to complete work.**

It might be that there are some tasks that simply cannot be handed over – for example, documenting in patient notes. It might be that if a task were to be handed over, then it might not get done if the team taking over is likely to get far too busy in their shift – for example, on night shifts when less urgent and less important tasks will inevitably be of a lesser priority. Or it might be that there are gaps in the on-call rota and that there is simply no one coming in to take



handover – but if that were to be the case, then why would trainees report that handover arrangements always ensure continuity of care?

This suggests that continuity of care is maintained only when doctors remain after their scheduled shifts to complete tasks that cannot be transferred. Failing to do so would mean admitting that we had knowingly failed in our duty of care. This could be a jarringly uncomfortable threat to one's sense of competence as a doctor; making it difficult to admit that handover arrangements do not always ensure continuity of care for patients without also implicating oneself as being unsafe.

Of the 1201 trainees who often or always stay after their shift to complete tasks, those who find themselves unable to Strongly Agree or Agree that handover arrangements ensure continuity of care are proportionately more likely to report physical and mental health problems. However, due to recall bias, it is possible that those with ongoing physical and mental problems are also more willing to admit that handover arrangements are not always ideal because the cost of staying after the shift has ended might be felt more acutely compared to those without health problems. (Table ii in Appendix B)

## Associations and Correlations

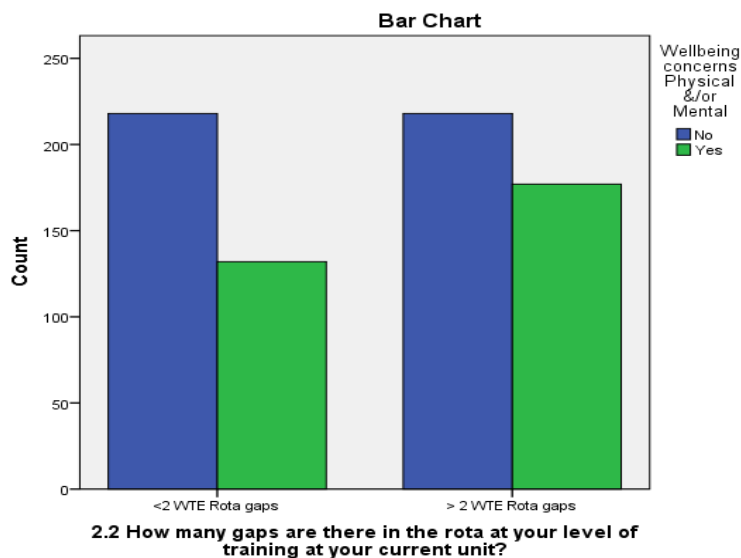
Responses were analysed on a continuous scale to study the correlations between relevant questions. For example, Likert scale data has been converted to numerical scale data from 1 to 5, with 1 being the worst and 5 being the best scores.

Responses were categorised into positive and negative to study the associations between GMC Domains and attrition, burnout and doctor well-being. The associations were analysed using multiple logistic regression analysis.

- 1) *Is there a correlation between people having to do admin in their personal time, well-being and the number of rota gaps?*

Although over 13 percent of respondents did not know the rota gaps in their unit, there was no statistically significant correlation between rota gaps and loss of admin time.

On the other hand, well-being concerns were strongly associated with rota gaps (Chi square statistic 11.3 with p value 0.023) (Figure 27).



**Figure 18. Number of rotas gaps reported at level of training by wellbeing concerns (physical and/or mental)**

- 2) *Is there a correlation between people feeling too tired to safely commute home after a night shift and no. of consecutive working nights?*

There were no significant differences in Likert scores between trainees who worked less than four to those who worked four or more consecutive nights (Mean scores 2.89 vs 2.80).

- 3) *Burnout*

To assess this, we used the symptoms of burnout such as defensive medical practice (DMP) and wellbeing concerns (WBC).

Using logistic regression analysis, we looked at associations between negative responses, E.g., Frequent loss of admin time, Poor supervision (disagreed and strongly disagreed to receiving appropriate supervision) and DMP and WBC. We used predictor variables as per GMC domains of ABC of doctors' care needs – Autonomy, Belonging and Competence. (Appendix B Table i)

Definitions:



We defined DMP as a negative response (always/often) to at least one of the questions 21.1.1 to 21.1.5.

We defined WBC as an affirmative response (Yes) to at least one of the questions – 22.1.1,22.2.1,22.5,22.6,22.7 and 22.90.

#### DMP and WBC

Results of the multivariable model are shown in TABLE 1 (Appendix C). Adjusted Odds Ratio was calculated based on regression model, adjusting for confounding factors. Trainees with lack of or suboptimal feedback support were twice (OR 2.02) as likely to engage in Defensive Medical Practices vs those with adequate or optimal support. Although, trainees who had frequent loss of admin time to provide service were less likely (OR 0.7) to have DMP, possibly due to more clinical exposure.

#### 4) Attrition

We defined attrition as a negative response (daily, weekly, monthly) to the question – 20.1.

We looked at associations between belonging, LTFT and four nights for attrition. Trainees who felt undervalued were 3.8 times more likely to have attrition with an adjusted OR of 3.8 (95% CI 2.3 to 6.19 p 0.0001). On the other hand, trainees who were full time were less likely to have attrition compared to trainees who were LTFT. This could be in part due to the trainees' choice to go LTFT, secondary to existing stressors. (Adjusted OR 0.629 95% CI 0.429 – 0.923 p 0.018)

## Conclusion

This report analyses wellbeing and burnout among O&G trainees using data from the 2024 TEF survey. Recognising that O&G is a high-stress field with significant burnout rates, this report examines key areas like working patterns, rest and attrition.

A substantial number of trainees face challenges with work-life balance, inadequate rest, and lack of non-clinical time, contributing to high attrition rates—23% of trainees consider leaving O&G monthly or more. Factors like long working hours, intense workload, and stress are primary drivers of attrition. Trainees who felt undervalued were 3.8 times more likely to have attrition.



While burnout has been linked to defensive medical practices and well-being concerns, 25% of our trainees reported mental health issues in the past year and 6-13 % of trainees engaged in defensive medical practices, more so in stage 1 training. Trainees with suboptimal feedback support were twice as likely to practice defensive medicine.

The report highlights the importance of addressing these issues by improving work-life balance, ensuring adequate rest, and fostering supportive leadership. By focusing on autonomy, belonging, and competence—core needs identified by the GMC—the O&G specialty can work towards a healthier, more sustainable training environment.

