



Comhairle na nDochtúirí Leighis
Medical Council



YOUR TRAINING COUNTS

RESULTS OF THE
NATIONAL TRAINEE EXPERIENCE SURVEY, 2014

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Finally, we are grateful to the 1,636 trainees across Ireland who took part in *Your Training Counts*. Each trainee who participated took time to share their experience by responding to approximately 100 questions. Without their contribution *Your Training Counts* would not be a success and we are grateful to everyone who took part.

FOREWORD FROM PRESIDENT AND VICE PRESIDENT

This first report from *Your Training Counts*, the annual national trainee experience survey, has provided all trainees with an opportunity to share their views on the places where they learn as doctors and enables them to put their voice at the heart of discussion of postgraduate medical education and training in Ireland. First and foremost, I want to thank everyone who took time to share their experience with us.



I am heartened that this report highlights that the majority of trainees think that the quality of care provided is good or better. While the information on the average experience of training is important, the report highlights that our initial priority should be to bring consistency to the clinical learning environment and to focus on getting basics – like feedback and proper induction – in place for all trainees.

With my fellow Medical Council members, I look forward to the interactions that will result from the issues emerging from this report and tracking trainee views over the coming years. We will be considering it in the context too of the wider environment in which medical education and healthcare must operate in an Ireland where resources have been severely constrained and where cultural change comes slowly. This report provides a baseline, and the Medical Council is committed to taking a leadership role and working with partner organisations to bring about positive changes in medical education and training over the coming years.

A handwritten signature in black ink that reads "Freddie Wood".

Professor Freddie Wood
President

As a recently qualified trainee, I heard a great deal from colleagues about their experience of training in other disciplines. I often wondered whether there was a significant difference in experience in the various specialties, and what were the perceived positives and negatives of training. Since joining the Medical Council, I and my colleagues have been keen to place a concern for doctors' professional development at the centre of our work. To do this, we knew we needed to listen to the voices of doctors in training. We decided there was a fundamental question to explore with them: what makes somewhere a good place to learn to be a doctor?



This report provides a starting point to answering these questions. With my fellow Medical Council Members, we are also listening to the public and to patient representatives. Patients recognise the pivotal role which a strong system of medical education and training plays in their care and are happy to help doctors learn so that they continue to place their trust in them. I also know how seriously those involved in medical education and training in Ireland take their responsibility for the future of the medical profession. From my own experience, it's clear to me just how generous so many doctors are in finding time in day-to-day practice to teach and mentor doctors in training. This report provides a comprehensive overview of what trainees perceive as the strengths and weaknesses of their experience of learning to be a doctor in the Irish health system. I look forward to the debate that it creates, and working with partner organisations to continue to raise standards of medical education.

A handwritten signature in black ink that reads "Audrey Dillon".

Dr Audrey Dillon
Vice-President

INTRODUCTION FROM THE CHIEF EXECUTIVE

I am pleased to introduce this report based on the feedback we received from over 1,500 doctors in training through *Your Training Counts*, the first ever National Trainee Experience Survey in Ireland.

Like all countries, medical education and training in Ireland faces challenges. This report provides a robust and comprehensive overview of how trainees perceive medical education and training in Ireland so as to inform continuous improvement.



It is clear that many trainees enjoy a positive experience. It's notable that more senior trainees are generally satisfied with their training. It is clear that some types of sites - like GP practices and mental health services - are able to manage the clinical learning environment in a way that meets trainee expectations. Many critical components of the clinical learning environments - like team work and peer collaboration - are working well. It is particularly important to note that consultants, GPs and others who act as clinical teachers in the workplace on a day-to-day basis are very well-regarded by trainees. It is not easy to balance this responsibility with delivering increasing busy clinical services so clinical teachers should take this commendation as recognition for a challenging but crucial job done well. The leadership they provide for the future of the medical profession is a resource to the health system which should be recognised and valued.

However, this report also clarifies some critical challenges for medical education and training in Ireland. Beneath the single, global measure offered by this report is significant and systematic variation in trainees' views of the place where they train as a clinical learning environment.

We heard from trainees that some of the key educational processes that need to be in place to help them learn - like defined and gradually increasing responsibility, feedback, supervision - need to be addressed.

There are issues raised in the report which need to be urgently addressed as basic good human resource management practices. Gaps and weaknesses in induction and orientation processes are a concern not just for trainees' achievement of learning objectives but also for the delivery of safe, high quality care. Furthermore, the prevalence of bullying and undermining behaviours in the clinical environment reported by trainees is stark and demands a comprehensive response at clinical sites.

Finally, while the transition from student to intern will always be a big step, too many trainees at this stage reported feeling under-prepared for that challenge. We need to understand this issue further, but remediation will require a joined-up approach between medical schools graduating medical students and the health services employing interns new to clinical practice.

We will only know if we are all making progress through continuing monitoring and evaluation of trainee views. This is the first of what will be a programme of annual national trainee experience surveys and we will be listening to trainee views over time to monitor developments. Change and improvement will not happen without commitment from everyone working in medical education and training. This report has been designed to provide a starting point for a joint approach to improving the clinical learning environment - improvements will benefit trainees, practising doctors, healthcare organisations and ultimately patients. I look forward to working with, trainees, educators, healthcare organisation and policy-makers to identify and share good practice, as well as addressing areas where improvements need to be made.

A handwritten signature in black ink that reads "Caroline Spillane".

Ms. Caroline Spillane
Chief Executive

ABOUT THE MEDICAL COUNCIL

Through the regulation of doctors, the Medical Council enhances patient safety in Ireland. In operation since 1979, it is an independent statutory organisation, charged with fostering and ensuring good medical practice. It ensures high standards of education, training and practice among doctors, and acts in the public interest at all times. The Medical Council is noteworthy among medical regulators worldwide in having a non-medical majority. It comprises 13 non-medical members and 12 medical members, and has a staff of approximately 70. The Medical Council's role focusses on four areas:



Maintaining the register of doctors

The Medical Council reviews the qualifications and good standing of all doctors and makes decisions about who can enter the register of medical practitioners. In December 2013, approximately 18,000 doctors were registered, allowing them to practise medicine in Ireland.

Safeguarding education quality for doctors

The Medical Council is responsible for setting and monitoring standards for education and training throughout the professional life of a doctor: undergraduate medical education, intern and postgraduate training and lifelong learning. It can take action to safeguard quality where standards are not met.

Setting standards for doctors' practice

The Medical Council is the independent body responsible for setting the standards for doctors on matters related to professional conduct and ethics. These standards are the basis to good professional practice and ensure a strong and effective patient-doctor relationship.

Responding to concerns about doctors

Where a patient, their family, employer, team member or any other person has a concern about a doctor's practice, the Medical Council can investigate a complaint. When necessary, it can take appropriate action following its investigation to safeguard the public and support the doctor in maintaining good practice.

Through its work across these four areas, the Medical Council provides leadership to doctors in enhancing good professional practice in the interests of patient safety. You can find out more about the Medical Council here: www.medicalcouncil.ie

EXECUTIVE SUMMARY

The Medical Council is responsible for setting and monitoring standards for medical education and training throughout the professional life of a doctor: undergraduate medical education, intern and postgraduate training and lifelong learning.

Your Training Counts, the annual national trainee experience survey, is a new programme, designed and delivered by the Medical Council, which aims to support the continuous improvement of the quality of postgraduate medical training in Ireland - workplace-based training for doctors which takes places across various clinical sites including hospitals, mental health services and GP practices. Specifically, the objectives of *Your Training Counts* are:

- To monitor trainee views of the clinical learning environment in Ireland
- To monitor trainee views of other aspects of postgraduate medical education and training including preparedness for transitions, retention and career plans, health and wellbeing, and trainee perceptions of safety at clinical sites
- To inform the role of the Medical Council in safeguarding the quality of medical education and training by identifying opportunities for strengthening standards and guidance, and through focussing its quality assessment role
- To inform dialogue and collaboration between all individuals and bodies involved in medical education and training in Ireland so as to continually improve the experience and outcomes of trainees in Ireland.

How did we do it?

Your Training Counts collected feedback from 1,636 trainees (just over half of all trainees invited) on more than 100 questions. D-RECT, the Dutch Residency Educational Climate Test, was used to collect trainee views of the clinical learning environment in Ireland. D-RECT questions were subtly adapted to make the language accessible to trainees in Ireland and an evaluation was conducted to confirm that it remained a useful instrument for measuring the clinical learning environment. Trainee views on inductions and orientation, preparedness for transitions, bullying and undermining behaviours, trainee safety, and quality of patient care in the clinical environment were elicited using questions from the General Medical Council's National Training Survey and questions developed by the UK Medical Careers Research Group. The survey ran from April to July 2014. Trainees provided views of their experience of training at a specific clinical site over the 12 months prior to the survey.

What did we find?

There were significant findings across a range of important themes.

The clinical learning environment

- Total D-RECT score provides a global, composite measure of trainee views of the clinical learning environment on a scale of 50 (lowest possible score) to 250 (highest possible score). The national mean total D-RECT score across all trainees in Ireland in 2014 was 170.8.
- There was very wide variation in trainee views of the clinical learning environment (25% reported scores lower than 151.3 and 25% reported scores higher than 192.7).
- The mean total D-RECT score from experts who rated their expectations for the clinical learning environment (mean total D-RECT score 203.9) was almost 20% higher than trainee-rated experience (170.8).

- Trainee experience in 2014 was similar to experience reported in a smaller 2012 study of trainees in Ireland (mean D-RECT score 173); it was less positive than the experience reported by Dutch trainees in 2010 (mean D-RECT score 188).

Different attributes of the clinical learning environment

- The views of trainees point to strengths and weaknesses in different attributes of the clinical learning environment.
- Overall, at national level, areas of the clinical learning environment rated highly were “Consultants’ role”, “Teamwork” and “Peer collaboration”; weaknesses included the attributes of “Feedback”, “Professional relations between consultants” and “Role of the educational supervisor”.

Variations in views of the clinical learning environment

- Younger trainees generally reported poorer views of the clinical learning environment.
- Interns reported poorer views of the clinical learning environment than trainees at all other stages of training. The poorer views of interns did not relate to their younger age, since interns of different ages had similar views.
- There was very wide variation in views of the clinical learning environment across specific sites (25% of sites had total D-RECT scores less than 167.0 and 25% had scores greater than 194.3).
- Size of clinical site did not affect trainee views of the clinical learning environment; however, type of site was relevant: in general, trainees had more positive views of the clinical learning environment at mental health services (mean total D-RECT score 190.9) and GP practices (mean total D-RECT score 183.4) than at hospitals (mean total D-RECT score 166.2 for smaller hospitals and 167.8 for larger hospitals).

Induction to the clinical environment

- While most trainees reported a positive overall experience of induction and orientation to the clinical environment as a place to work and learn, many trainees identified deficiencies in core areas: discussing educational objectives with their educational supervisor (absent for 43.5% of trainees), receiving basic information about the workplace (absent for 35.3% of trainees) and explanation of their role and responsibilities (absent for 28.9% of trainees).
- An experience of good induction to the clinical site, for example through discussing educational objective with an educational supervisor, was associated with trainees having a better view of the overall clinical learning environment.
- The views of trainees in Ireland on induction and orientation were poorer than the views of their UK counterparts; for example, 9-in-10 trainees in the UK reported having discussed educational objectives with an educational supervisor, compared with 5-in-10 trainees in Ireland.
- In general, trainees at intern and basic specialist training stages reported poorer experiences of induction and orientation to the clinical site as a place to work and learn; for example, 7-in-10 higher specialist trainees and registrar trainees rated induction as at least good, compared with 5-in-10 intern and basic specialist trainees.
- Trainee-reported experience of induction and orientation was poorer at hospitals than at GP practices and at mental health services: for example, 7-in-10 trainees at mental health sites rated induction as at least good, compared with 5-in-10 trainees at smaller hospitals.

Preparedness for transitions

- Almost 9-in-10 trainees completing specialty training felt they had been well prepared for their next role.
- In contrast, approximately 3-in-10 interns reported that their previous medical education and training did not prepare them well for intern training. The prevalence of this issue among trainees in Ireland is 2-3 times greater than among their UK counterparts.
- For 5-in-10 interns who reported that preparedness was an issue, lack of preparedness was a 'medium-sized' or 'serious' problem. Again, for those who felt under-prepared, compared with their UK counterparts, trainees in Ireland were 2 times more likely to report that the problem was significant.
- While feeling unprepared was less commonly reported with respect to clinical knowledge and interpersonal skills, the problem more commonly arose with regard to administrative duties and the physical/emotional demands of clinical work as an intern.
- It is important to note that the prevalence of feeling underprepared was not associated with trainee-related characteristics. Critically, the problem was no more or less common for interns depending on their medical school of graduation or the intern training network overseeing their intern learning experience.
- Interns who rated the quality of induction to the clinical environment positively were more likely to also report that they felt well prepared for intern training.
- Interns who felt less well prepared for intern training reported a poorer experience of the clinical learning environment; for those who reported the problem to be more serious, their experience of the clinical learning environment was worse.

Bullying and undermining behaviour

- Based on trainee-reported experience, bullying and undermining behaviours were endemic in the clinical learning environment. In total, approximately 3-in-10 trainees reported personal experience of bullying and undermining behaviour, and this experience was over 2 times more prevalent than for their UK counterparts. Where bullying and undermining behaviour was experienced, the frequency was greater among trainees in Ireland compared with their UK counterparts.
- The prevalence of trainee-reported personal experience of bullying and undermining behaviours was greater among younger trainees and among those at the intern stage of training.
- Type of clinical site was relevant: the prevalence of trainee-reported personal experience of bullying and undermining behaviours was greater among trainees at hospitals than among trainees at GP practices.
- Trainee-reported experience of bullying and undermining behaviours was associated with a poorer trainee view of the clinical learning environment.

Safety and quality of care at clinical sites

- Over 8-in-10 trainees felt physically safe at the clinical site where they trained; 1-in-20 did not.
- Trainees with poorer views of the quality of induction at the clinical site were more likely to report that they did not feel safe.
- Trainees who reported that they did not feel safe at the clinical site also reported poorer views of the clinical learning environment.

- Over 8-in-10 trainees rated the quality of care at the clinical site where they trained as good or very good.
- Compared with other trainees, interns had a poorer view of the quality of care; trainees at smaller hospitals also had poorer views on the quality of care.
- Trainees who reported a positive experience of induction at the clinical site were also more likely to rate the quality of care as good or very good; interns who felt prepared for intern training were also more likely to positively rate the quality of clinical care.
- Trainees who rated the quality of care at the clinical site as good or very good reported most positive views of the clinical learning environment.

What does this mean?

The views of trainees across over 100 different but interlinked areas of the clinical learning environment have been evaluated. It is clear from what we heard that trainee experience of postgraduate training in Ireland is a complex and multi-faceted issue.

Establishing an evidence-base and monitoring progress

This report, for the first time, provides a robust and comprehensive picture of postgraduate training in Ireland from the perspective of trainees. It comes at a time of debate and discussion about medical education, training and career structures in Ireland, when the issue of medical graduate retention is in focus and in the context of an ambitious programme of health system reform. This debate and discussion should be based on information and be learner-focussed. *Your Training Counts* establishes a valuable evidence-base about the needs and experience of doctors in training to inform decision-making. Future reports will provide a framework for monitoring progress and evaluating outcomes.

Appreciating strengths and sharing good practices

Many trainees are enjoying a positive experience of the clinical learning environment in Ireland. This is a strong and clear message emerging from *Your Training Counts* 2014. Their experience must not be overlooked, not least since contained within it may be important lessons for improvement.

The report also identifies facets of postgraduate medical training that were rated positively by many trainees; for example, team working and peer collaboration. These competencies are critical for patient safety and it is positive to note that these are strengths of the clinical learning environment in Ireland.

Valuing clinical teachers

Trainee recognition of the role of their clinical teachers stands out in *Your Training Counts* 2014. Consultants, GPs and other clinical teachers face multiple competing demands in the delivery of increasingly busy clinical services. Yet it is clear that they are providing strong leadership to doctors in training, and this is to be commended. Formalisation of medical education and training has, undoubtedly, helped improve quality for the benefit of the public and the profession alike. However, the importance of apprenticeship should not be lost.

Addressing variation and building reliability through educational governance

Your Training Counts 2014 also points to areas for improvement. Across the attributes of the clinical learning environment, it is clear that some basic educational processes – like feedback, educational supervision and adjustment of responsibility to fit the trainee's competence – are working less well than others. Weaknesses regarding patient handover need to be addressed not just for the benefit of trainees but in the interest of patient safety.

Overall, the report highlights a lack of consistency in the experience of trainees across clinical sites. This variation is not random or explained by individual perceptions – it is sizeable, significant and systematic. For example, trainees at acute hospital sites reported poorer experience than trainees at other healthcare facilities. Some variation is to be expected, and nobody – not even the experts surveyed in this study – expects that clinical sites challenged to deliver busy clinical services will consistently deliver an optimum clinical learning environment. But it is reasonable to expect that a greater number of trainees should have a more reliable experience of clinical learning environment. Reliability can only be achieved if trainee experience is treated as a priority at clinical sites

Getting early experiences right for interns

The most significant and systematic variation in trainee experience to emerge through *Your Training Counts* 2014 is the challenge facing interns. They reported poorer experiences across the range of domains examined this year and their challenges may be interlinked, beginning with the issue of feeling under-prepared for intern training. Transitions in professional development will never be easy and a step change will present a stretch for trainees – indeed that very stretch is rich in learning experience. But is it acceptable that trainees at the earliest stage of their professional development should face a challenge of the scale and scope described in *Your Training Counts* 2014?