## Key findings

- 23% of trainees consider leaving O&G monthly or more.
- 25% of our trainees reported mental health issues in the past year and 6-13 % of trainees engaged in defensive medical practices, more so in stage 1 training. Trainees with suboptimal feedback support were twice as likely to practice defensive medicine.
- Just over a third (36%) of trainees report that they do not have access to a private area with bedding or a comfortable chair to use for rest during a night shift.
- When work intensity is too high, it appears that trainees are more likely to report physical and mental health problems and work-related injuries if there is low decision latitude compared to high decision latitude.
- Trainees are more likely to participate in defensive medical practices if poorly supported following a serious clinical incident or poor outcome; however, the sample size for this is small (n=95).

## Recommendations

1. RCOG to include the Copenhagen Burnout Inventory in the 2025 TEF survey, to ensure a specific burnout measure is included.
2. The Association of Anaesthetists have produced a fatigue tool to identify if someone is too tired to drive home; this should be promoted in all units.
3. Trusts should implement clearer guidelines on which tasks must be completed before shift change and which can be safely handed over.
4. Handover processes should be reviewed regularly to identify potential gaps in coverage, particularly during night shifts and periods of high workload.

5. Trusts and RCOG should consider promoting targeted retention strategies, such as enhanced career mentorship programs and wellbeing support, to address the concerns and burnout that may be driving trainees to consider leaving.
6. Trusts should provide formal training in resilience, stress management, and self-care for trainees, as part of induction, particularly in stage 1 training, to mitigate the practice of defensive medicine.
7. Trusts should consider implementing policies that mandate the provision of adequate rest facilities and require regular audits to ensure compliance.

These recommendations aim to enhance trainee wellbeing, reduce attrition, and improve the overall training experience in obstetrics and gynecology, while also addressing the risks associated with mental health, work intensity, and defensive medical practice.

## Appendix A - 2024 TEF Questions analysed – Rotas, wellbeing and burnout

### Working environment and rota

2.1	Are there any gaps in the rota at your level of training in your current unit?	Yes   No   Don't know
2.2	How many gaps are there in the rota at your level of training at your current unit? (Please see the NHS website for an explanation of how Whole Time Equivalent [WTE] is calculated <a href="https://faq.nhsbsa.nhs.uk/knowledge-base/article/KA-23611/en-us">https://faq.nhsbsa.nhs.uk/knowledge-base/article/KA-23611/en-us</a> ).	Less than 2 WTE gaps   2-5 WTE gaps   More than 5 WTE gaps   Don't know
2.3	What type of ST1-2 level (including junior cover by other doctors e.g. Foundation & GP trainees) oncall rota does your unit have?	ST 1-2 level doctor on call for obstetrics and gynaecology only   ST 1-2 level doctor on call for O&G and other specialities   Other (please specify)   Don't know



2.4	If ST1-2 oncall for other speciality please indicate which speciality	General Surgery   Orthopaedics   ENT   Other (please specify)
2.5	What type of middle grade oncall rota does your unit have during the <u>day</u> , excluding consultant cover?	Single middle grade oncall rota with ST1-2 level cover (including junior cover by other doctors e.g. Foundation & GP trainees)   Single middle grade oncall rota without ST1-2 level cover (including junior cover by other doctors e.g. Foundation & GP trainees)   Two tier middle grade rota with one senior and one junior middle grade with ST1-2 level cover (including junior cover by other doctors e.g. Foundation & GP trainees)   Two tier middle grade rota with one senior and one junior middle grade without ST1-2 level cover (including junior cover by other doctors e.g. Foundation & GP trainees)   Two middle grades oncall working at the same level with ST1-2 level cover (including junior cover by other doctors e.g. Foundation & GP trainees)   Two middle grades oncall working at the same level without ST1-2 level cover (including junior cover by other doctors e.g. Foundation & GP trainees)  Other (please specify)   Don't know
2.6	What type of middle grade oncall rota does your unit have during the <u>night</u> , excluding non resident consultant cover?	Single middle grade oncall rota with ST1-2 level cover (including junior cover by other doctors e.g. Foundation & GP trainees)   Single middle grade oncall rota without ST1-2 level cover (including junior cover by other doctors e.g. Foundation & GP trainees)   Two tier middle grade rota with one senior and one junior middle grade with ST1-2 level cover (including junior cover by other doctors e.g. Foundation & GP trainees)

		<p>Two tier middle grade rota with one senior and one junior middle grade without ST1-2 level cover (including junior cover by other doctors e.g. Foundation &amp; GP trainees)  </p> <p>Two middle grades oncall working at the same level with ST1-2 level cover (including junior cover by other doctors e.g. Foundation &amp; GP trainees)  </p> <p>Two middle grades oncall working at the same level without ST1-2 level cover (including junior cover by other doctors e.g. Foundation &amp; GP trainees)  Other (please specify)   Don't know</p>
2.7	Is the senior middle grade resident or oncall from home at night?	Resident   Oncall from home  Other (please specify)   Don't know   N/A
2.8	For how many days in the week is there a consultant resident overnight?	0   1   2   3   4   5   6   7   Other (please specify)   Don't know
2.9	There are appropriate arrangements made for covering consultant absence in outpatient clinics	Yes   No   Don't know
2.1 0	Has your unit got a policy for when a consultant must attend?	Yes   No   Don't know
2.1 0.1	Have you requested a consultant to attend under these conditions but they did not?	Yes   No
2.1 1	To what extent do you agree or disagree with the following statements?	
2.1 1.1	The work intensity is too high for my learning needs	Strongly Agree   Agree   Neither Agree nor Disagree   Disagree   Strongly Disagree
2.1 1.2	The work intensity is too low for my learning needs	Strongly Agree   Agree   Neither Agree nor Disagree   Disagree   Strongly Disagree



2.1 1.3	I am allowed study leave for appropriate courses (i.e. not regional teaching)	Strongly Agree   Agree   Neither Agree nor Disagree   Disagree   Strongly Disagree
2.1 1.4	I feel supported to submit exception reports when appropriate	Strongly Agree   Agree   Neither Agree nor Disagree   Disagree   Strongly Disagree
2.1 1.5	How many exception reports have you submitted in the last six months	0   1   2   3   4   5   6   7   Other (please specify)
2.1 1.6	Exceptions reports are used by my trust to improve training	Strongly Agree   Agree   Neither Agree nor Disagree   Disagree   Strongly Disagree
2.1 1.7	Exceptions reports are used by my trust to improve the delivery of safe patient care	Strongly Agree   Agree   Neither Agree nor Disagree   Disagree   Strongly Disagree
2.1 2	Are there any physician associates working in your department?	Yes   No   Don't know
2.1 2.1	What tasks do they perform?	Free Text
2.1 2.2	Are there any other tasks that could suit them? Please list the tasks.	Free Text
2.1 3	Are there any tasks from your day to day work that could be delegated to another member of the team?	Yes   No   Don't know
2.1 3.1	Who can you delegate these tasks to? Please select all that apply.	Nurse   Midwife   Advanced nurse practitioner   Physician associate   Other
2.1 4	Do you have any additional comments you would like to make on your working environment and rota? (please do not share any names or personal identifiable information as part of your response)	Free Text

## Rotas and rest

2.15	What is the on call frequency at your level of training? You should find this information on your work schedule or by seeing how many WTE doctors are on your tier of rota e.g. if 8 then then you are a 1:8.	1:4   1:5   1:6   1:7   1:8   1:9   1:10   1:11   1:12   1:14   1:15   1:16   1:18   1:19   1:20   Don't know   Other (please specify)
2.16	How many consecutive weekday nights do you work?	1   2   3   4   5   6   Other (please specify)
2.17	How many days off do you have after working consecutive weekday nights?	1   2   3   4   5   6   Other (please specify)
2.18	How much time off do you have after working days over the weekend? (a session is defined as a morning or afternoon shift)	1 session   2 sessions   3 sessions   4 sessions   Other (please specify)
2.19	How many days off do you have after working consecutive weekend nights?	1   2   3   4   5   6   Other (please specify)
2.20	Do you have accessible and adequate rest facilities available during your night shifts (i.e. private area with bedding/comfortable chair)?	Yes   No
2.21	If rest facilities are available during your night shifts, how often do you use such facilities?	Never   Rarely   Sometimes   Often   Always   N/A
2.22	How often do you have at least 30 minutes of uninterrupted rest during a night shift?	Never   Rarely   Sometimes   Often   Always
2.23	How do you normally commute home after a night shift?	Cycle   Drive – car   Drive – motorcycle   Public transport   Taxi or equivalent   Walk   Other (please specify)
2.24	If applicable, do you ever feel too tired to safely travel home after a night shift?	Never   Rarely   Sometimes   Often   Always   N/A



2.25	Do you have access to "too tired to drive" facilities after a shift if you need them?	Yes   No   Don't know   N/A
2.26	How often do you feel adequately rested when returning to daytime duties after working consecutive night shifts (either weekday or weekend) within the current rota?	Never   Rarely   Sometimes   Often   Always
2.27	How often do you have an adverse event during a night shift (such as a complaint, serious untoward event, conflict with a colleague?)	Never   Rarely   Sometimes   Often   Always
2.27.1	What support have you had after these events?	Free text
2.28	Have you ever taken any time out of programme (OOP) for experience/training? (Please select all that apply)	Out of programme for clinical training   Out of programme for clinical experience   Out of programme for research   Out of programme for career break   Out of programme experience/training   Out of programme for research /training   Parental leave   No   Other (please specify)
2.29	Do you intend to take time out of programme (OOP) for experience/training over the next 2 years? (Please select all that apply)	Out of programme for clinical training   Out of programme for clinical experience   Out of programme for research   Out of programme for career break   Out of programme experience/training   Out of programme for research /training   Parental leave   No   Other (please specify)
2.30	Within your average working week how many non-clinical sessions do you have? For audit, admin,	0 session   1 session   2 sessions   3 sessions   4 sessions   Other (please specify)



	projects, private study time (a session is defined as a morning or afternoon shift)?	
2.31	How often are you asked to cover service clinical work during these "admin/ private study" sessions?	Never   Rarely   Sometimes   Often   Always
2.32	When do you find time to update your ePortfolio/study for exams:	Early morning   During the working week   Evenings   Weekends   Designated study leave time   Annual leave

### Attrition

20.1	Since starting specialty training how often have you seriously considered leaving O&G?	Daily   Weekly   Monthly   Occasionally   Never
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20.1.2	If you have seriously considered leaving speciality training what are the reasons? (Please only select those that would impact on your decision)	Family   Lack of work-life balance   Pay   Long working hours   Shift working   Intense workload   Rota gaps   Delayed rota provision   Desire to work abroad   Inability to work less than full time   Issues with gaining adequate clinical experience when working less than full time   Preference to work in another geographic area   Preference to work in another specialty   Personal Health   Physical demands of the job   Personal mental health   Stress   Lack of clinical supervision   Poor pastoral support   Poor educational supervision   Low morale   No support from colleagues   No social interaction with colleagues   Commuting distance   Frustration with training   Frustration with health service   Blame culture   Lack of improvement   Litigation   Fear of litigation   No opportunities to debrief following adverse event or serious incident   No support following adverse event or serious incident   Patient care/safety concerns   Concerns with new contract   Insufficient financial remuneration   Under resourced health service   N/A   Other (Please specify)
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20.2	Which of the following do you think might lead you to consider leaving speciality training in the future?	Family   Lack of work-life balance   Pay   Long working hours   Shift working   Intense workload   Rota gaps   Delayed rota provision   Desire to work abroad   Inability to work less than full time   Issues with gaining adequate clinical experience when working less than full time   Preference to work in another geographic area   Preference to work in another specialty   Personal Health   Physical demands of the job   Personal mental health   Stress   Lack of clinical supervision   Poor pastoral support   Poor educational supervision   Low morale   No support from colleagues   No social interaction with colleagues   Commuting distance   Frustration with training   Frustration with health service   Blame culture   Lack of improvement   Litigation   Fear of litigation   No opportunities to debrief following adverse event or serious incident   No support following adverse event or serious incident   Patient care/safety concerns   Concerns with new contract   Insufficient financial remuneration   Under resourced health service   N/A   Other (Please specify)
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## Burnout

	The following questions have been adapted and taken from Bourne, T., Shah, H., Falconieri, N., et al. <i>Burnout, well-being and defensive medical practice among obstetricians and gynaecologists in the UK: cross-sectional survey study</i> . BMJ Open 2019;9:e030968. doi: 10.1136/bmjopen-2019-030968 <a href="https://bmjopen.bmj.com/content/9/11/e030968">https://bmjopen.bmj.com/content/9/11/e030968</a>
21.1	Within the last 3 months, have you taken any of the following actions for fear of possible consequences such as complaints, disciplinary actions by managers, being sued, or publicity in the media?