Building good places to learn, to work and to care

Reading across a number of areas examined by *Your Training Counts*, it is evident that more can be done in some places to make the clinical environment a better place to work and to care for patients as well as to learn to be a doctor. That a culture of bullying and undermining behaviour was endemic in the clinical learning environment in Ireland should not be surprising, given that the phenomenon is well described internationally and may be seen as part of the culture of learning in medicine. But the scale of the issue and the systematic variation in this specific aspect of trainee experience of this culture is concerning. Added to this, there are implications arising from learning in this culture for the future of medical professionalism. Furthermore, the relationship of some of the issues identified in *Your Training Counts* – like patient handover, induction and orientation, a sense of under-preparedness among the most junior trainees – to patient safety and quality of care cannot be overlooked. The clinical environment must become a better place to learn, to work and to care for patients.

Who is responsible for the quality of the clinical learning environment?

Overall, the findings from *Your Training Counts* 2014 point to a need, first and foremost, for healthcare organisations to address a number of inter-related issues regarding the governance and management of the clinical site – both as a place for trainees to learn and a place to work. The variation in trainee experience must be tackled, first and foremost, through organisational commitment to improvement, supported by strong leadership. These improvements relate to the clinical site as a learning environment; however, the findings in this report are not simply a problem for educationalists. Good human resource management practices are required to improve trainee experience. Educational governance at clinical sites needs to be strengthened, and an integrated approach adopted, which joins up corporate areas that have responsibility for the safety and quality of clinical care and those that have responsibility for management of the learning environment.

The Health Service Executive has a role, above its role in respect of the management of individual training sites. As the organisation that makes proposals of posts to the Medical Council for doctors to be registered as interns and trainee specialists, the Health Service Executive's Medical Education and Training function must be assured that it is making proposals of posts at clinical sites that have effective systems and processes in place to control the quality of the clinical learning environment. To do otherwise would be to fall short of its responsibility under the Medical Practitioners Act 2007 to promote the development of specialist medical education and training.

The bodies overseeing intern and postgraduate training already demonstrate commitment to the highest standards of medical education and training in Ireland. As these bodies embed standards set by the Medical Council, they will continue to take a role in working with healthcare organisations in managing the quality of postgraduate training through, for example, selection and training of clinical teachers and through review of the quality of clinical sites from a specialty-specific perspective.

The Medical Council has defined expectations for clinical sites where interns and specialist trainees learn. It already has a programme of intern training site inspections in place and will shortly be commencing a programme of specialist training site inspections. Under the Medical Practitioners Act 2007, the Medical Council has powers to remove training status from clinical sites if concerns for the quality of the clinical learning environment cannot be in any other way ameliorated. Through its approval of bodies that oversee training, it will also ensure that these bodies are effectively managing the quality of clinical learning environments. Through defining what is required, through monitoring, and through taking action where standards are not met, the Medical Council will quality assure the clinical learning environment.

Finally, while this report focusses on the clinical learning environment, the issues it raises link with good human resource management and governance of the quality of care. Organisations like the Health Information and Quality Authority and the Health and Safety Authority have roles in ensuring robust and effective workforce governance at clinical sites for the benefit of patients and healthcare professionals alike.

Supportive learning environments – an agenda for continuous improvement

Your Training Counts 2014 sets an agenda for continuous improvement that can help to build supportive learning environments in Ireland. Improving the clinical learning environment will benefit the future of the medical professional, contribute to a strong and sustainable health system and ultimately benefit the public.

For healthcare organisations and the Health Service Executive

- We expect healthcare organisations to have in place educational governance arrangements so as to discharge the responsibility for the control of the quality of the clinical learning environment and to have an accountable person delegated with this responsibility. That person should have a plan in place which describes the actions being taken to manage the clinical learning environment in line with Medical Council criteria for clinical sites; the plan should be monitored and progress should be reported to the board or equivalent overseeing management of the organisation. This accountable person and that plan will be the initial point of interaction with the Medical Council when inspections of clinical sites take place in 2015.
- We expect the Health Service Executive, in its annual proposals of intern and specialist training posts to the Medical Council for the purpose of registering trainees, to provide assurance that the quality of the clinical learning environment at the sites where these posts are located is being controlled in line with Medical Council criteria.
- We expect healthcare organisations who employ trainees to ensure that good human resource management practices are in place to deal with simple matters like induction and orientation at the clinical site.
- We expect healthcare organisations who employ trainees to ensure that necessary policies and procedures are defined and embedded to ensure that the clinical environment is a safe place for them to work and learn. This includes a strategy to reduce the prevalence of bullying and undermining behaviours.

- We expect healthcare organisations to work collaboratively with the Medical Council and with medical education and training bodies, recognising the connection between their educational governance arrangements and the overall safety and sustainability of the health system.

For education and training bodies

- We expect all bodies involved in medical education and training to identify and share good practices with regard to management of the clinical learning environment.
- We expect all bodies involved in medical education and training to identify actions, which they will take from 2015 onwards, that are informed by *Your Training Counts* and which specifically address weaknesses in the clinical learning environment. We will track these actions through our monitoring of their approval as training bodies.
- We expect all bodies involved in medical education and training to continue to work with clinical sites to help ensure - through quality management processes - that they consistently provide a good clinical learning environment for trainees. We expect postgraduate training bodies to pay particular attention to aspects of the clinical learning environment relevant to their individual specialty.
- We expect engagement and cooperation from all bodies involved in medical education and training to address challenges set out regarding intern training.
- We expect all bodies involved in medical education and training to work collaboratively to better manage safer and smoother progression between different stages of doctors' professional development.

For policymakers and other stakeholders

- We expect the Department of Health to support the Medical Council's role in the quality assurance of medical education and training. This means enabling us to develop requisite capacity and capability to effectively assure that quality issues highlighted by *Your Training Counts* 2014 are addressed.
- We expect other organisations with roles involving the governance of healthcare organisations (that are complementary to the role of the Medical Council in quality assuring the clinical learning environment) to ensure the clinical environment is a good place to work for trainees for the benefit of patients and trainees alike.

For the Medical Council

- We will continue to monitor training experience of postgraduate training in Ireland through *Your Training Counts* and will share results with trainees and with all relevant stakeholders.
- Through our Student and Trainee Consultative Forum we will seek to better understand the issues facing medical students and trainees so as to inform our decisions about medical education and training and to ensure that these are learner-centred.
- We will set out a strategy for our role in Medical Education, Training and Professional Development 2015-2020, which will identify areas of focus and priority objectives for the Medical Council.
- Recognising the specific challenges faced by interns, we will review intern training in Ireland to see how interns can be better prepared to make this transition and better supported to benefit from this rich and important stage of professional development.
- In 2015, we will begin a programme of clinical site inspections to understand progress being made on the ground with embedding the criteria set by the Medical Council for places where doctors learn.

- In 2015, we will work with the Health Service Executive Medical Education and Training function to ensure that, in respect of places where posts it proposes to the Medical Council for trainee specialist registration are located, it is satisfied that robust and effective systems and processes are in place to quality control the clinical learning environment.
- We will continue to work with other stakeholders who have a role in the governance of the quality agenda in medical education and training, especially the bodies overseeing training whose role we approve against defined standards.
- In 2015, we will publish a framework for research to enable us to gain a deeper understanding of medical education and training in Ireland and to support informed decision-making about quality-assurance.

SECTION 1:

WHY YOUR TRAINING COUNTS?

SECTION 1: WHY YOUR TRAINING COUNTS?

Your Training Counts, the Annual National Trainee Experience Survey is a new programme, designed and delivered by the Medical Council, which aims to support the continuous improvement of the quality of postgraduate medical training in Ireland. This section sets the scene for this work.

1.1 Medical education and training in Ireland

There are just over 18,000 doctors registered to practise medicine with the Medical Council in Ireland.¹ A system of medical education and training is in place in Ireland to support the professional development of doctors from student to medical specialist. At the end of 2013, 788 doctors were registered with the Medical Council as interns and a further 2,355 doctors were registered as specialist trainees (in general, this report will refer to both groups of doctors as “trainees”, unless qualified). The training pathway for doctors in Ireland is illustrated in Figure 1.

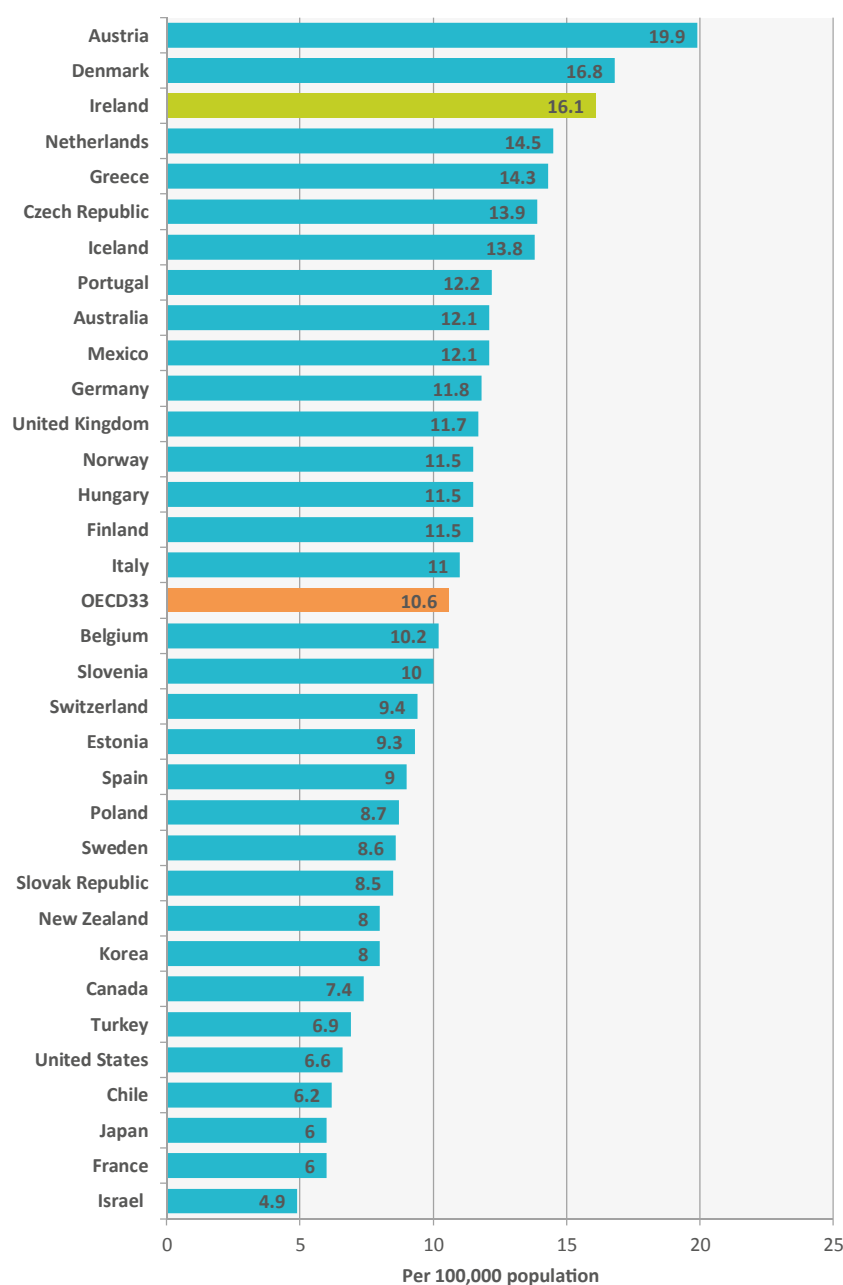
Figure 1: Overview of the stages of professional development in Ireland *



*This diagram is not intended to display duration of training.

Currently, over 600 students complete medical education at one of six medical schools in Ireland (undertaking their medical degree as either a direct-entry or graduate-entry student).² Medical schools and their programmes of basic medical education are approved by the Medical Council. Compared with other OECD countries, a relatively high number of students graduate as doctors in Ireland (Figure 2).³

Figure 2: Medical graduates per 100 000 population across OECD 33 Countries, 2011



Students who graduate with a medical degree commence their professional lives as doctors by training as interns. They complete a 12-month programme of intern training, mostly in acute hospitals, though placements for intern training are becoming more diverse and may include GP practices and mental health services. Following this, they are awarded a certificate of experience by the Medical Council. Intern training in Ireland is delivered through intern training networks, associated with the six medical schools in Ireland. These arrangements are approved by the Medical Council of Ireland.

Following award of a certificate of experience, doctors may proceed to commence specialist training. Those pursuing general practice as a specialty undertake specialist training in that area (General Practice Training). Doctors pursuing training in other specialties may proceed to Basic Specialist Training, and then

progress to Higher Specialist Training; in some specialties, the training is contiguous (Run-through Training) and some doctors undertake a Registrar Training Programme between Basic and Higher Specialist Training. Upon completion of specialist training, trainees are awarded a certificate of completion of specialist training and can be registered as specialists. Specialist training is variable in duration; some doctors may complete specialist training in three years, others may take five to six years, or longer. These programmes of training are designed and delivered by 12 postgraduate training bodies distributed across nine training organisations (see Appendix 2). Postgraduate training bodies and their training programmes are approved by the Medical Council against standards. At any point along their training pathway, some doctors move out of training and are registered in the General Division by the Medical Council; other doctors move between training programmes.

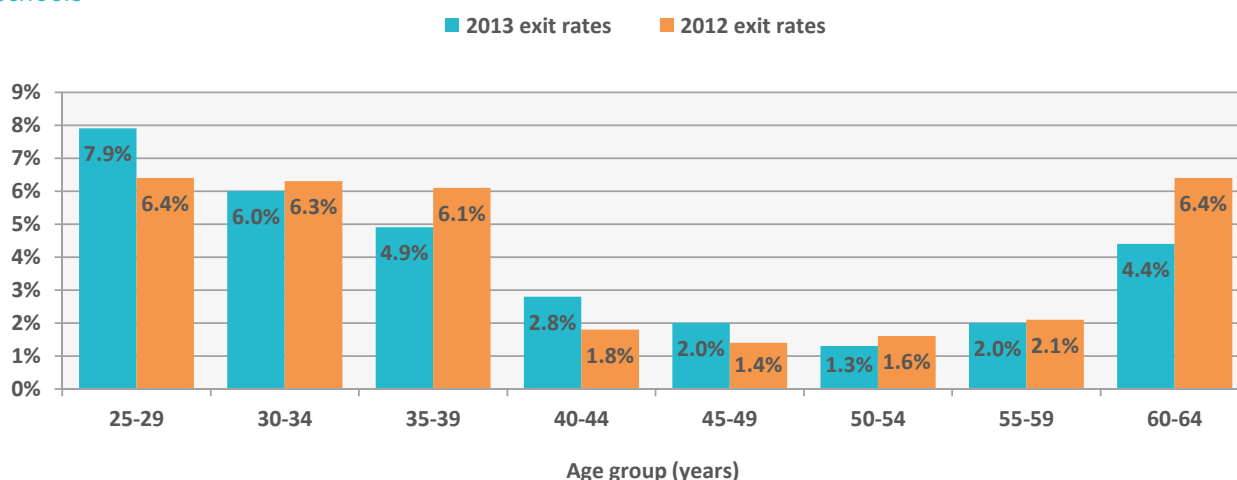
All postgraduate training (intern and specialist training) is delivered at clinical sites, most of which are healthcare delivery organisations operated or funded by the Health Service Executive; some clinical sites are general practices and some training takes place at other organisations such as university departments or government departments.

Responsibility for policy and legislation regarding doctors' education and training is shared between the Department of Health and the Department of Education. Ultimately, planning responsibilities also rest with these government departments. Planning and resourcing functions are delegated to the Higher Education Authority for undergraduate medical education in Ireland. The Health Service Executive has a defined role in relation to the workforce planning for doctors and funding postgraduate training in Ireland.

Undergraduate medical education and postgraduate training in Ireland was the subject of policy review in the last decade through "Medical Education in Ireland: A New Direction" and "Preparing Ireland's Doctors to Meet the Health Needs of the 21st Century" respectively.^{4,5} Consequent to these reviews, the landscape of medical education and training in Ireland was reformed based on a number of strategic focuses that emerged. These included: increased emphasis on an outcome-based approach to medical education; establishing graduate-entry route to medical school; increasing the number of medical graduates; review of the training value of non-consultant hospital doctor posts; robust medical workforce planning systems; mechanisms for medical graduate retention; and strengthening the governance of the quality agenda in medical education and training. In 2007, the role of the Medical Council in medical education and training was expanded and enhanced through the Medical Practitioners Act. A description of the progress made by the Medical Council in taking forward its functions in this area is set out in "Medical Education, Training and Practice in Ireland 2008-2013 - A Progress Report".⁶

Latterly, postgraduate medical training has been the subject of policy review again, in part driven by concerns regarding graduate retention.⁷ The Medical Council's Workforce Intelligence Report has described the challenge facing the Irish health system in terms of retention of medical graduates (see Figure 3).¹

Figure 3: Age-specific exit rates from the register of medical practitioners, graduates of Irish medical schools



1.2 Safeguarding quality – the role of the Medical Council

While the Medical Council is well known for its role regarding professional standards for practising doctors, it is also responsible for safeguarding the quality of doctors' education, training and lifelong learning in Ireland. Quality assurance safeguards the standard of medical education and training and supports improvement. It provides an independent and objective basis for stakeholder confidence in quality. The Medical Council ensures that medical education and training programmes, the bodies that deliver them and the clinical sites where learning takes place are fit-for-purpose. It has powers to hold educational and training bodies accountable, to ensure that the medical education and training they manage is designed and delivered to standards defined by the Medical Council.

Specifically, with regarding to undergraduate, intern and specialist training in Ireland, the role of the Medical Council is ...

... At basic medical education stage

- To approve (or otherwise) programmes of basic medical education and the bodies that deliver these
- To establish guidelines on curriculum and content and standards for the award of a basic medical qualification
- To monitor adherence to guidelines and standards in basic medical education, including inspecting programmes, the bodies that deliver these, and the associated clinical sites
- To establish guidelines to bodies delivering programmes of basic medical education on ethical standards and behaviour.

... At intern training stage

- To specify the number of training posts approved for intern training, based on the proposals made by the Health Service Executive (HSE)
- To establish guidelines on intern training
- To advise the HSE on minimum entry requirements for intern posts
- To establish standards for granting a certificate of experience (which is granted by the Medical Council to interns upon completion of intern training)

- To inspect places with intern posts to ensure adherence to guidelines and standards, and take action wherein standards are not met, including removal of approval as a place for intern training.

... At postgraduate specialist training stage

- To specify the number of training posts approved for specialist training, based on the proposals made by the HSE
- To establish guidelines on specialist training
- To advise the HSE on minimum entry requirements for specialist training posts
- To establish standards for granting specialist medical qualifications
- To inspect places with specialist training posts to ensure adherence to guidelines and standards, and take action wherein standards are not met, including removal of approval as a place for specialist training
- To approve (or otherwise) specialist training programmes and the bodies which may grant evidence of satisfactory completion of specialist training in that medical specialty
- To arrange careers information
- To determine new medical specialities.

There are other bodies responsible for related but distinct quality assurance roles. The Medical Council recognises the role of, and works with, other bodies with quality assurance roles related to its functions.

Quality Qualifications Ireland (QQI) is responsible for the external quality assurance of further and higher education and training (including English language provision), validates programmes and makes awards for certain providers in these sectors. It is also responsible for the maintenance, development and review of the National Framework of Qualifications (NFQ). QQI has a distinct but complementary quality assurance role with many of the education and training bodies that are overseen by the Medical Council.

The Health Information and Quality Authority (HIQA) is the statutory body responsible for driving continuous improvement in Ireland's health and social care services. It assesses the quality of health and social care services. HIQA has a distinct but complementary quality assurance role from the Medical Council, as it scrutinises the quality of services at clinical sites. These are also assessed by the Medical Council from the perspective of delivering education and training.

1.3 How do doctors learn and why does the clinical learning environment count?

A key feature of medical education and training is that learning is largely workplace-based.

Planned and formal activities, such as attending lectures or skill-based workshops, have a role in doctors' professional development. However, learning to be a doctor also involves participative, social processes that are embedded in the workplace, and through which the clinical learning environment influences learning outcomes.⁸ As a consequence, the context where doctors learn is paramount: the environment; the people in that environment – how they talk, interact and the values they share, how they relate to the learner – and how the learner relates to the environment all shape knowledge, thinking and learning.⁹ This holistic perspective on how doctors learn – emphasising participation in the workplace and the role of the environment – is supported by research.^{10, 11} This thinking about the role of the clinical learning environment strongly influences how policy, planning and practice in medical education and training should be approached, especially at the intern and postgraduate stages of learning.^{12, 13}

In summary, the 'formal curriculum' of carefully planned and managed teaching and learning experiences is important in postgraduate medical training.¹⁴ However, the 'informal curriculum' (comprising unscripted, unplanned and highly interpersonal interaction between trainees and other people at the clinical site) and the 'hidden curriculum' (comprising the network of unwritten social and cultural values, rules, assumptions, and expectations at the clinical site and beyond) powerfully shape how doctors learn once they enter the workplace.^{15, 16} Doctors' learning and the clinical environment are inextricably linked.

An important implication of this perspective is that a concern to ensure the quality of medical education and training must include a concern for the clinical environment where learning takes place.¹⁷

The term 'climate' is used to describe trainees' perceptions of the clinical learning environment.¹⁸ How the clinical learning environment is viewed by trainees can impact (positively and negatively) on their motivation to learn, their self-confidence and self-efficacy, their achievement of learning outcomes and their overall success.¹⁹ The environment in which trainees learn has also been linked to their future performance as doctors.²⁰ In addressing the quality of postgraduate training, environment must be a key concern, and this concern demands that climate - trainees' views of the clinical learning environment - is measured.²¹

In summary, engagement with the clinical learning environment - which begins with measurement of climate through listening to trainees' views - is necessary if postgraduate training is to successfully foster good professional practice among tomorrow's doctors.

This has significant implications for organisations like the Medical Council who have responsibility for safeguarding standards in doctors' education and training. For example, the Accreditation Council for Graduate Medical Education (ACGME), which oversees postgraduate training in the USA, is moving towards its "Next Accreditation System (NAS)". NAS will provide a greater focus on the clinical learning environment through its "Clinical Learning Environment Review Programme (CLER)".²² The ACGME already makes extensive use of surveys to inform its oversight of postgraduate training. A similar focus on the clinical learning environment is evident in the General Medical Council's recent review of its quality assurance role in medical education and training in the UK.²³ Like the ACGME, the General Medical Council (GMC) has also well-established systems for routinely surveying trainee views. It has been able to use this information to provide a framework for evaluating progress in continuous improvement of medical education and training.²⁴

Besides being good in terms of doctors' learning experiences and outcomes, does the quality of the clinical learning environment have wider implications for patients and the health system? Many of the attributes of a good clinical learning environment overlap with systems and processes that would be expected to be in place at a clinical environment focussed on supporting its health workforce and on providing safe, high-quality care. It is notable that in the UK the General Medical Council have established a link between trainees' views of a healthcare organisation as a place to learn and how these same healthcare organisations perform across a number of measures regarding the workforce and patient safety.²⁵

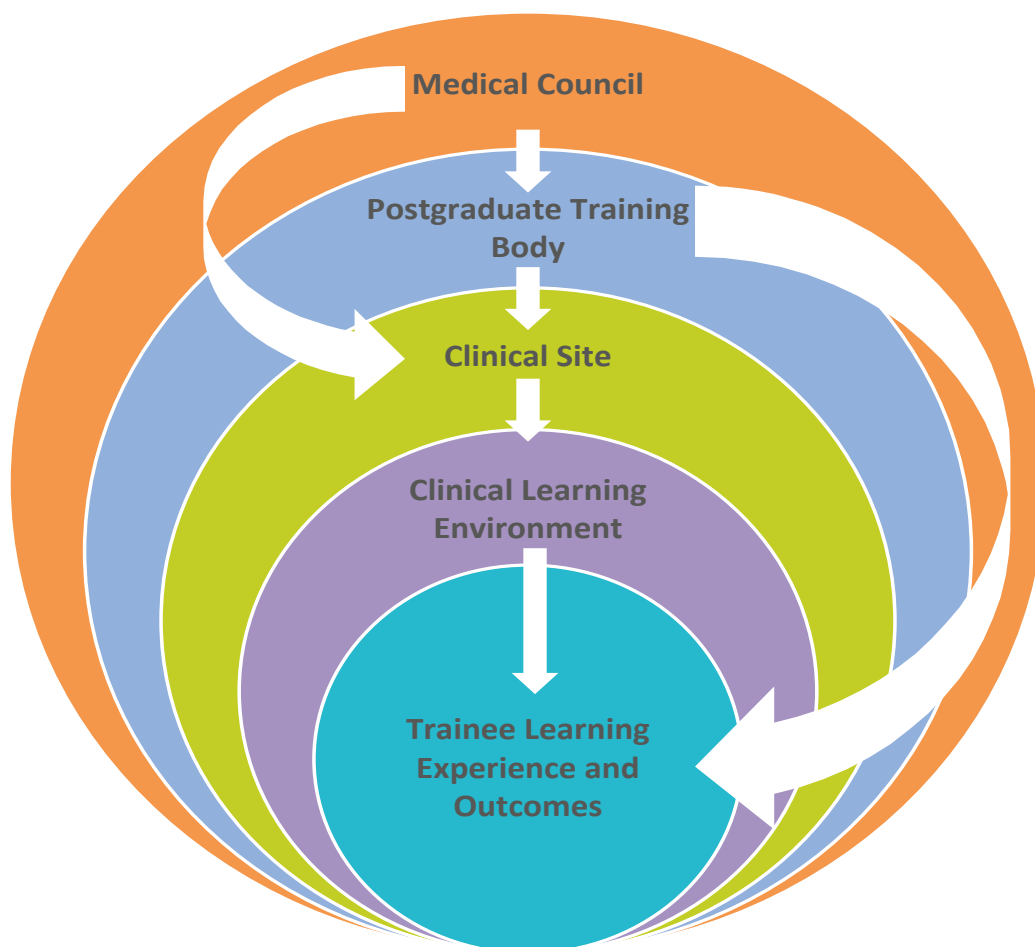
1.4 Who is responsible for the quality of the clinical learning environment?

First and foremost, the healthcare organisation where a trainee works and learns is responsible for the quality of the clinical learning environment. This is an increasingly recognised role for healthcare organisations and is referred to as "educational governance": *"The systems and standards through which organisations control their educational activities and demonstrate accountability for continuous improvement of quality and performance"*.²⁶ For healthcare organisations, these systems are closely related to the systems they require to deliver high-quality and safe healthcare and good human resource management practices.²⁷

Postgraduate bodies also play a critical role. The Medical Council sets standards for the approval of these bodies and their programmes of specialist training which describe this role.²⁸ Specifically, these bodies have responsibilities with regard to specifying the requirements for clinical sites involved in training programme delivery. They assess clinical site quality, select and recognise clinical sites for training, and ensure the clinical site is a safe environment for training. Postgraduate bodies also have a role with regard to supervising and training. Besides influencing the clinical learning environment through their role with clinical sites, these bodies also have a direct relationship with trainees in respect of their learning experiences and outcomes, through the design and delivery of the training programmes.

Finally, the Medical Council has a statutory role to specify requirements for clinical sites that offer posts to intern and other trainees, to inspect these sites, and to take action to safeguard standards. The Medical Council has published criteria for this purpose.²⁹ Through its work with postgraduate bodies, it also oversees their role with respect to the clinical learning environment. These roles and their relationships are illustrated in Figure 4.

Figure 4: Who is responsible for the quality of the clinical learning environment?



It is recognised that other organisations, such as the Health and Safety Authority and the Health Information and Quality Authority have related roles with healthcare organisations in respect of their duties to their workforce and their duty to provide patients with safe, high-quality care.

1.5 Aim, objectives and structure of this report

Your Training Counts, the Annual National Trainee Experience Survey, is a new Medical Council programme that aims to inform and support continuous improvement of medical education and training in Ireland.

Specifically, the objectives of *Your Training Counts* are:

- Monitor trainee views of the clinical learning environment in Ireland
- Monitor trainee views of other aspects of postgraduate medical education and training including preparedness for transitions, retention and career plans, health and wellbeing, and trainee perceptions of safety at clinical sites
- Inform the role of the Medical Council in safeguarding the quality of medical education and training through identifying opportunities for strengthening standards and guidance, and through focussing its quality assessment role
- Inform dialogue and collaboration between all individuals and bodies involved in medical education and training in Ireland so as to continually improve the experience and outcomes of trainees in Ireland.

This report takes the following structure:

- Section 2 describes the methods used to conduct *Your Training Counts* and to produce this report. It includes a report on an independent evaluation commissioned by the Medical Council to examine the psychometric properties and the usefulness of D-RECT, the Dutch Residency Educational Climate Test. D-RECT was the main instrument used to listen to trainee views of the clinical learning environment in Ireland.
- Section 3 presents the findings from *Your Training Counts* 2014. This section is broken down into the following themes:
 - The clinical learning environment;
 - Different attributes of the clinical learning environment;
 - Induction to the clinical environment;
 - Preparedness for transitions;
 - Bullying and undermining behaviour;
 - Safety and quality of care at clinical sites.

The findings are described in some detail, including the results of statistical tests conducted to understand variation in views across different groups of trainees. At the start of each theme, the findings are summarised and the implications discussed.

- **Section 4** reflects on what we heard from trainees through *Your Training Counts* 2014, and discusses some next steps.



SECTION 2:

HOW WE DID THE SURVEY

SECTION 2: HOW WE DID THE SURVEY

Your Training Counts, the Annual National Trainee Experience Survey, was conceived in 2013 to take forward the Medical Council's strategic objective of creating a supportive learning environment for doctors to enable good professional practice.³⁰ This section explains how we did the study.

2.1 Design and development

Following a review of relevant theory, evidence and practice in the area of the clinical learning environment and surveying trainee experience, a consultation was undertaken to gather stakeholder input into the design and development of *Your Training Counts*.³¹ Plans were refined and finalised based on feedback received.³² A key decision emerging from this process was to use D-RECT, the Dutch Residency Educational Climate Test, as the way to gather trainee views on the clinical learning environment in Ireland.³³ The process for development and testing of D-RECT in the Netherlands showed it to be a very useful way of examining trainee views. While other questionnaires are available to assess the clinical learning environment, a recent review of various options identified D-RECT as a leader in its class.³⁴ Panel 1 provides some information about D-RECT from the team in the Netherlands that developed it.

2.2 The *Your Training Counts* questionnaire

D-RECT was used to collect trainee views of the clinical learning environment in Ireland. The original version of the D-RECT questionnaire is presented in Appendix 3. D-RECT contains 50 questions, which measure trainee views of the overall clinical learning environment on a scale of 50 (lowest score, indicating the poorest possible trainee experience of clinical learning environment) to 250 (highest score, indicating the best possible trainee experience of clinical learning environment). D-RECT also enables trainee views to be examined across constituent attributes of the clinical learning environment through arrangement of the 50 items into 11 subscales: Supervision, Coaching and assessment, Feedback, Teamwork, Peer collaboration, Professional relations between attendings, Work is adapted to resident's competence, Attendings' role, Formal education, Role of the specialty tutor, Patient sign out (see Appendix 3). For each attribute, trainee views are measured on a scale of 1 (lowest score, indicating the poorest possible trainee experience of that clinical learning environment attribute) to 5 (highest score, indicating the best possible trainee experience of that clinical learning environment attribute). Recognising the diversity of clinical learning environments, respondents were reminded to adapt the questions to suit their own particular experience, e.g. consultant would mean GP in GP training etc.

It was necessary to subtly amend some of the language used in D-RECT to reflect the Irish context so that it would be more user-friendly for trainees: for example, in the Netherlands, consultants are referred to as "attendings" and trainees are referred to as "residents". This process was undertaken by the Medical Council in consultation with Prof Fedde Scheele and involving Dr Deirdre Bennett at University College Cork. The amendments to the D-RECT questionnaire made for the purpose of this study are shown at Appendix 3. To confirm that these amendments did not impact on the usefulness of D-RECT an evaluation was conducted, which is described later in this section of the report.

The most important theme emerging from stakeholder feedback on the development of *Your Training Counts* was that trainee views should be gathered across a wide range of issues. While D-RECT comprises the majority of questions used to collect trainee views of the clinical learning environment in Ireland, it was supported with other questions (Appendix 4). In total the *Your Training Counts* questionnaire included over 100 questions - 50 from D-RECT and over 50 additional questions. Trainee views on induction and orientation were elicited using questions from the General Medical Council's National Training Survey (GMC-NTS).³⁵ GMC-NTS was also the source of questions used to elicit trainee views on bullying and undermining behaviours and on safety and patient quality in the clinical environment. The source of these questions

is gratefully acknowledged. Finally, preparedness for transitions was assessed drawing on questions developed by Goldacre et al. at the Oxford Medical Careers Research Group.³⁶ The source of these questions is gratefully acknowledged.

Your Training Counts included questions on other themes (trainee health, retention/emigration plans and career intentions), which will be the subject of separate reports in 2015.

Panel 1: The development of D-RECT and its use in the Netherlands

In 2004, the educational Professor Fedde Scheele and his just-beginning PhD student Klarke Boor chose to research the clinical learning climate. Both were working as doctors as well and they recognised the pivotal role of a safe and stimulating environment when you're learning to become a doctor. Literature searches offered much insight into important features of such an environment. However, many things were left to reveal.

They started their research in cooperation with an educational research group from Maastricht and performed qualitative studies to gain understanding of the concept of a 'good' learning climate. They interviewed interns and residents and performed extensive qualitative analyses.^{37, 38}

The findings of their qualitative studies and literature reviews formed the basis for the development of a new questionnaire to measure the clinical learning climate. Forty experts in a Delphi panel pointed out which items were - in their opinion - of utmost importance and which items should be left out. At the same time, over 1200 residents from different specialties filled out the same questionnaire. Comprehensive analyses led to a 50-item questionnaire, covering 11 sub-scales varying from the amount and quality of feedback to working together as a team. The instrument was evaluated and proved to be a valid and reliable tool. This instrument is the Dutch Resident Educational Climate Test (D-RECT).^{33, 39}

At that time, in the Netherlands, major changes occurred in postgraduate training. On the one hand teachers and trainees recognised the importance of repetitive, formal and validated evaluation of different competencies using, for instance, OSATS, a Mini-CEX like format and multisource feedback. All specialties adopted a competency-based training with attention not only for medical skills, but also for communication, management, professionalism etcetera. The Can Meds framework served as the basis for this change.

However, on the other hand, quality of training and teachers gained interest too. A committee of educationalists, doctors and other involved parties advised that evaluation should not only focus on residents, but also ascertain the quality of training, teachers and departments.⁴⁰ They described a tool box hospitals could use to assess their postgraduate training. For individual teachers they advised, for instance, to use the SET-Q, an instrument that offers individual feedback to every teacher. For evaluation of departments they suggested to use, amongst others, D-RECT.

D-RECT has been used over the past few years on a 1-2 yearly basis in many hospitals in the Netherlands. The instrument hopes to offer departments insight in their strengths and weaknesses as a basis for improvement. When a department uses the instrument recurrently it shows in which areas a department is on the right track and where there is room for improvement. A recent study shows that a positive learning climate has a positive influence on individual teachers' assessment. This suggests that a positive learning climate can reinforce good teachers to become even better.⁴¹

Measuring the learning climate is now a well established indicator of the educational quality of a single department. Researchers from countries like Australia, Germany as well as European organisations use D-RECT to evaluate learning climates.⁴² Irish researchers have studied their learning environment using this instrument too.⁴³ Results of these studies offer opportunities for further research and refinement of the concept and measurement of an optimal learning climate.