21.1.1	Conducted more investigations than warranted by the patient's condition	Always   Often   Sometimes   Rarely   Never
21.1.2	Referred a patient for diagnostic testing or special services in unnecessary circumstances	Always   Often   Sometimes   Rarely   Never
21.1.3	Admitted patients to hospital when the patient could have been discharged home safely or managed as an outpatient	Always   Often   Sometimes   Rarely   Never
21.1.4	Asked for more frequent observations to be carried out on a patient than necessary	Always   Often   Sometimes   Rarely   Never
21.1.5	Decided on management based on concerns about legal/media/disciplinary consequences	Always   Often   Sometimes   Rarely   Never
21.1.6	How often have you had to stay after shift ended to complete a task or document in notes?	Always   Often   Sometimes   Rarely   Never
21.1.7	Do you have concerns that your direct supervisors/management team may be over critical of your work?	Yes   No   Unsure   NA

## Wellbeing

22.1	In the past 12 months have you experienced:	
22.1.1	Any physical health problems (e.g. chronic fatigue, cardiovascular disease, high blood pressure etc.)	Yes   No   Prefer not to say
22.1.1.1	If you are happy to disclose the details please do so here	Free text (not mandatory)



22.2.1	Any mental health problems (e.g. anxiety disorders, depression etc.)	Yes   No   Prefer not to say
22.2.1.1	If you are happy to disclose the details please do so here	Free text (not mandatory)
22.3.1	Any additional life stressors (e.g. bereavement, accident etc.)	Yes – currently (in the last 6 months)   Yes – in the past (more than 6 months ago)   No   Prefer not to say
22.3.1.1	If you are happy to disclose the details please do so here	Free text (not mandatory)
22.4.1	Is there anything else you feel is relevant to mention at this stage of the survey?	Yes (Please specify)   No   Prefer not to say
22.5	In the past 12 months, have you experienced a work related injury?	Yes (Please specify)   No   Prefer not to say
22.5.1	If Yes, please specify	Free text (not mandatory)
22.6	Have you been started on prescribed medication in the last 6 months based on any work related injury, physical health problems, mental health problems or additional life stressors?	Yes   No   Prefer not to say
22.7	Have you had time off work for any work related injuries, physical health problems, mental health problems or additional life stressors?	Yes   No   Prefer not to say
22.7.1	If yes, did you feel supported to have this time off?	Yes   No   Prefer not to say

22.8	How many days have you had off in the last six months?	Free Text
22.90	Do you think your working pattern may have contributed to the days of sickness/health concerns?	Yes   Yes in part   Not at all   Prefer not to say   N/A
22.1	What other factors contributed to the days of sickness/health concerns? (select all that apply)	Workplace environment   Colleagues   Team dynamics   Personal circumstances   N/A   Other (specify)   Prefer not to say

## Appendix B – ABC of doctors’ core needs

Variables assessed according to GMC domains, adopted from Caring for doctors, Caring for patients (GMC report from 2019):

Table i - Questions based on GMC Variables

		Question number	Question
Autonomy and perceived control	Job control	2.11.1	The work intensity is too high for my learning needs.
	Job control	2.11.2	The work intensity is too low for my learning needs.
	Time control	2.31	How often are you asked to cover service clinical work during these “admin/private study” sessions?



	Decision latitude	16.1.1	I was given sufficient independence and clinical responsibility appropriate to my level of training (i.e., given the opportunity to practice independently).
Belonging and perceived support	Supervision support	5.5.1	I have had appropriate supervision for my level of training in elective gynaecology theatre.
	Supervision support	5.5.2	I have had appropriate supervision for my level of training in gynaecology clinic.
	Supervision support	6.1.4	I have had appropriate supervision and support whilst on labour ward – outside of normal working hours.
	Supervision support	6.1.8	I have had appropriate supervision for my level of training in antenatal clinic.
	Feedback support	5.5.4	Trainers were supportive in completing the required gynaecology workplace-based assessments.
	Feedback support	5.5.5	My clinical supervisors have provided me with feedback that is constructive and helpful. (Gynaecology)
	Feedback support	6.1.5	Trainers were supportive in completing the required obstetric workplace-based assessments.



	Feedback support	6.1.6	My clinical supervisors have provided me with feedback that is constructive and helpful. (Obstetrics)
	General sense of belonging	17.7	As an O&G trainee in this unit, I feel valued in the workplace.
	General sense of belonging	17.8	This unit has a sense of community and belonging.
Competence and perceived performance	Patient safety performance	2.34	Handover arrangements in this post always ensure continuity of care for patients between shifts.
	Clinical care performance	21.1.1	Conducted more investigations than warranted by the patient's condition.
	Clinical care performance	21.1.2	Referred a patient for diagnostic testing or special services in unnecessary circumstances.
	Training performance	5.6	I am on track to fulfil my training requirements for the year in gynaecology.
	Training performance	6.1.1	I am on track to fulfil my training requirements for the year in obstetrics.

## Appendix C – Additional graphs

Those most likely to seriously consider leaving O&G daily were trainees working at less than full time (LTFT) 70%. (Table 1 below, Figures A and B in Appendix C)

**Table 1. Trainees who consider leaving O&G “daily” by FT/LTFT %**

	Trainees who consider leaving O&G “daily”	% of n
Full time (n=1168)	34	3%
LTFT 90% (n=11)	0	0%
LTFT 80% (n=441)	15	3%
LTFT 70% (n=40)	3	8%
LTFT 60% (n=236)	15	6%
LTFT 50% (n=16)	0	0%



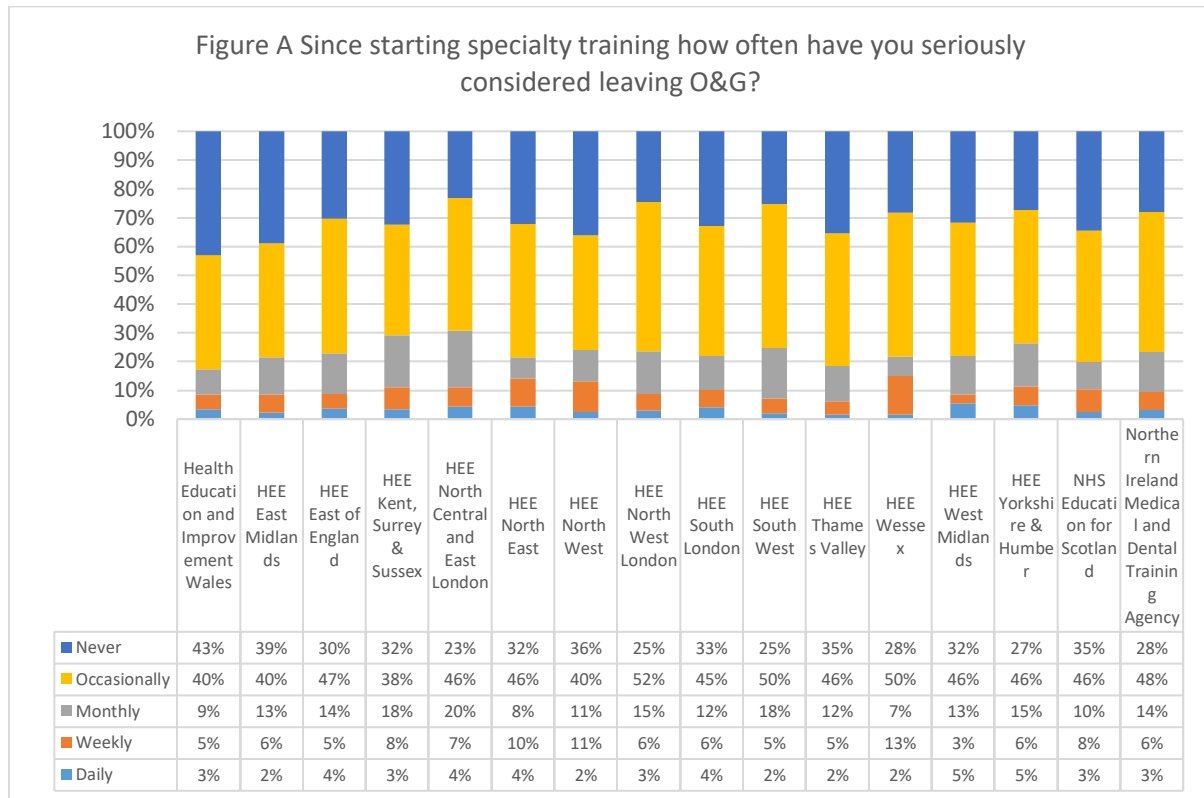


Figure A – Since starting specialty training, how often have you seriously considered leaving O&G? – by deanery

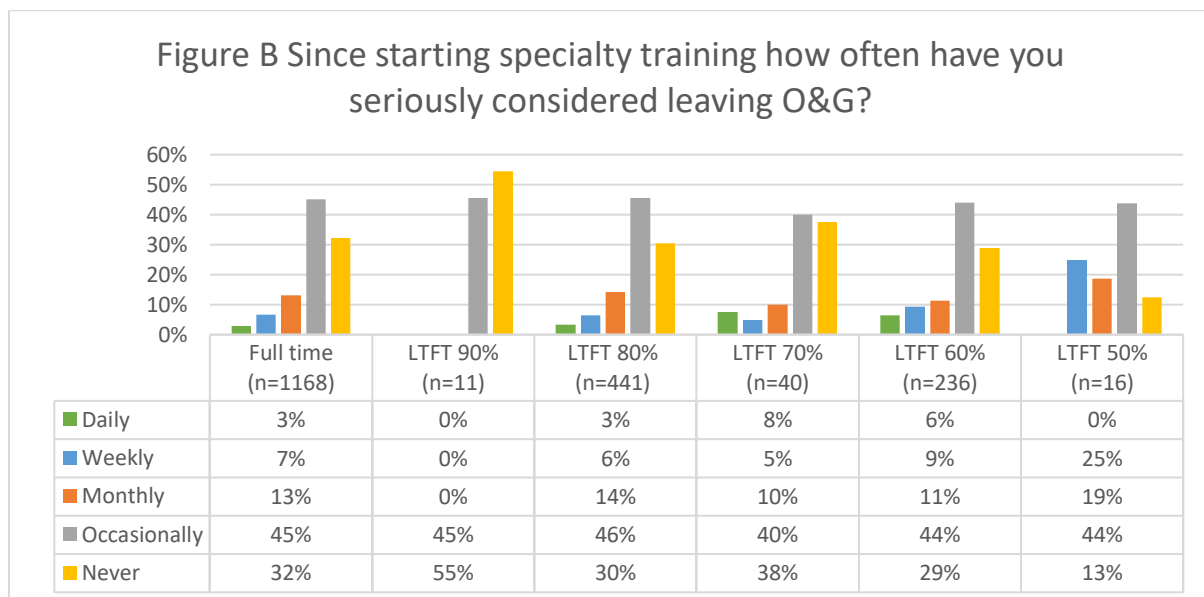


Figure B – Since starting specialty training, how often have you seriously considered leaving O&G?  
– FT/LTFT %

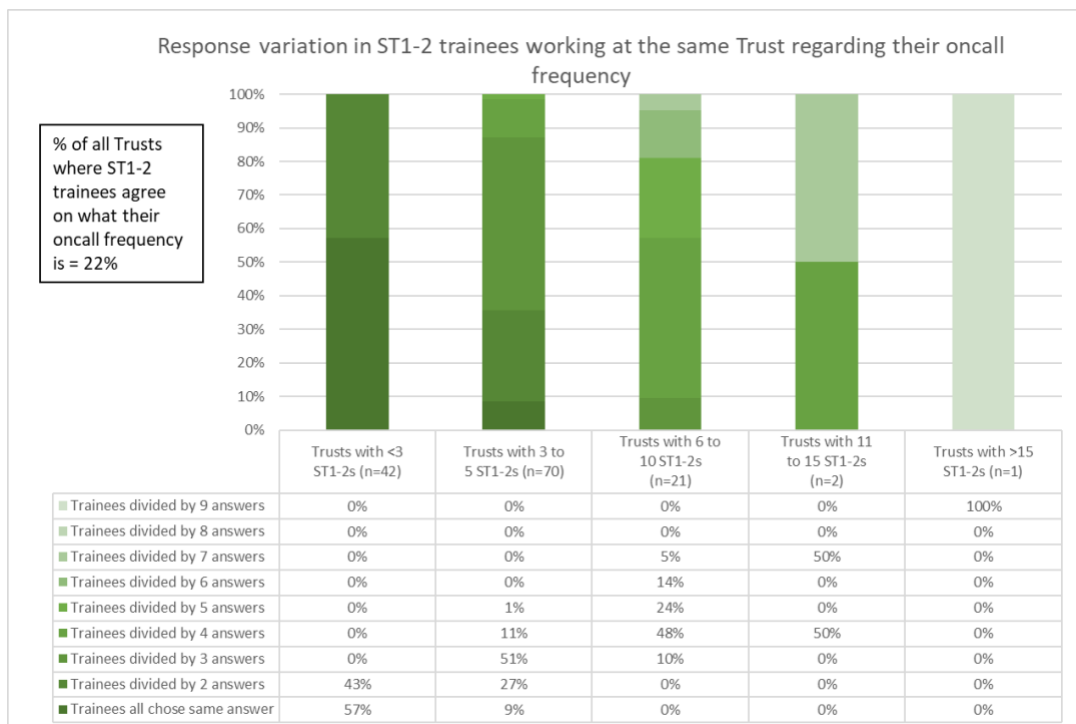


Figure C. Response variation in ST1-2 trainees working at the same Trust regarding their on-call frequency