Dr Klarke Boor, Prof Dr Fedde Scheele

2.3 Collecting trainee views

Your Training Counts was launched on Monday 28th April 2014. In total 3,097 trainees were invited to participate. The survey was aimed at doctors in training since it was designed to inform the Medical Council's role in quality assuring medical education and training in Ireland. It was not aimed at doctors in non-training posts. Through using registration status, trainees eligible for the survey could be identified and automatic invitations to participate issued to all doctors registered as interns and specialist trainees with the Medical Council during the period of the survey. However, it is recognised that a small number of doctors on training pathways (e.g. doctors in research or academic positions) who were not in a recognised training post proposed by the Health Services Executive to the Medical Council were not registered as trainees and did not receive an automatic invitation to participate. *Your Training Counts* was widely promoted and any doctor in this position who contacted the Medical Council and was able to verify their participation in a training programme outside a recognised training post was subsequently issued an invitation to participate.

Through our consultation on our plans for *Your Training Counts*, we heard that trainees had concerns about the confidentiality of their feedback and wanted to be assured that it would not be available on an identifiable basis to individuals and organisations that manage their training. Trainee views were collected through the Medical Council's online registration account management system for doctors. This is a secure system that enables doctors registered with the Medical Council to safely share information. Usual good practice principles regarding data collection were observed. Trainees were presented with information about the purpose of the survey and an explanation of how their data would be held and used by the Medical Council was provided. Responses were managed in absolute confidence. An opportunity was provided to opt in or opt out based on this information. The responses were reconciled with the Medical Council registration information system and held securely in line with legislative requirements and organisation policy and procedure. Trainees were also offered the opportunity to opt in to a linked Health Research Board funded study examining the issue of doctor migration, which was being undertaken by the Royal College of Surgeons in Ireland.⁴⁴ Arrangements for information-sharing were made explicit to trainees, who could choose to opt in or not. That study was approved by the Royal College of Surgeons in Ireland Research Ethics Committee.

The *Your Training Counts* questionnaire comprised a series of closed-answer questions (Appendix 3), most of which required the trainee to respond using 5-point Likert scales to assess strength of agreement with various statements; not applicable responses were allowed. Information given to trainees on how to complete the questionnaire specifically requested that they respond either in relation to their current training post and clinical site or their previous post and clinical site if they had rotated in the preceding month. This was important, since responses needed to be attributable to specific training experiences and, while some training may have rotated over the preceding period, it was important that they did not provide a global response in relation to their training experience across different posts and clinical sites; this information recurred as a reminder throughout the survey.

Your Training Counts was widely promoted by the Medical Council.⁴⁵ A number of automatic reminders were issued to doctors over the data-collection period and incentives (entry into a draw to win one of ten gift vouchers valued at €100) were used to encourage participation.

The survey closed on Tuesday 22nd July 2014.

2.4 Collecting expert views

In parallel to the trainee survey, experts involved in medical education and training policy, planning, funding, design, delivery and oversight, were invited to provide their views on what they expected from a good clinical learning environment. The purpose of this part of the study was to identify an expert

expectation benchmark against which trainee experience could be compared. This is an established practice in studies of this nature.⁴³

The expert views were collected using D-RECT, which was subtly adapted to measure expert expectations instead of trainee experience.

Respondents were specifically asked to avoid expressing an expectation of the clinical learning environment, which was maximal or perfect, and were instructed to reflect on what they thought was reasonable to expect of clinical sites for a satisfactory training experience in Ireland. The study to collect expert expectations ran from 6th of May to 4th of June 2014.

2.5 Response rate and representativeness

In total, 1,636 trainees responded to *Your Training Counts* - a response rate of 53%. This is better than a previous study of trainee experience in Ireland,⁴³ and general experience of surveys of this nature.⁴⁶ Table 1 presents the characteristics of respondents and compared this with the characteristics of all doctors registered as interns and trainee specialists at the time of the survey (the reference population). The age, gender and country of basic medical qualification of the respondents were broadly similar to the reference population. However, there was a lower representation of interns in the respondents compared with the reference population (16% versus 26%).

Table 1: Characteristics of Your Training Counts respondents compared with the reference population

Characteristic	Reference population	Respondents
Mean age	30.4 years	30.9 years
Males	42%	44%
Females	58%	56%
Graduates of Irish medical schools	83%	80%
Graduates of other medical schools	17%	20%
Interns	26%	16%
Other trainees	74%	84%

With regard to the respondents to the expert expectation survey (n=43), 78% were medical doctors, 70% had experience of being a trainee doctor in Ireland and 65% were directly involved in day-to-day training of doctors.

2.6 Analysis of data and presentation of findings

Trainee responses were exported from the Medical Council's online registration account management system for doctors and were imported to SPSS, which was the statistical package used to analyse data.

Total and attribute-specific D-RECT scores were calculated using procedures described by Boor et al.³⁸ When calculating D-RECT scale scores, any D-RECT question that were skipped by trainees (or attracted a not-applicable (n/a) response) were categorised as missing data. Rules for the management of missing data have to be defined for any survey of this nature. Wherein a trainee provided responses on 45 questions or more (i.e. were 90% complete or more), their data was used in calculation of total D-RECT scores and factored-up. Missing data was also managed for D-RECT subscales. For smaller D-RECT sub-scales (i.e. those comprised of 5 or fewer questions), trainees responses were only used to calculate a D-RECT sub-scale score when all questions were answered. For larger D-RECT subscales (i.e. those with 6-8 items), trainee responses were used where all questions were answered and where all but one question were answered; a mean D-RECT sub-scale score was calculated using responses. Modelling of various scenarios for handling missing data confirmed that these approaches did not significantly skew total or sub-scale D-RECT scores.

Data was analysed using SPSS. In terms of statistical procedures, all those reported were conducted with an alpha level of 0.05. The dataset contained a mix of continuous and categorical variables and these were, in general, handled in those formats. The distribution of continuous data was examined and parametric or non-parametric procedures were used as appropriate. In the cases of some categorical data, aggregation of levels was undertaken where this enabled easier communication of findings (for example, in some analysis, 5-point Likert scales of agreement were re-coded into 2 or 3 level categories). Some statistics, for example mean D-RECT scores, are reported with 95% Confidence Intervals (these are shown as error bars on some of the figures in the report). Hypothesis testing was conducted to examine relationships between variables. Bivariate correlation tests were conducted to examine relationships between continuous variables, with Pearson correlation coefficients being reported. When examining relationships between categorical variables and continuous variables, independent t-Tests and one-way ANOVAs were used. Appropriate equality of variance and post-hoc tests were applied to understand how variables interacted with each other. Chi-squared tests were used to examine relationships between categorical variables. For 2x2 tables Continuity Correction values were reported, for larger tables, Pearson Chi-Square values were reported. Where hypothesis testing was conducted, the report contains reference to the type of test, number of respondents, the degree of freedom, the test statistic and the p-value. Statistically significant relationships were reported where p-values were less than 0.05; however, while the meaning of these relationships is discussed in the report, they are not interpreted to infer causality.

2.7 Is D-RECT a useful way to listen to trainees in Ireland?

Your Training Counts 2014 was the second time that D-RECT was used in Ireland to assess trainee views of the clinical learning environment; it is the first time it has been used on such a comprehensive and representative basis. While the usefulness of D-RECT has been established in relation to the Dutch system of postgraduate training, D-RECT was subtly adapted for use in Ireland and the question arose as to how useful it was as a way of listening to trainee views in this context.

To address this matter, a group at University College Cork, led by Dr. Deirdre Bennett, Senior Lecturer, Medical Education Unit, and Dr. Sean Hammond, Senior Lecturer, Department of Psychology, were commissioned to examine the properties of D-RECT to examine the response. Panel 2 contains a summary of their findings.

Panel 2: Is D-RECT a good way to measure the clinical learning environment in Ireland?

The D-RECT instrument has been validated for measurement of clinical learning environment in the Netherlands.³⁸ This means that it has been shown to measure clinical learning environment along 11 distinct dimensions, or subscales, and to do so in a manner that is consistently reproducible. These properties make D-RECT a useful way to measure the clinical learning environment in the Netherlands.

Using D-RECT in the Irish healthcare system, and slightly amending terms used in the instrument, to fit that context, required a re-evaluation of its usefulness as an instrument to measure clinical learning environment in Ireland. To answer this question, an independent analysis of the **reliability** and **validity** of the D-RECT tool in the Irish context was conducted at University College Cork by a group led by Dr. Deirdre Bennett, Senior Lecturer, Medical Education Unit and Dr. Sean Hammond, Senior Lecturer, Department of Psychology.

What is reliability?

D-RECT requires respondents to interpret 50 statements (or items) and indicate a level of agreement with each statement. The reliability of an instrument, such as D-RECT, refers to its ability to produce consistent scores under consistent conditions. An alpha coefficient (α), which can range from 0 to 1, is used to indicate the degree to which individual items are consistent across the test. An alpha coefficient of 1 means total consistency: in other words, you would expect that if the clinical learning environment is good, that the individual items in a test to measure the clinical learning environment would be consistently be highly rated. We would not expect them to be totally consistent however, as within the clinical learning environment there are separate elements, or factors, which may vary. In considering acceptable reliability, the purpose of data collection and the need for precision for that purpose are taken into account. Reliability is a relative rather than absolute concept; however, an alpha coefficient >0.8 is generally considered to be a more acceptable measure of reliability.

What is validity?

The validity of a questionnaire refers to evidence that it is measuring what it claims to measure. Validity evidence can be derived from multiple sources:⁴⁷

- Evidence based on the content of the questionnaire;
- Evidence based on responses to the questionnaire items;
- Evidence based on the structure of the questionnaire; its reliability and analysis of the relationships between the responses to the individual items in the instrument.

Reliability and validity of D-RECT in the Your Training Counts Survey

The full set of D-RECT responses (50 questions) are used to examine the overall clinical learning environment. The responses to D-RECT collected in the *Your Training Counts* survey were shown to be a very reliable single measure, or total rating of satisfaction, in relation to overall clinical learning environment ($\alpha=0.96$).

D-RECT has been designed to measure 11 distinct dimensions of the clinical learning environment using subscales, each comprising 2-8 questions. The reliability of the D-RECT subscales is lower than the total scale (α coefficient range 0.67-0.92). The majority of these subscales have acceptable reliability ($\alpha > 0.8$) but some subscales are less reliable. Specifically these are *Work adapted to competence* ($\alpha=0.78$), *Supervision* ($\alpha=0.75$), and *Peer collaboration* ($\alpha=0.67$). The reliability of these subscales toward the lower end of acceptable reliability, although they are broadly consistent with the Dutch findings

The validity evidence relating to the content of D-RECT is found firstly in the manner of its original development. The items used are derived from expert opinion, previous research and theories of how people learn in workplaces. This theoretical foundation suggests that the D-RECT has content validity beyond its original context of use. Content validity for the Irish context is also supported by the prior use of D-RECT for measurement of clinical learning environment, with a subset of the trainee group surveyed in *Your Training Counts*.⁴³ Furthermore, the consultation exercise undertaken by the Medical Council in relation to selection of the D-RECT instrument and the expert bench-marking process, also strongly support the validity of the content of D-RECT for use in Ireland.

A statistical approach, known as generalisability theory, was used to assess validity. This confirmed that D-RECT scores were generalisable from groups defined by specialty, postgraduate training body, training network/ area (site) and stage of training to the wider population within that group. The generalisability of scores in further sub-categories defined by combinations of these variables, for example postgraduate training body and stage of training, are less robust. In general, where a minimum of thirty respondents is achieved in each group, the generalisability score is more acceptable (g index >0.8) and it is possible to generalise from these groups with confidence. While it is possible to use D-RECT scores from smaller groups of respondents, a more cautious approach is required in generalising to the wider population within that group.

Construct validity was examined using a statistical technique called multiple group factor analysis. This demonstrated that D-RECT was measuring clinical learning environment in the same 11 domains described in the Dutch context. Ten thousand randomly generated alternative structures were compared with this 11 factor structure but no equivalent or better fitting structure was identified. Therefore, trainees in both countries understand the questionnaire similarly and respond in similar patterns. D-RECT is measuring a stable construct in both Ireland and the Netherlands. Therefore it is an instrument with good construct validity.

Summary

In summary, is D-RECT a good way to measure the clinical learning environment in Ireland? The content and constructs of D-RECT have good validity. The total scale and the majority of subscales are reliable. These findings mean that the total D-RECT score measures the target, clinical learning environment in the Irish context, with a high level of precision. Most of subscale scores also measure their targets, the distinct dimensions of the clinical learning environment, with acceptable precision. Some subscales do so with less precision than we would like, and caution is required in their interpretation. The small number of items in some of the subscales is an important contributor to this lack of precision. Generalising from respondent groups of at least 30 trainees, to the wider population of trainees, is valid. More detailed analysis, at subscale level and with smaller groups of respondents should be interpreted more cautiously. Overall, this makes D-RECT a useful way to examine the clinical learning environment in Ireland, especially when using total score from larger numbers of respondents. Care should be taken when interpreting results based on small groups of trainees, especially at subscale level.

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SECTION 3:

THE CLINICAL LEARNING ENVIRONMENT IN IRELAND 2014

SECTION 3: THE CLINICAL LEARNING ENVIRONMENT IN IRELAND 2014

3.1 Trainee views of the clinical learning environment

What did we find?

- Total D-RECT score provides a global, composite measure of trainee views of the clinical learning environment. D-RECT scores range from 50 to 250. A higher total D-RECT score indicates a more positive view of the clinical learning environment.
- The national mean total D-RECT score across all trainees in Ireland in 2014 was 170.8.
- There was very wide variation in trainee views of the clinical learning environment: 25% reported scores lower than 151.3 and 25% reported scores higher than 192.7.
- The mean total D-RECT score from experts who rated their expectations for the clinical learning environment (mean total D-RECT score 203.9) was almost 20% higher than trainee-rated experience.
- Trainee experience in 2014 was similar to experience reported in smaller study of Irish trainees in 2012 (mean total D-RECT score 173); it was less positive than the experience reported by Dutch trainees in 2010 (mean total D-RECT score 188).

What does this mean?

This is the first time that trainee views on the overall clinical learning environment have been comprehensively assessed in Ireland using a robust, valid and reliable instrument. These results provide an important and useful baseline against which future progress can be monitored and evaluated.

The total D-RECT score in this study is similar to the results of a smaller study conducted in Ireland using the same instrument which examined the views of trainees at one training body only (mean total D-RECT score in that study was 173).⁴³

The total D-RECT score among trainees in Ireland is, however, less than that measured among trainees in the Netherlands (mean total D-RECT score in that study was 188).³³

The difference between the trainee views and the expert expectations indicates that there is some scope to improve the clinical learning environment in Ireland so that trainee experience meets the ambition of leaders who plan, deliver and oversee postgraduate training in Ireland. This scope is also supported by the comparison of the mean total D-RECT score between trainees in Ireland and the Netherlands. Are the expert expectations overly ambitious and unrealistic? While an overly ambitious bias among experts cannot be ruled out, the processes and the response rate for the expert expectation survey provide good reassurance that the views are representative. We were careful to frame the expert expectation survey in a way that explained that views were sought on a “good”, but not necessarily ideal or perfect clinical learning environment. It is interesting and important to note that the total D-RECT score reported by experts in this study (203.9 (95% CI 195.0-212.7)) was similar to the expectations expressed by trainees in an expectation study conducted by Bennett et al. (193).⁴³

Overall, the single most important feature of the total D-RECT scores reported by trainees in Ireland is the wide variation in the scores (Figure 6). While many trainees rated their experiences close to the mean total D-RECT score, a quarter of trainees reported total D-RECT scores above 192.7 and a quarter reported scores below 157.3. This variation in the experience of trainees, all of whom are training in the same health system, points to an important and significant opportunity to develop and improve the clinical learning environment in Ireland to promote greater consistency in the quality of trainees' experience.

Trainee views of the clinical learning environment were assessed across the 50 questions that comprise the D-RECT instrument. The responses to individual questions can be reviewed at Appendix 5. Each trainee's responses were then used to calculate a total D-RECT score, which can range between 50 (minimum) and 250 (maximum). A higher total D-RECT score indicates a more positive view of the clinical learning environment.

The national mean total D-RECT score across all trainees in the study was 170.8 (95% CI 169.1-172.5). However, individual trainee views varied by a range of 189.0, from 61.0 (minimum) to 250.0 (maximum); 50% of trainees reported a total D-RECT score between 151.3 and 192.7, 25% reported scores lower than 151.3 and 25% reported scores higher than 192.7. This spread of scores indicates wide variation in trainee views of clinical learning environments in Ireland.

Expert expectations for the clinical learning environment in Ireland was measured and the mean total D-RECT score was 203.9 (95% CI 195.0-212.7). There was a 33.1 point difference between the trainee total D-RECT score and the expert score, which was large and statistically significant ($t(1466) = 6.57, p < 0.001$).

The mean total D-RECT score reported by trainees in *Your Training Counts* 2014 was similar to that reported in a smaller sample of trainees in Ireland (170.8 *Your Training Counts* 2014 versus 173 Bennett et al. 2012).⁴³ However, it is less than the mean total D-RECT score reported by trainees in the Netherlands (188; N=1251), which was measured in 2010 across 26 different specialties, at different levels of training, in 76 hospitals.³³

The frequency of trainee-reported total D-RECT scores is illustrated in Figure 5 and benchmarking is presented in Figure 6.