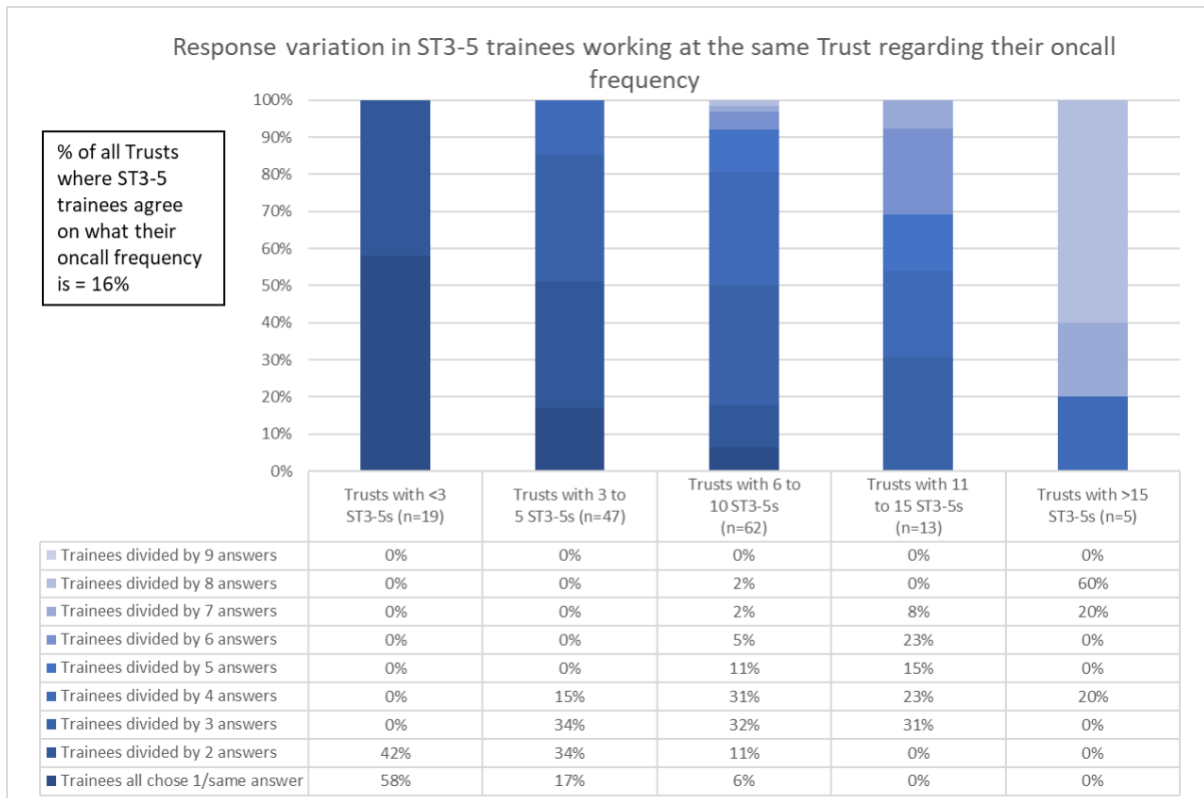


Figure D. Response variation in ST3-5 trainees working at the same Trust regarding their on-call frequency

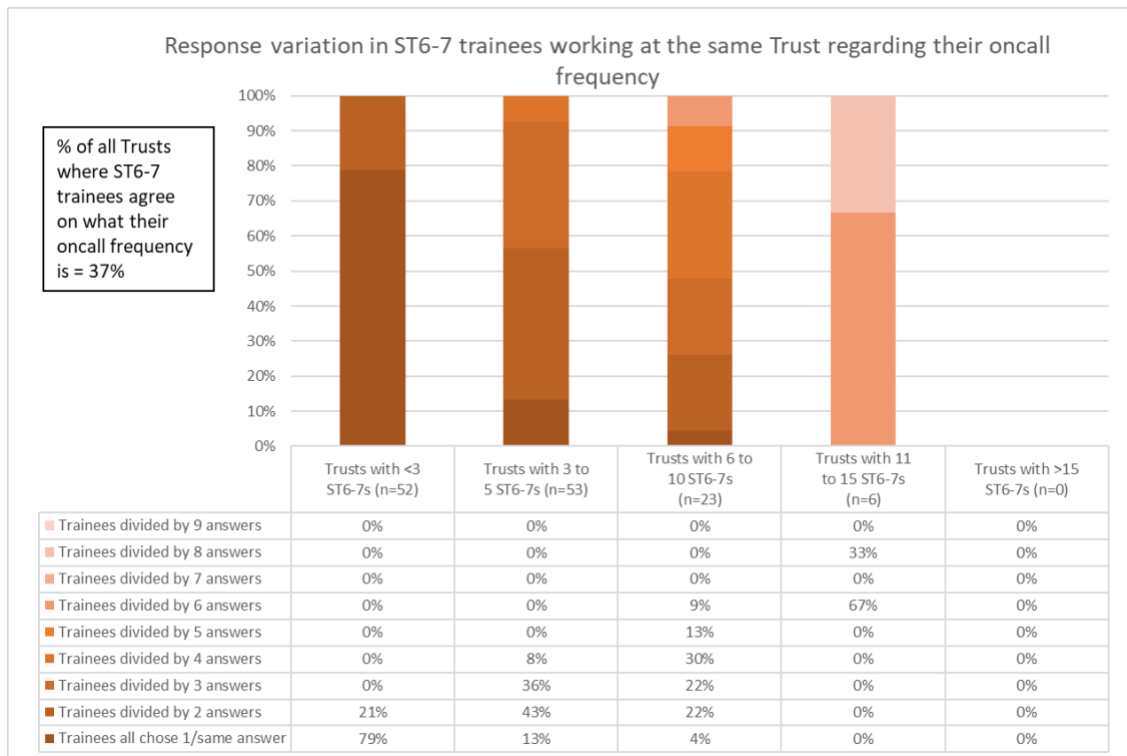


Figure E. Response variation in ST6-7 trainees working at the same Trust regarding their on-call frequency

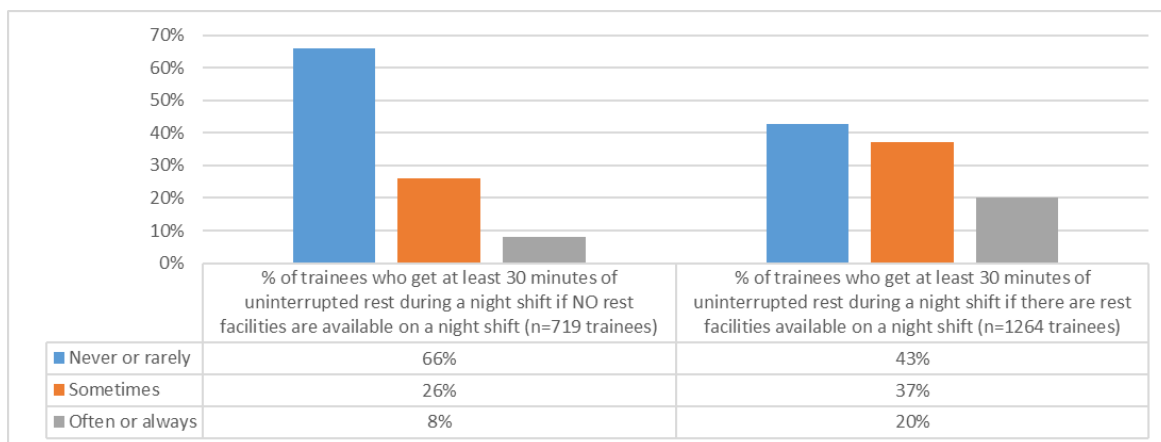


Figure F. % of trainees who get at least 30 minutes of uninterrupted rest during a night shift by whether or not they have rest facilities available on a night shift

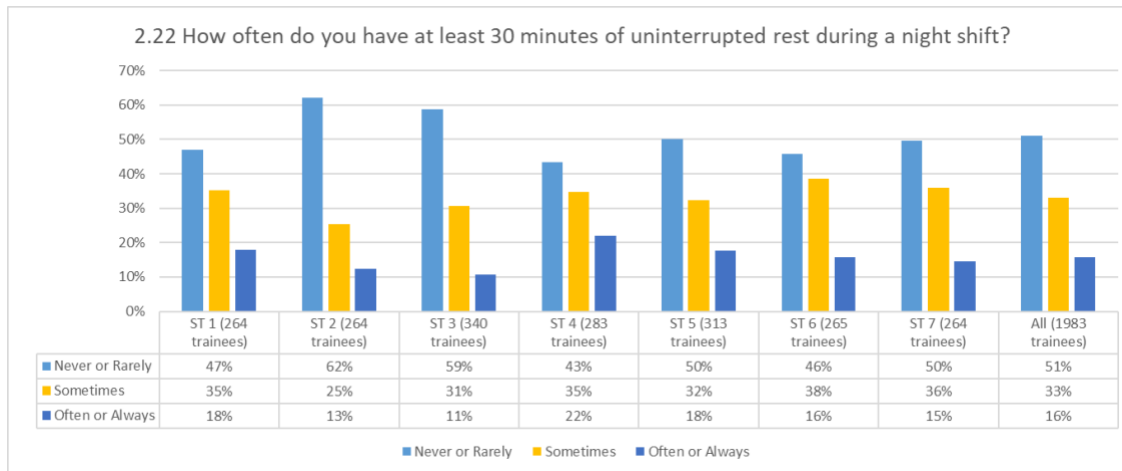


Figure G. The frequency of doctors in training having at least 30 minutes of uninterrupted rest during a night shift by ST Year.



Figure H. ST level and Trainee rest

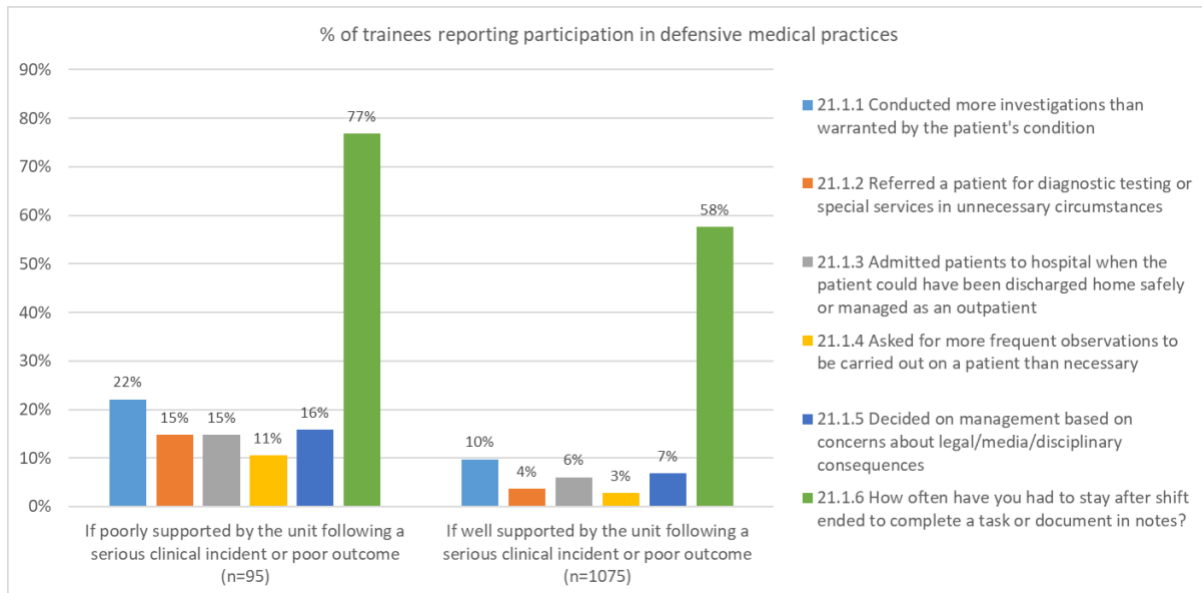


Figure I. % of trainees reporting participation in defensive medical practices by how supported they feel by the unit following a serious clinical incident or poor outcome