Figure 5: Summary of trainee views of the clinical learning environment

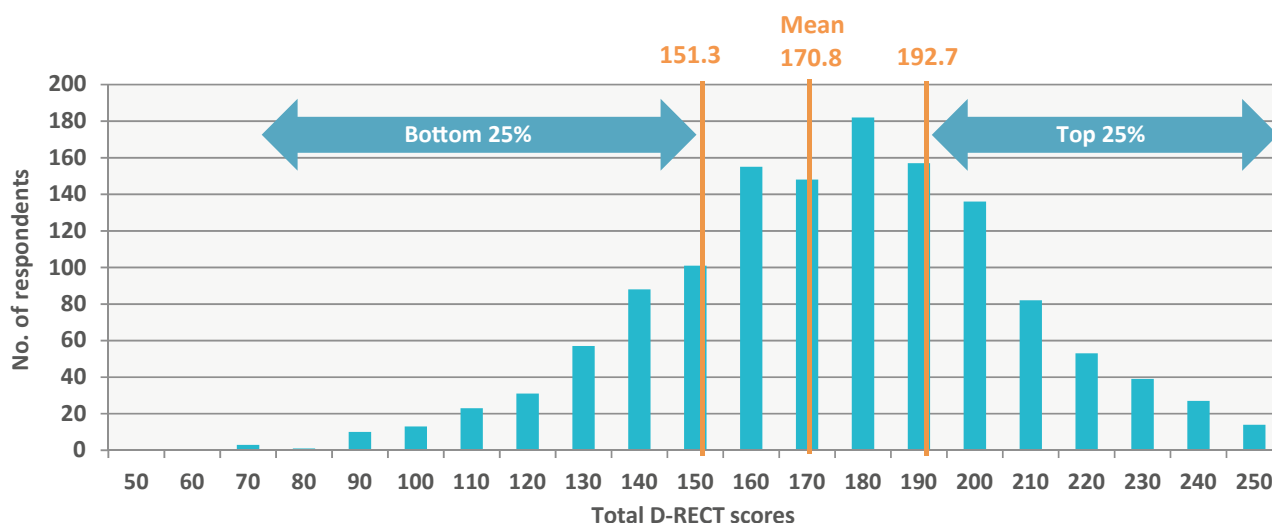
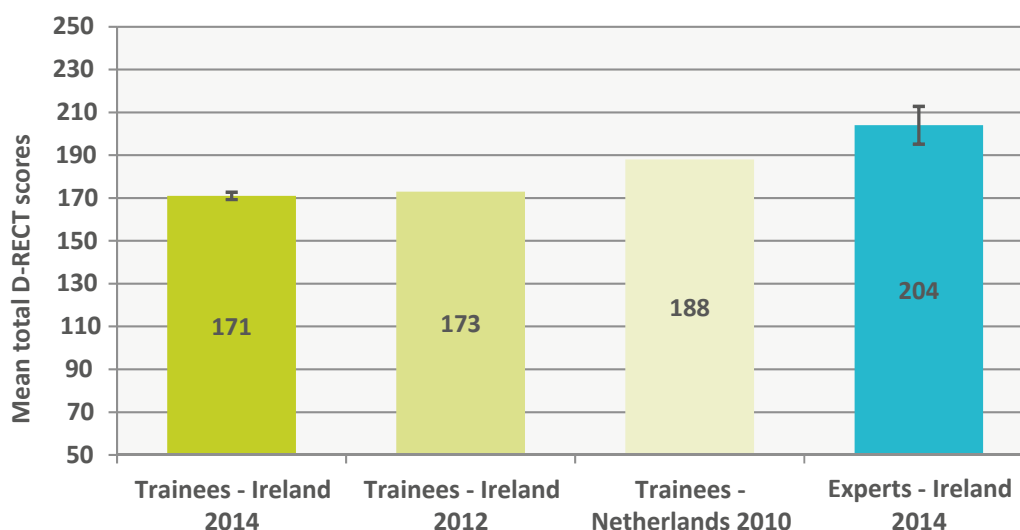


Figure 6: Benchmarking trainee views of the overall clinical learning environment



3.2 Trainee views of different clinical learning environment attributes

What did we find?

- The views of trainees point to strengths and weaknesses in different attributes of the clinical learning environment. In general, training rating of different attributes were lower than expert expectations.
- Overall, at national level, strengths of the clinical learning environment included “Consultants’ role”, “Teamwork” and “Peer collaboration”; weaknesses included “Feedback”, “Professional relations between consultants” and “Role of the educational supervisor”.

What does this mean?

The clinical learning environment is a complex and rich entity which supports trainees experience of learning and achievement of learning outcomes in a number of different and interlinked ways. This report provides the first assessment of the relative strengths and weaknesses of the clinical learning environment in Ireland from the perspective of trainees.

Experiences of peer collaboration and teamwork were rated positively by trainees. This is important, given the team-based competencies necessary for good professional practice among doctors. While a knowledge base can be taught, these competencies must be developed through workplace-based learning. It is clear that trainees value the opportunities for collaboration and teamwork provided in the clinical learning environment.

The consultant role was also regarded positively by trainees. While the term “consultant” was used in the survey, information to trainees reminded them that this terms also applied to GPs and other clinical teachers. This is an important finding since most learning in the workplace is informal and the role of consultants, GPs and other clinical teachers is key to the learning experience of trainees. Balancing service commitments with clinical teaching can be difficult for consultants, GPs and other clinical teachers. However, not all of the factors that make for a good experience, from the trainee perspective, of a consultant or GP as a clinical teacher are dependent on available time and many are attitudinal. It is noteworthy that the key strengths in the clinical learning environment identified in *Your Training Counts* 2014 are similar to those identified by Bennett et al in a more limited study of trainees in Ireland in 2012.¹¹

Your Training Counts also identifies some critical areas for focus emerging from the views of trainees who took part in the study.

Trainees' views on their experience of feedback are concerning. Put simply, safe and effective clinical learning cannot take place without feedback;⁹ and providing feedback is a critical competency for clinical teachers.⁴⁸ At a practical level, capacity and capability for feedback needs to be built into the clinical learning environment. This involves faculty development for clinical teachers and provision of supports for assessment of trainees in the workplace. However, at a broader level, this change needs to be supported by a culture shift, which places a higher value on objective assessment of trainees' clinical performance and providing feedback to trainees about their performance.

While trainees generally identified their individual consultant or GP as a positive role model, they were less positive about professional relations between consultants. This finding is also concerning, and in some way is contrary to the findings regarding teamwork and peer collaboration, which were positively regarded by trainees. However, the components of this attribute are quite specific and relate to interactions observed by trainees between consultants and GPs. This is, however, an important finding given that consultants, GPs and other clinical teachers act as key role models for trainees. While it is positive that trainees can reflect on their experience and identify it as not meeting their expectations, the processes of workplace learning mean that this aspect of medical culture may be reproduced in the future by trainees unless it is disrupted.⁴⁹

Trainees were also less positive regarding the role of educational supervisor than they were regarding other attributes of the clinical learning environment. In conjunction with the finding on feedback, trainee views regarding this attribute of the clinical learning environment point to a significant and important opportunity to ensure – between the organisations designing training programmes and the organisations delivering these on the ground in day-to-day clinical practice – basic educational capacity and capability is in place to support trainees in navigating the clinical site so that they can achieve a satisfactory learning experience.

Finally, the findings regarding patient handover and adaptation of work to trainee competence warrant focus, given that these attributes closely relate to the overall governance of patient safety and healthcare quality at clinical sites. A number of high-profile failings of care, well described in the health system in Ireland, have pointed to the need to address deficits in patient handover and clinical supervision.⁵⁰ Again, this finding highlights the need for better management of the clinical environment as a place of learning for trainees, with the effective human resource management of the health workforce generally and robust governance of the safety and quality of clinical care.

3.2.1 Strengths and weaknesses of clinical learning environment attributes

The D-RECT instrument enables trainee views of the overall clinical learning environment to be examined across 11 thematic areas or attributes. The questions corresponding to each of these component attributes can be reviewed in Appendix 3. Attribute scores can range from 1 (minimum) to 5 (maximum) and higher attribute scores indicate a more positive view on that component of the clinical learning environment.

Table 2 presents mean attribute scores across the 11 components of the clinical learning environment assessed by the D-RECT instrument. Trainee mean scores are compared with expert mean scores.

Table 2: Mean attribute scores for 11 components of the clinical learning environment, including benchmarks

Attribute	Trainee mean score Ireland 2014	Expert mean score Ireland 2014	Difference* (95% CI)	Trainee mean score Netherlands 2010	Difference**
1. Peer collaboration	3.9	4	-0.1 (-0.4 - 0.1)	4.3	-0.4
2. Consultants' role***	3.8	4.2	-0.4 (-0.7 - -0.2)	4.0	-0.2
3. Teamwork	3.8	3.9	-0.1 (-0.3 - 0.1)	3.6	0.2
4. Coaching and assessment	3.7	4.1	-0.4 (-0.7 - -0.3)	3.3	0.4
5. Supervision	3.6	4	-0.4 (-0.7 - -0.1)	4.0	-0.4
6. Formal education	3.5	4.2	-0.7 (-1.0 - -0.5)	3.7	-0.2
7. Work adapted to trainees' competence	3.4	4.1	-0.7 (-0.9 - -0.4)	3.8	-0.4
8. Role of the educational supervisor	3.3	4.1	-0.8 (-1.0 - -0.6)	3.9	-0.6
9. Patient handover	3.3	3.9	-0.6 (-0.9 - -0.4)	3.9	-0.6
10. Professional relations between consultants	3.2	4	-0.8 (-1.0 - -0.5)	3.6	-0.4
11. Feedback	2.6	3.9	-1.3 (-1.6 - -0.9)	3.5	-0.9

* Trainee mean score Ireland 2014 minus expert mean score Ireland 2014: a negative difference means expert score was significantly greater than trainee score

** Trainee mean score Ireland 2014 minus trainee mean score Netherlands 2010: a negative difference means trainee score in Netherlands was greater than trainee score in Ireland

*** Consultant also refers to GPs and other clinical teachers

There is variation in trainee views across the attributes. The mean attribute scores identify a number of strengths in the clinical learning environment (including peer collaboration, consultants' role and teamwork) and they identify weaknesses (including feedback, professional relations between consultants, role of the educational supervisor, patient handover and work being adapted to the residents' competence). In general, expert expectations are similar across the different core attributes of the clinical learning environment. Comparing the views of trainees and experts, trainee experience falls significantly short of expert expectation across a number of critical attributes. Trainee views in Ireland across different core attributes of the clinical learning environment were also poorer than those of their counterparts in the Netherlands, with the exception of teamwork and coaching and assessment, which were viewed more positively by trainees in Ireland.

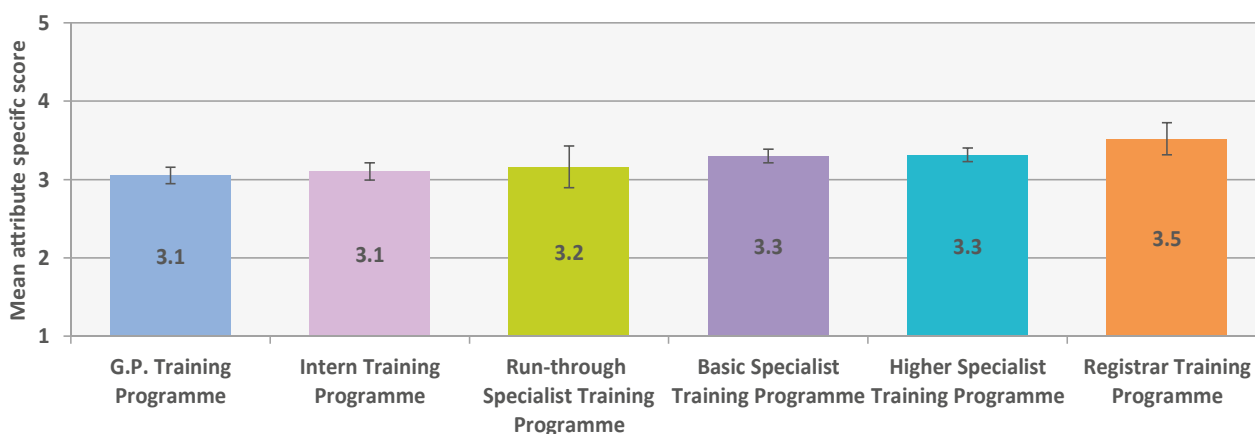
3.2.2 Variations in trainee views of different clinical learning environment attributes

Variation in trainee views on the attributes of the clinical learning environment was explored by stage of training. Across a number of the attributes, including supervision, feedback, coaching and assessment, teamwork, work adapted to trainee's competence and consultant role, interns reported lower scores compared with trainees at other stages of training. See Figure 7 as an example of how trainee views varied across stage of training for Feedback, the attribute of the clinical learning environment which had the lowest score across all trainees. However, the picture was mixed and for some attributes there was no significance difference in trainee views across stage of training, see for example Figure 8. Details of variation in trainee views on each clinical learning environment attribute by stage of training are presented in Appendix 5.

Figure 7: Trainee views of "Feedback" as an attribute of the clinical learning environment, by stage of training



Figure 8: Trainee views on "Professional Relations Between Consultants" as an attribute of the clinical learning environment, by stage of training



3.3 Variations in trainee views on the clinical learning environment

What did we find?

- Male and female trainees had similar views of the overall clinical learning environment, but trainee views varied by other trainee-related characteristics.
- Younger trainees generally reported poorer views of the clinical learning environment.
- Trainees who were graduate-entry medical students also reported poorer views of the clinical learning environment than trainees who were direct-entry medical students; this difference was not related to age differences among younger trainees, but among older trainees there was no difference in views of the clinical learning environment by route of entry to medical school.
- Compared with internationally qualified trainees, Irish qualified trainees reported poorer views of the clinical learning environment.
- Interns reported poorer views of the clinical learning environment than trainees at all other stages of training. The poorer views of interns does not relate to their younger age, since interns of different ages had similar views.
- There was very wide variation in views of the clinical learning environment across specific sites (25% of sites had total D-RECT scores less than 167.0 and 25% had scores greater than 194.3).
- Size of clinical site did not affect trainee views of the clinical learning environment; however, type of site was relevant: in general, trainees had more positive views of the clinical learning environment at mental health services (mean total D-RECT score 190.9) and GP practices (mean total D-RECT score 183.4) than at hospitals (mean total D-RECT score 166.2 for smaller hospitals and 167.8 for larger hospitals).

What does this mean?

Some variation in trainee views on the clinical learning environment in Ireland might reasonably be expected; however, the large, systematic and significant variations in views point to a need to better plan, manage and monitor the clinical learning environment experienced by trainees.

Stage of training was an important trainee-related factor affecting views of the clinical learning environment. The findings regarding stage of training are similar to those reported by Bennett et al. in a small study in 2012.¹¹ This study found that training at earlier stage of trainees reported poorer views of the clinical learning environment than those at later stages. The large, systematic and significant difference in clinical learning climate by stage of training points to a need to better align the clinical learning environment with learner needs and expectations. The issue is not subtle or individualised; it relates to differences in large cohorts of trainees which are easily identifiable from a policy and practice perspective. It is both feasible and necessary to address the gaps in trainee views by stage of training through better design, management and monitoring of the clinical learning environment and through responding to the learning needs of different groups of trainees. The misalignment between learner needs, learner expectations and the learning environment has implications for the quality of learning experience and outcomes; while these are not reported in this study, trainee views on other aspects of learning experience have been collected through *Your Training Counts* and their relationship with the clinical learning climate will be reported in 2015. The relationship between climate and learning outcomes is well-established;^{52, 53} the case for targeting climate to safeguard and improve the quality of learning outcomes is also strong and clear.^{52, 53} As *Your Training Counts* continues, it will be possible to contribute to the evidence base linking clinical learning environment with learning outcomes for doctors.

Age is a trainee-related characteristic that relates to views on the clinical learning environment. It is critical to note that the finding in *Your Training Counts* 2014 regarding poorer views of interns in relation to the clinical learning environment is not explained by age difference. Age-related variation was observed at other stages of training. These differences may relate to trainee expectations and their expertise in navigating the clinical environment to ensure a good learning experience.

Given the policy trend towards expansion of graduate-entry medical education in Ireland, the findings of differences in trainee views of the clinical learning environment by route of entry to medical school are important and need to be monitored to ascertain if this is a certain trend. It is important to note that trainee age does not fully explain these differences. The finding of more positive views of the clinical learning environment among international medical graduates versus their Irish qualified counterparts is interesting and may point to differences in expectations.

Trainee views of the clinical learning environment across individual clinical sites varied widely; in short, some sites were viewed as better places to learn by trainees than others. The scale of variation points to an urgent need to bring consistency to the planning, management and monitoring of clinical sites as clinical learning environments at a postgraduate level so that trainees have a more reliable experience. The quality-governance agenda necessary to support this change begins at the site of the individual clinical site. Education and training of doctors needs to be a board and management level priority. The case for this is wider than the objective of improved educational experience for trainees. Improving the quality of education and training processes will also encompass broader human resource and service delivery agendas that will benefit staff and patients generally.²⁷ The agenda of quality governance of the clinical learning environment must take account of the re-organisation of health system structures, especially the establishment of hospital groups and the re-distribution of clinical services.⁵⁴ Clinical sites should use information on trainee views of the clinical learning environment to manage the quality of training delivery; for newly established hospital groups, D-RECT scores should be a board-level indicator to assure satisfactory performance as part of the overall educational governance framework.²⁶

Ultimately, in the same way as there is now recognition in Ireland that every clinical site may not be fit to deliver every clinical service, the question of whether every clinical site should be a clinical learning environment at every stage of training needs to be addressed.

The quality-governance agenda also involves the bodies that oversee intern and postgraduate training. These bodies need to ensure that the curricula that they design are being effectively and consistently implemented across clinical sites. Postgraduate training bodies in Ireland have a long tradition, experience and expertise in reviewing clinical sites from a training-quality perspective, and this mechanism needs to continue. This report highlights some variation in trainee views across different specialty groups and postgraduate bodies, pointing to some opportunities to share good practices.

Finally, from a national perspective, there is a role for the Medical Council of Ireland. This role is specified in the Medical Practitioners Act 2007, which underpins the role of the Medical Council, and is being given effect under the current Statement of Strategy for the organisation. Criteria for intern training sites have been in place since 2010 and criteria for clinical sites that support postgraduate training have been recently published.^{28, 29} From 2015, a robust and comprehensive programme of clinical site inspection will commence, which will be informed by the findings of *Your Training Counts*.

While these individual “layers” of the quality governance agenda need to be individually strong and effective, communication, coordination and appropriate collaboration is required for the quality of the clinical learning environment in Ireland to become more consistent and enhance in Ireland. Finally, efforts to quality enhance and ensure the quality of the clinical learning environment must be complemented by, and happen in the context of, organisational governance with regarding to fit-for-purpose healthcare workforce and basic good human resource management practices.

3.3.1 Exploring variations

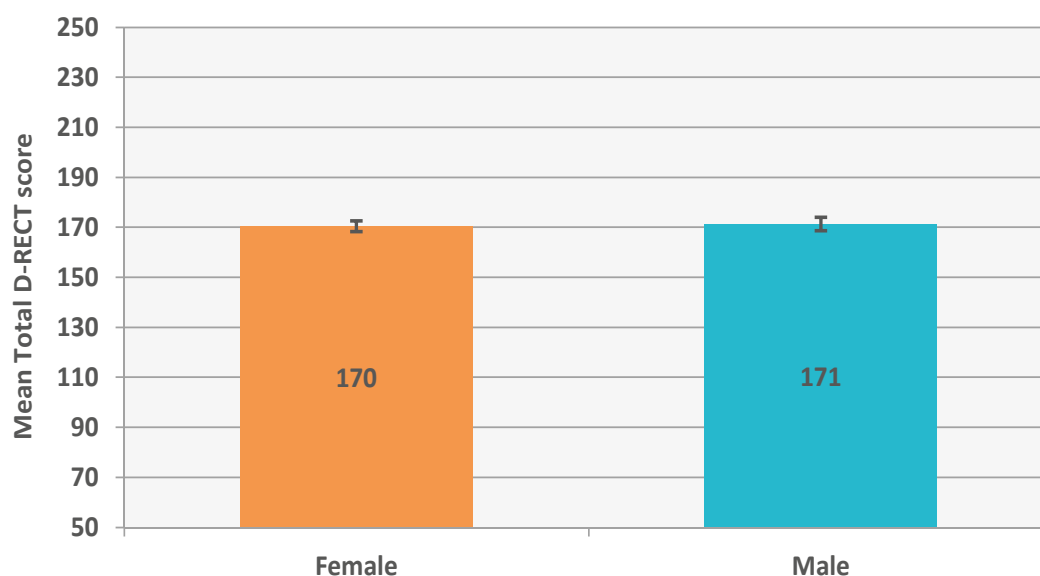
The issue of wide variation in trainee views of the clinical learning environment in Ireland was explored by examining differences in total D-RECT score across trainee-related characteristics and across environment-related characteristics.

3.3.2 Variations and trainee-related characteristics

Did views vary by gender?

The mean total D-RECT score for female trainees was 170.4 (95% CI 168.2-172.6) and for male trainees was 171.3 (95% CI 168.6-174.1); there was no significant difference between these groups ($t(1169)=0.521$, $p > 0.05$). This is illustrated in Figure 9.

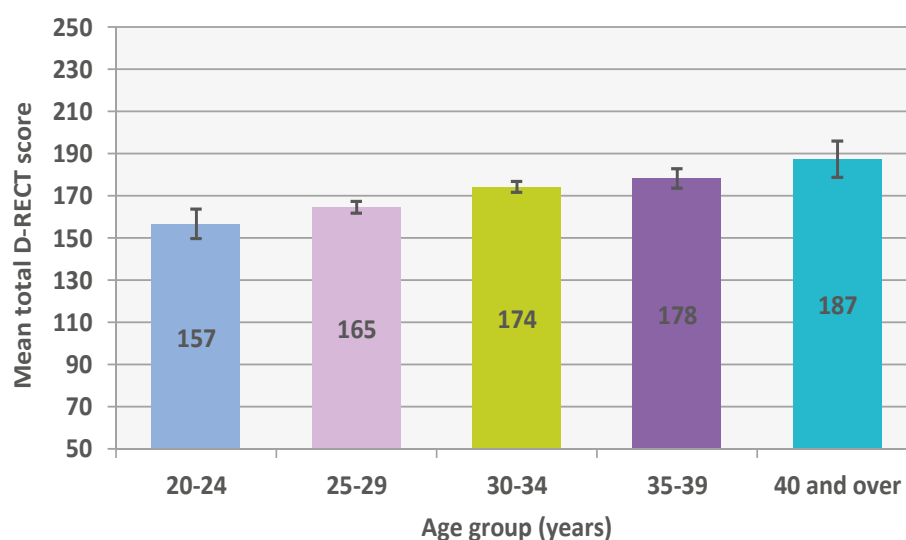
Figure 9: Trainee views of the overall clinical learning environment, by gender



Did views vary by age?

The mean total D-RECT score increased with increasing trainee age ($r(1319) = .225$, $p < 0.001$). Across age groups, trainees in the youngest age group (20-24 years) had the lowest mean total D-RECT score (156.7 (95%CI 149.8-163.6)) while those in the older age group (40 years and older) had the highest D-RECT score (187.2 (95% CI 178.7-195.8)). Total D-RECT scores from trainees in their 20s were significantly lower than those from any other age category ($F(4,1314) = 17.87$, $p < 0.001$). This is illustrated in Figure 10.

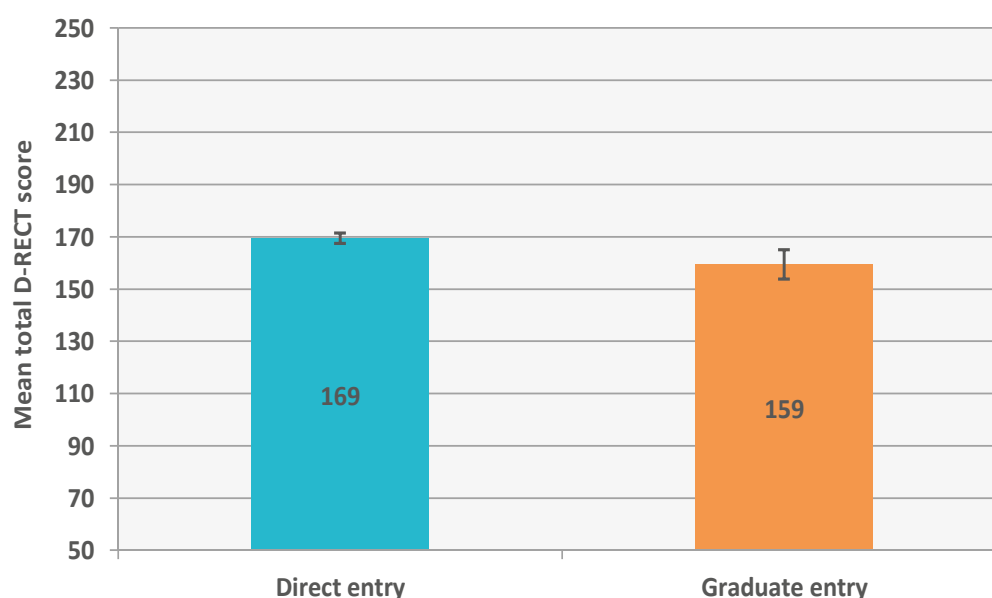
Figure 10: Trainee views of the overall clinical learning environment, by age group



Did views vary by medical school entry route?

The mean total D-RECT score for trainees who were direct-entry medical students was 169.4 (95% CI 167.4-171.4), and was higher than for trainees who were graduate-entry medical students (159.4 (95% CI 153.9-165.0)); there was a significant difference between these groups ($t(189) = 3.63$, $p = 0.001$). This is illustrated in Figure 11.

Figure 11: Trainee views of the overall clinical learning environment, by medical school entry route

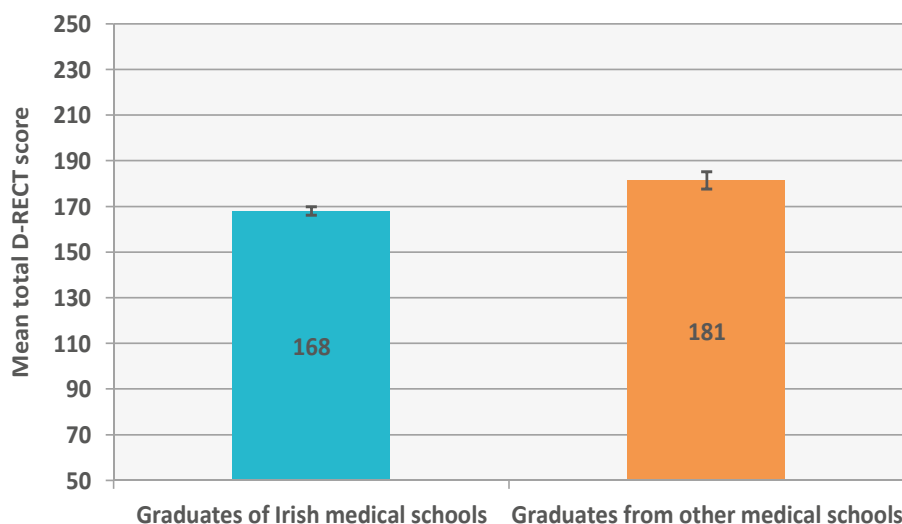


To explore whether the differences in total D-RECT scores by route of entry to medical school was, in fact, due to age differences between these groups, a stratified analysis was conducted. Lower D-RECT scores were observed among trainees who were graduate entry medical students in the 25-29 year age group and the 30-34 year age group, and these differences were significant ($t(473) = 3.25$, $p < 0.001$ and $t(76.56) = 3.19$, $p = .002$ respectively); the difference was attenuated in older age groups and was not significant.

Did views vary by country of qualification?

The mean total D-RECT score for trainees who qualified in Ireland was 168.0 (95% CI 166.1-169.9), and was lower than for trainees who qualified outside Ireland (181.4 (95% CI 177.6-185.2)); there was a significant difference between these groups ($t(189) = 3.63$, $p = 0.001$). This is illustrated in Figure 12.

Figure 12: Trainee views of the overall clinical learning environment, by country of qualification

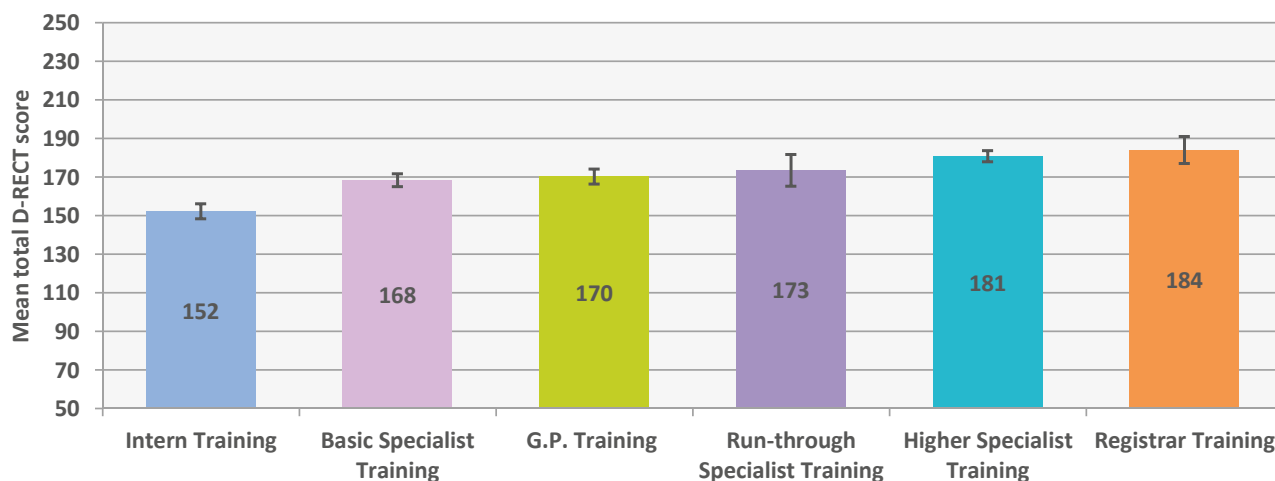


To explore whether the differences in total D-RECT scores by country of qualification was, in fact, due to age differences between these groups, a stratified analysis was conducted. Lower D-RECT scores were observed among graduates of Irish medical schools, however, this relationship was only significant in the 25-29 year age group and the 35-39 year age group ($t(514) = 2.36$, $p = .019$ and $t(198) = 2.34$, $p = 0.021$).

Did views vary by stage of training?

The mean total D-RECT score differed depending on the trainee's stage of training, with those trainees at the earliest stage of training, intern training, reporting lower total D-RECT scores compared with other trainees (152.3 (95% CI 148.3-156.3)); this difference was significant ($F(5,1311)=27.06$, $p < 0.001$)). This is illustrated in Figure 13.

Figure 13: Trainee views of the overall clinical learning environment, by stage of training



Stage of training is generally related to trainee age. To examine how age and stage of training related to trainee experience, stratified analysis was used. In each age group, trainees in intern training reported lower D-RECT scores than trainees in other stages of training and these differences were significant; among interns, age group was not significantly associated with D-RECT score.

3.3.3 Variations and environment-related characteristics

Did views vary by clinical site?

Each trainee provided information on the clinical site at which they were training and to which they related their responses in *Your Training Counts*. We examined the relationship between trainee views on the clinical learning environment and clinical sites in a number of different ways.

In total, responses were received from trainees at 81 different clinical sites. Site-specific mean total D-RECT scores ranged from 119.0 to 246.0. In total, 25% of sites had total D-RECT scores less than 167.0 and 25% had scores greater than 194.3. This wide variation is illustrated in Figure 14. As would be expected, wider variation was observed among clinical sites with small numbers of respondents. However, there was still some variation at sites with greater numbers of respondents (30 or more trainees providing views), as illustrated in Figure 15; the variation was significant ($F(10,748) = 2.25$, $p = 0.014$).

Figure 14: Trainee view of the clinical learning environment, by clinical site

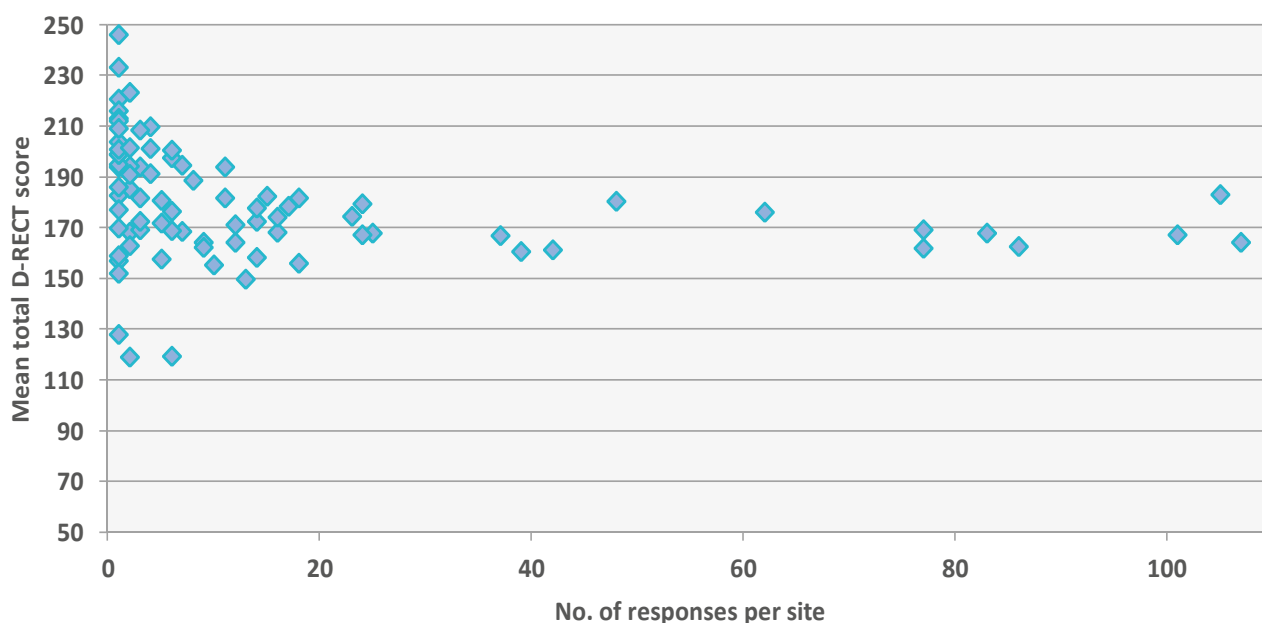
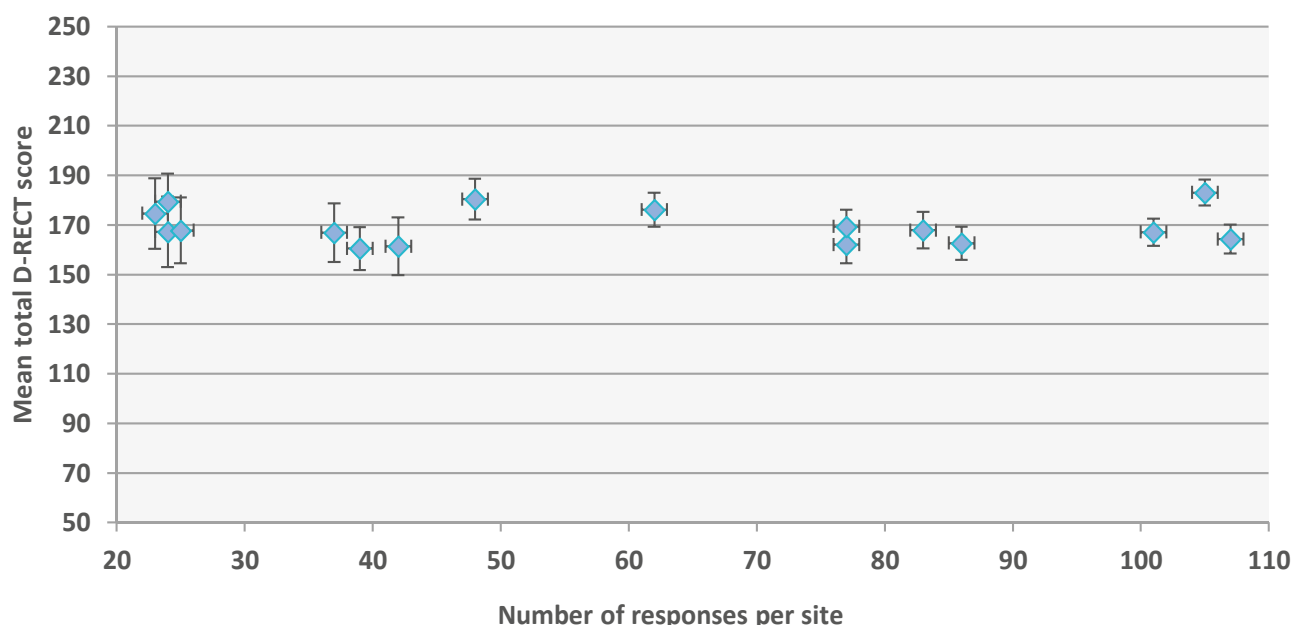


Figure 15: Trainee view of the clinical learning environment, by clinical site (larger sites only)



The relationship between mean total D-RECT score per site and number of respondents per site was examined; there was no significant correlation ($r(82) = -.087$, $p = 0.436$).