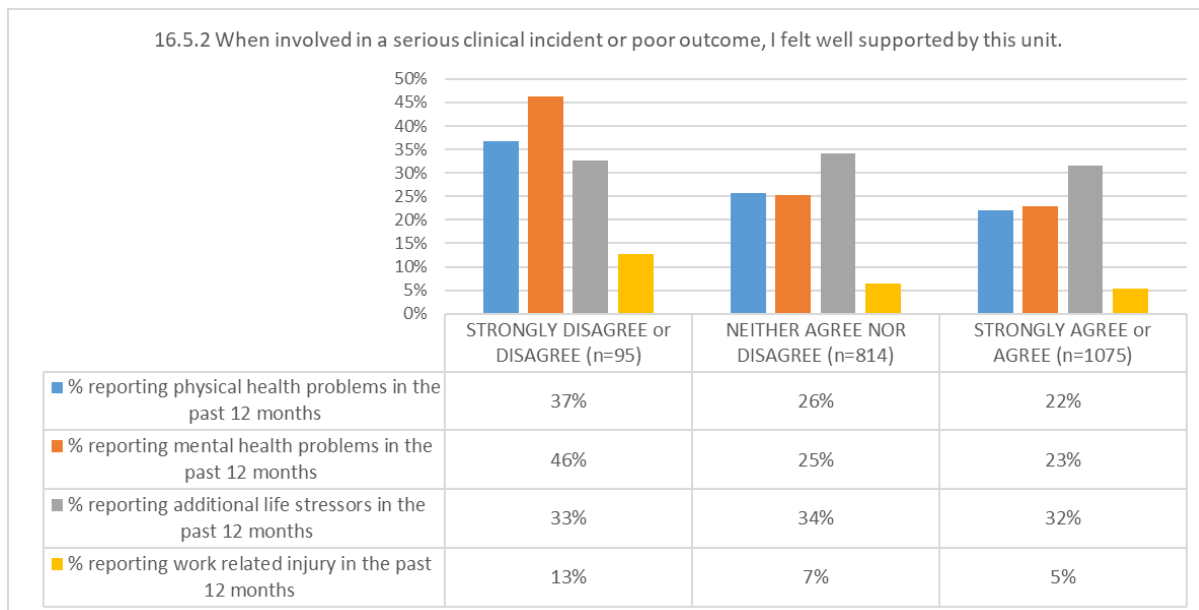


Figure J. % of trainees reporting physical health concerns, mental health concerns, additional life stressors or work-related injuries in the past 12 months by how supported they feel by the unit following a serious clinical incident or poor outcome



Table ii Handover arrangements and Physical/Mental Health and Work-related Injuries.

2.34 Handover arrangements in this post always ensure continuity of care for patients between shifts										
Strongly disagree or disagree = 123 (6% of all trainees)			Neither agree nor disagree = 132 (7% of all trainees)			Strongly agree or agree = 1729 (87% of all trainees)				
21.1.6 How often have you had to stay after shift ended to complete a task or document in notes?										
	Never or rarely = 7 (6% of 123 trainees)	Sometimes = 27 (22% of 123 trainees)	Often or always = 89 (72% of 123 trainees)	Never or rarely = 12 (9% of 132 trainees)	Sometimes = 25 (19% of 132 trainees)	Often or always = 95 (72% of 132 trainees)	Never or rarely = 188 (11% of 1729)	Sometimes = 524 (30% of 1729)	Often or always = 1017 (59% of 1729)	Total number of trainees = 1984
Physical health problems in the past 12 months	0/7 (0%)	6/27 (22%)	30/89 <b>(34%)</b>	3/12 (25%)	4/25 (16%)	30/95 <b>(32%)</b>	31/188 (16%)	113/524 (22%)	265/1017 <b>(26%)</b>	482/1984 <b>(24%)</b>
Mental health problems in the past 12 months	0/7 (0%)	9/27 (33%)	30/89 <b>(34%)</b>	4/12 (33%)	8/25 (32%)	35/95 <b>(37%)</b>	30/188 (16%)	115/524 (22%)	264/1017 <b>(26%)</b>	495/1984 <b>(25%)</b>
Additional life stressors in the past 12 months	2/7 (29%)	8/27 (30%)	33/89 (37%)	5/12 (42%)	11/25 (44%)	43/95 (42%)	45/188 (24%)	160/524 (31%)	341/1017 (34%)	648/1984 (33%)
Work-related injury in the past 12 months	0/7 (0%)	0/27 (0%)	7/89 (8%)	0/12 (0%)	1/25 (4%)	6/95 (6%)	5/188 (3%)	26/524 (5%)	77/1017 (8%)	122/1984 (6%)

### Appendix D - TABLE 1 – MUTLIVARIABLE MODEL FOR DEFENSIVE MEDICAL PRACTICE

Predictor variable	Defensive Medical Practice (DMP) (n=1650, missing values excluded)	
	Adjusted OR (95% CI)	P value
<b>Autonomy and Perceived Control</b>		
<b>Job Control</b>		
Work Intensity too high for learning needs vs Appropriate (Q 2.11.1)	0.84 (0.59 – 1.19)	0.344



Work Intensity too low for learning needs vs Appropriate (Q 2.11.2)	0.81 (0.43 – 1.5)	0.504
<b>Time Control</b>		
Frequent vs Infrequent loss of admin time to cover service (Q 2.31)	<b>0.7 (0.5-1.9)</b>	<b>0.049</b>
<b>Decision Latitude</b>		
Suboptimal vs Optimal Independence (Q 16.1.1)	0.67 (0.40 - 1.12)	0.13
<b>Belonging and Perceived Support</b>		
<b>Supervision support (Suboptimal vs Optimal)</b>		
Gynae Theatre (Q 5.5.1)	1.31 (0.82 - 2.09)	0.243
Gynae Clinics (Q 5.5.2)	0.94 (0.64 - 1.37)	0.77
Labour Ward (Q 6.1.4)	0.64 (0.39 - 1.07)	0.09
Antenatal Clinics (Q 6.1.8)	0.98 (0.65 - 1.49)	0.95
<b>Feedback Support (Suboptimal vs Optimal)</b>		
WPBA (Workplace Based Assessments) (Q 6.1.5)	<b>2.07 (1.14 - 3.73)</b>	<b>0.016</b>
<b>General sense of Wellbeing (Suboptimal vs Optimal)</b>		
Feeling valued at workplace (Q 17.7)	1.04 (0.64 - 1.68)	0.85
Unit- Sense of community and belonging (Q 17.8)	0.78 (0.50 - 1.21)	0.27
<b>Competence And Perceived Performance</b>		



Training Performance (Suboptimal vs Optimal)		
On Track – Gynaecology Training (Q 5.6)	1.04 (0.74 - 1.48)	0.78
On Track – Obstetrics Training (Q 6.1.1)	0.84 (0.53 - 1.32)	0.44

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