To explore whether the trainee view of the clinical learning environment varied across clinical site type, sites were categorised as small hospital, larger hospital, mental health service or GP practice (larger hospitals were defined as those with an annual budget >€100m or a stand-alone single specialty hospital as defined in the report “The Establishment of Hospital Groups as a transition to Independent Hospital Trusts”).* The mean total D-RECT score of clinical learning environments categorised by clinical site type is shown in Figure 16. Trainees in larger hospitals (167.8) and smaller hospitals (166.2) had lower mean D-RECT scores than trainees in GP practices (183.4) and in mental health services (190.9); the variation across clinical site type was significant ($F(3,1299) = 23.9$, $p < 0.001$) and remained significant for specialist trainees only ($F(3,1087) = 15.1$, $p < 0.001$).

Trainee views of the clinical learning environment by hospital group arrangement (hospital groups were constructed based on the name of the clinical site and taking account of a hospital group configuration defined in the report “The Establishment of Hospital Groups as a transition to Independent Hospital Trusts”) is shown in Figure 17.* While there was variation, differences in mean total D-RECT scores were not significantly different between hospital groups ($F(5,1021) = 1.51$, $p = 0.184$).

* Department of Health (2014). The Establishment of Hospital Groups as a transition to Independent Hospital Trusts - A report to the Minister for Health, Dr James Reilly, TD. <http://health.gov.ie/wp-content/uploads/2014/03/IndHospTrusts.pdf>

Figure 16: Trainee view of the clinical learning environment, by clinical site type

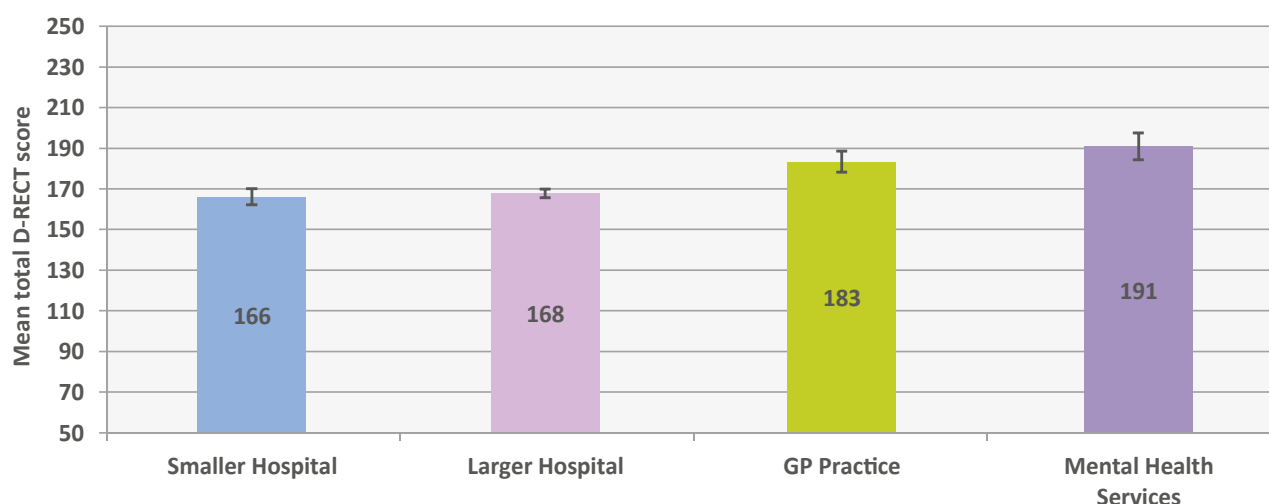
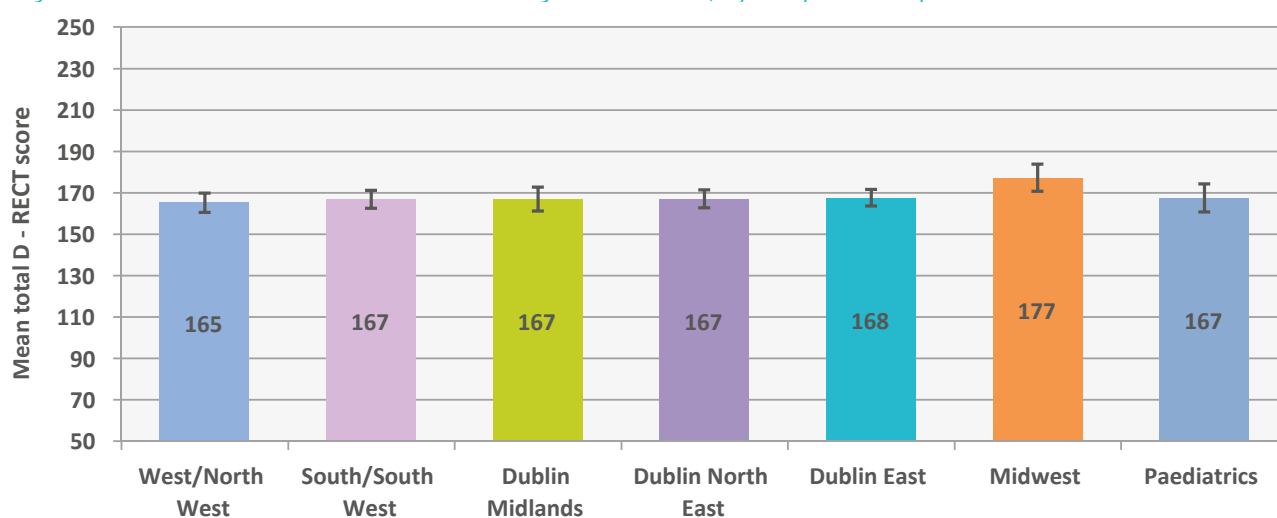


Figure 17: Trainee view of the clinical learning environment, by Hospital Group



Did views vary by body overseeing training?

Postgraduate training in Ireland is overseen by different bodies. Intern training is overseen by six geographically based intern training networks, each of which is associated with a medical school. Specialist training is overseen by postgraduate training bodies. Appendix 2 shows the relationship between different postgraduate training bodies and specialities. The structure of GP training is also worth noting. It is overseen by the Irish College of General Practitioners and takes place between hospitals, mental health services and GP practices.

The variation in intern views of the overall clinical learning environment according to overseeing intern training network was examined. While there were some differences between the intern training networks, the differences were not significant ($F(5,202) = .796, p = 0.554$). For all other trainees, the variation in their views of the clinical learning environment was also examined. Some bodies had smaller numbers of respondents (less than 30) making the measurement of mean total D-RECT score less precise for these bodies, so they were omitted from analysis. Across postgraduate training bodies, the College of Psychiatry in Ireland had a higher than average mean total D-RECT score (192.9); this difference was significant ($F(4,1024) = 9.65, p < 0.001$).

Did views vary by specialty?

Trainees were asked to identify the clinical specialty of the post in which they were training. Table 3 shows the variation in total D-RECT score by specialty block (a useful broad categorisation used by the Medical Council (Appendix 2)). There was significant variation in trainee views of the clinical learning environment across the different specialty blocks ($F(11,1087) = 7.39, p < 0.001$).

Table 3: Trainee views of the overall clinical learning environment, by specialty of current post

Specialty block	N	Mean total D-RECT score (95% CI)
Anaesthesia	114	176.8 (171.7-181.9)
Emergency medicine	60	165.2 (156.8-173.5)
General practice	112	180.8 (175.2-186.3)
Medicine	411	165.4 (162.4-186.5)
Obstetrics & gynaecology	74	163.0 (155.6-170.3)
Ophthalmology	14	171.5 (159.1-184.0)
Paediatrics	109	168.3 (162.8-173.7)
Pathology	29	177.0 (165.1-188.9)
Psychiatry	111	192.3 (186.8-197.8)
Radiology	40	188.9 (179.4-198.3)
Surgery	223	163.1 (158.6-167.5)

3.4 Trainee views of induction to the clinical environment

What did we find?

- While most trainees reported a positive overall experience of induction and orientation to the clinical environment as a place to work and learn, many trainees identified deficiencies in core areas: discussing educational objectives with their educational supervisor (absent for 43.5% of trainees), receiving basic information about the workplace (absent for 35.3% of trainees) and explanation of their role and responsibilities (absent for 28.9% of trainees).
- An experience of good induction to the clinical site, for example through discussing educational objectives with an educational supervisor, was associated with trainees having a better view of the overall clinical learning environment.
- The views of trainees in Ireland on induction and orientation were poorer than the views of their UK counterparts; for example, 9-in-10 trainees in the UK reported having discussed educational objectives with an educational supervisor, compared with 5-in-10 trainees in Ireland.
- In general, trainees at intern and basic specialist training stages reported poorer experiences of induction and orientation to the clinical site as a place to work and learn; for example, 7-in-10 higher specialist trainees and registrar trainees rated induction as at least good, compared 5-in-10 intern and basic specialist trainees.
- Trainee-reported experience of induction and orientation was poorer at hospitals than at GP practices and at mental health services: for example, 7-in-10 trainees at mental health sites rated induction as at least good, compared with 5-in-10 trainees at smaller hospitals.

What does this mean?

Postgraduate training is workplace-based. This means that, for trainees, the clinical site is both a place of learning and a place of work. It is fundamental for every trainee – in their dual and equally important roles as learner and worker at a clinical site – that they experience comprehensive and effective induction and orientation. Each role needs to be addressed through formal, structured induction so as to support trainees to fulfil their potential both in terms of achieving defined learning outcomes and in contributing to safe, good quality patient care.

The gaps and weaknesses in trainee induction and orientation identified in this study underscore an urgent need to better support trainees as learners and workers at clinical sites. This need is highlighted by the difference in experience of trainees in Ireland versus their UK counterparts. The much higher UK ratings suggest that it is possible to achieve greater trainee satisfaction with induction and orientation processes. The systematic variation in trainee-reported experience of induction is especially concerning; those at earliest stages of learning and practising in the clinical workplace were least likely to report experience of induction and orientation across key domains. This is, in effect, an example of inverse care, since those with arguably the greatest need for induction and orientation appear least likely to receive it. In the case of interns, this is especially important, given some of the issues regarding perceptions of preparedness highlighted elsewhere in the report. There was also systematic variation in induction and orientation by type of clinical site, with trainees reporting poorest experiences at hospitals. The nationally integrated delivery of acute hospital services through the HSE offers an opportunity to implement national-level solutions to the variation in trainee experience of induction and orientation in the hospital setting.

What do these gaps and weaknesses in induction and orientation mean in practice? *Your Training Counts* is a survey and it is difficult to establish direct cause-effect type relationships from the findings. However, it is noteworthy that experience of discussing educational objectives with an educational supervisor was associated with a more positive trainee view of the overall clinical learning environment. It could be the case that these attributes are linked – good educational environments may also be places that ensure robust and effective induction and orientation. However, effective orientation of the trainee to the clinical site as a learning environment may enable the trainee to better understand what to expect and to better navigate the clinical environment to secure a positive learning experience.

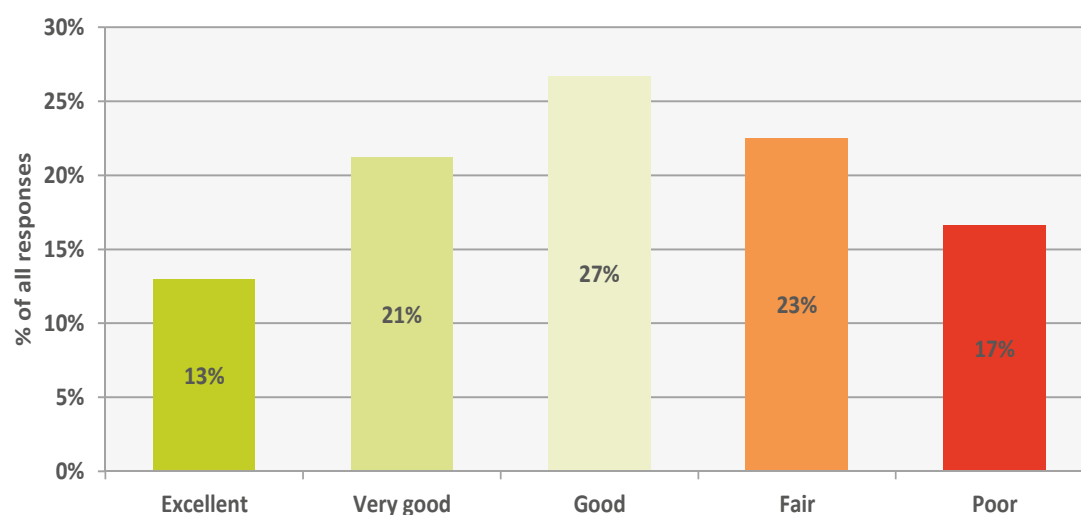
Do gaps and weaknesses in trainee induction and orientation create challenges for patient safety and quality of care? Trainee perceptions of quality of care will be discussed later in this report. However, the importance of induction and orientation for any healthcare professional new to a clinical environment cannot be overstated, as they are essential elements of the healthcare governance framework to safeguard patients.²⁷ Doctors in training can and do provide good care to patients.⁵⁵ However, a body of literature points to vulnerabilities in service delivery that can arise during periods of clinical staff changeover. This underlines the importance of induction and orientation in managing potential risk.^{56, 57}

3.4.1 Induction and its components

By the nature of their training, trainees rotate between clinical environments. Induction of new staff is a core competency for any healthcare organisation in delivering safe, high-quality care. For trainees, this induction needs to orientate them to the clinical environment as a place of work as well as a place to learn, so should include discussion of educational objectives with the clinician who will supervise their learning.

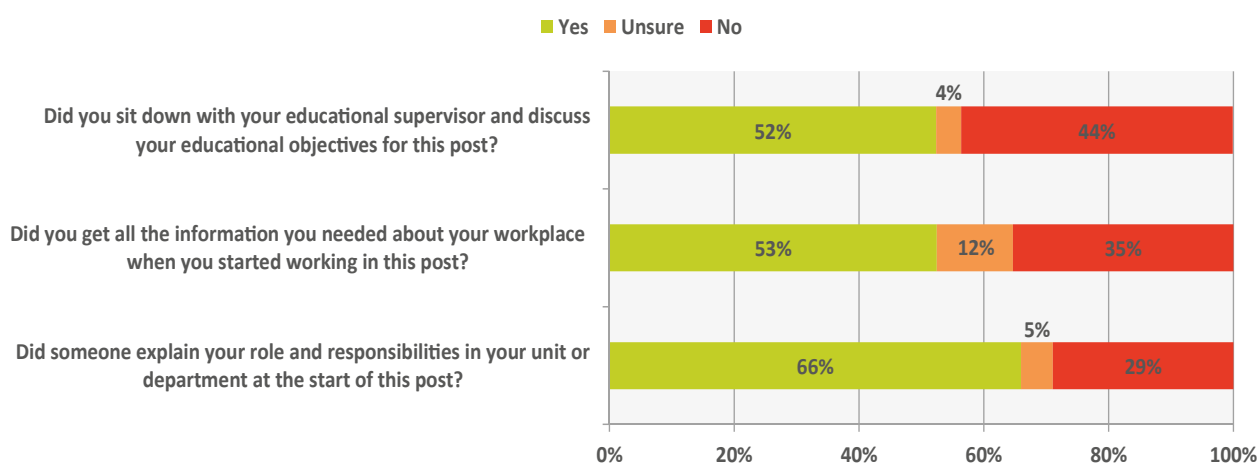
The view of trainees on the overall quality of induction is illustrated in Figure 18. While 60.9% of trainees viewed the overall quality of induction as good, very good or excellent, 16.6% of trainees rated the quality of induction as poor.

Figure 18: Trainee views of the overall quality of induction to the clinical environment



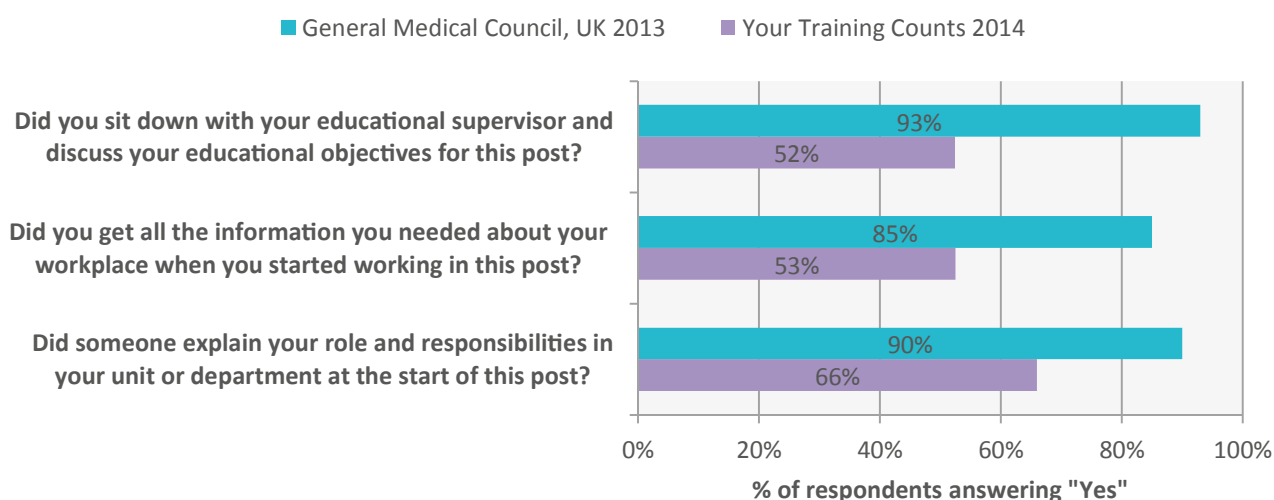
Trainee views on specific aspects of induction to the clinical learning environment were assessed and are illustrated in Figure 19. Many trainees reported gaps in core aspects of induction to the clinical site as both a workplace and as a place for learning; 43.5% did not discuss educational objectives with their supervisor; 35.3% did not receive sufficient workplace-related information; and 28.9% did not have their role and responsibilities explained.

Figure 19: Trainee views of specific aspects of induction to the clinical environment



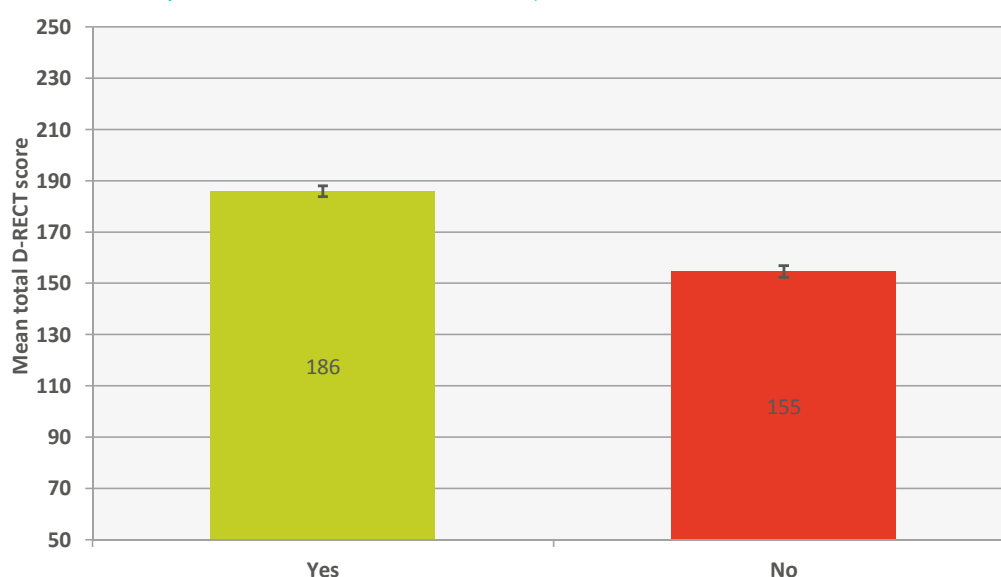
The experience of trainees in Ireland of specific aspects of induction was compared with recent data from UK trainees collected by the General Medical Council using identical questions. The results are shown in Figure 20. Across all aspects of induction, trainees in the UK reported more positive experiences than trainees in Ireland.

Figure 20: Trainee views of specific aspects of induction to the clinical environment, trainees in Ireland and UK



The relationship between trainees' experience of educational objective discussion with their educational supervisor and their view of the overall clinical learning environment was explored. Trainees who reported educational objective discussion with their educational supervisor reported high total D-RECT scores (mean 185.6) than those who did not (154.6); this was a large and significant difference in trainee view of the clinical learning environment (Figure 21, $t(1248) = 19.61$, $p < 0.001$).

Figure 21: Trainee views of the clinical learning environment, comparison by reported experience of discussing educational objectives with an educational supervisor



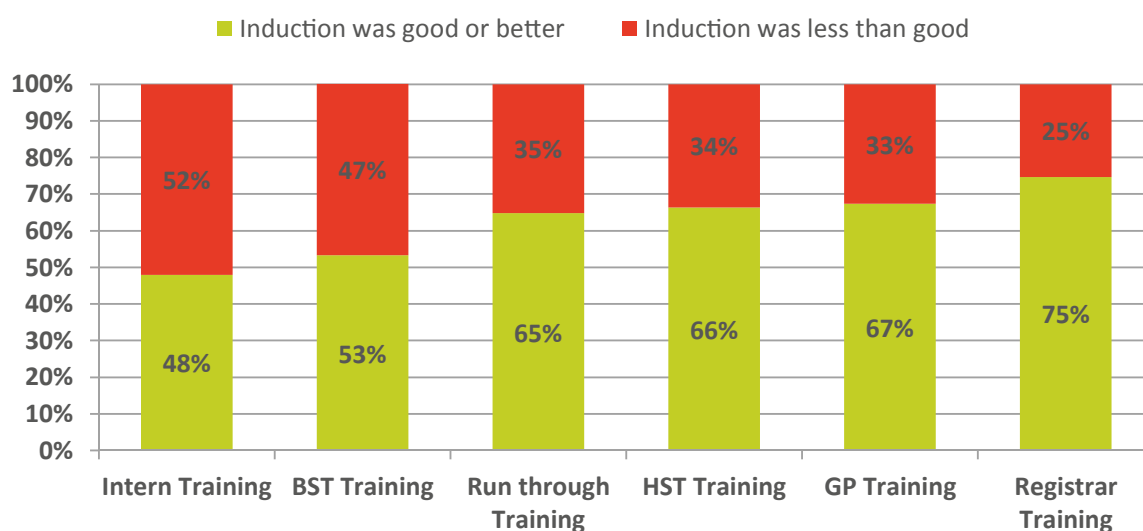
3.4.2 Variations in trainee views of induction to the clinical environment

Variation in trainee views on induction at the clinical learning environment was explored by stage of training and by type of clinical site.

Did views vary by stage of training?

The view of trainees on the overall quality of induction to the clinical learning environment by stage of training is shown in Figure 22. Intern (48%) and basic specialist trainees (53%) rated their experience of induction as 'good or better' less commonly than trainees at other stages of training; this variation was significant ($\chi^2(5, N = 1551) = 45.15, p < 0.001$).

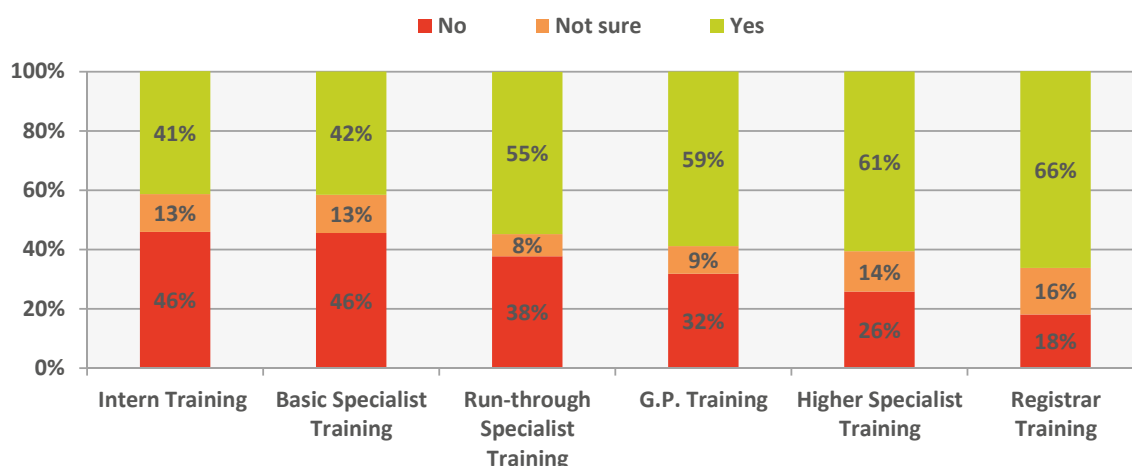
Figure 22: Trainee views of the overall quality of induction to the clinical environment, by stage of training



There was also significant variation in trainee view by stage of training for individual aspects of induction.

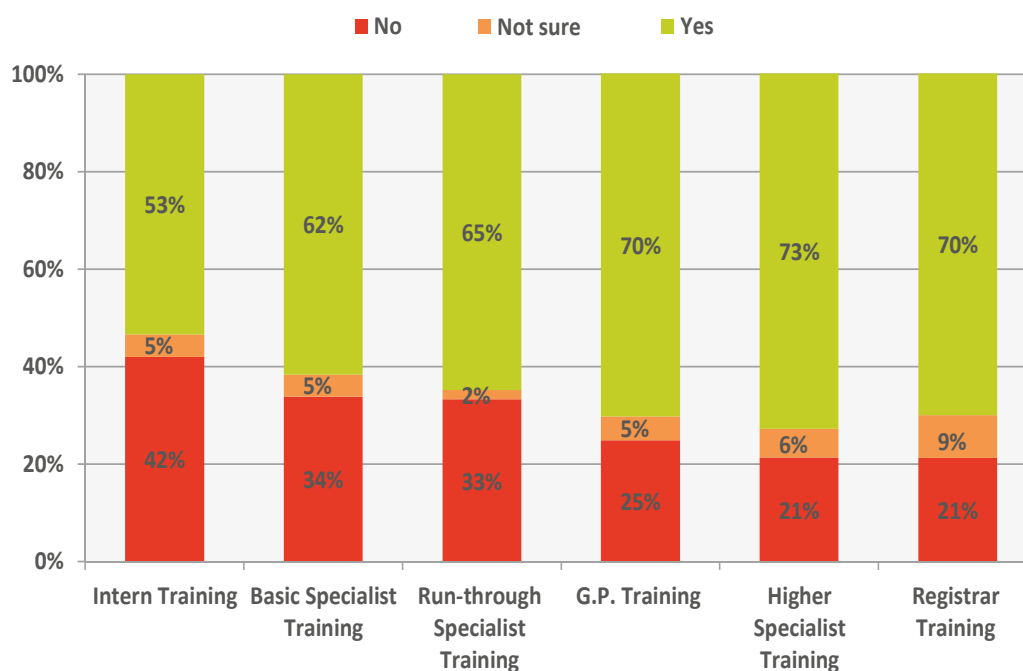
Trainees at intern (46%) and basic specialist training (46%) stages were more likely to say they did not receive all the information they needed about their workplace than trainees at other stages, particularly those at higher specialist (26%) and registrar training (18%) stages; this difference was statistically significant (see Figure 23, $\chi^2(10, N = 1550) = 69.31, p < 0.001$).

Figure 23: "Did you get all the information you needed about your workplace when you started working in this post?" Analysed by stage of training



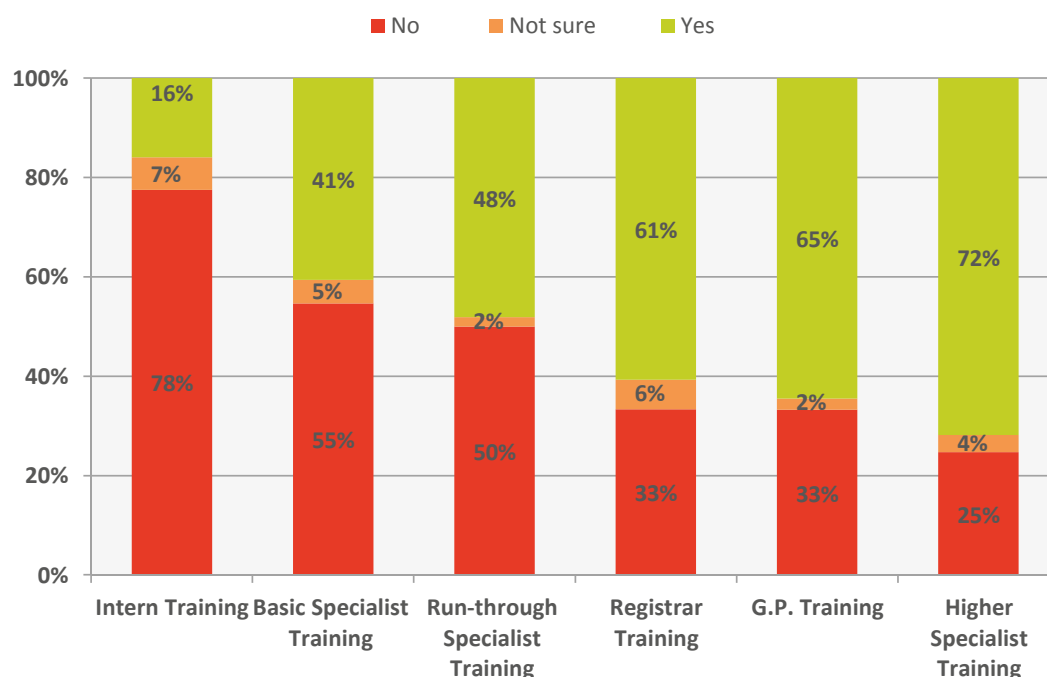
Trainees at intern (42%) and basic specialist training (34%) stages were also more likely to say they did not have someone explain their role at the start of their post than other trainees; particularly trainees in higher specialist and registrar training stages (21%); this difference was statistically significant (Figure 24, χ^2 (10, N = 1549) = 45.14, $p < 0.001$).

Figure 24: "Did someone explain your role and responsibilities in your unit or department at the start of this post?" Analysed by stage of training



Finally, trainees at intern (16%) and basic specialist training (41%) stages were less likely to say that they had discussed their educational objectives with their educational supervisor than trainees on other training programmes, particularly GP (65%) and higher specialist training programmes (72%); this difference was also statistically significant (Figure 25, χ^2 (10, N = 1555) = 238.49, $p < 0.001$).

Figure 25: “Did you sit down with your educational supervisor and discuss your educational objectives for this post?” Analysed by stage of training



Did views vary by type of site?

Trainee views on induction were compared across clinical sites categorised as smaller hospitals, larger hospitals, mental health services and GP practices.

Trainee rating of the overall quality of induction to the clinical environment varied by type of clinical site (Figure 26). More trainees in GP practices (84%) and mental health services (74%) rated the overall quality of induction as ‘Good or better’ than trainees in larger hospitals (57%) and smaller hospitals (51%); this variation was significant ($\chi^2(3, N = 1527) = 69.19, p < 0.001$) and remained significant for specialist trainees only ($\chi^2(3, 1292) = 58.9, p < 0.001$).

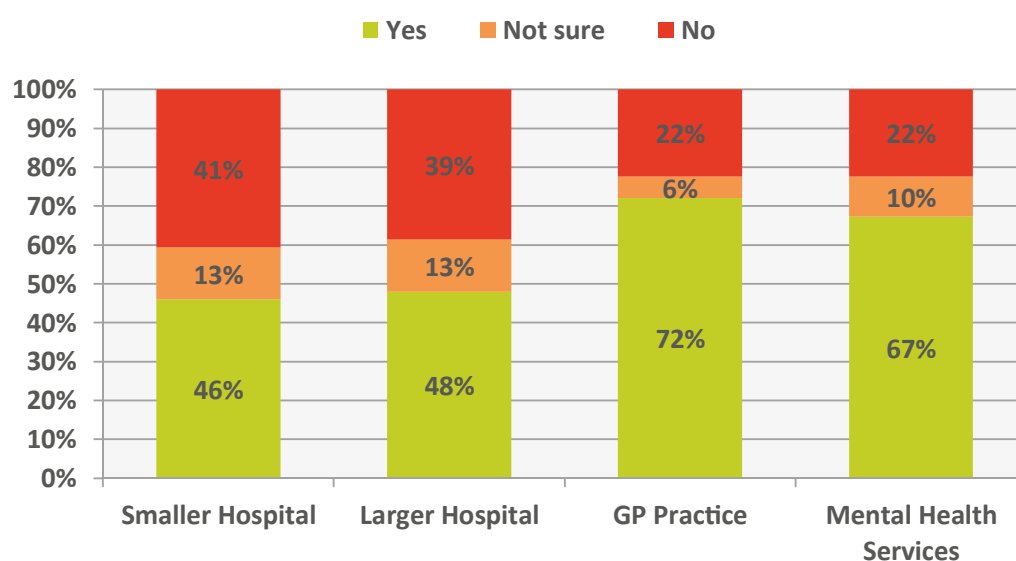
Figure 26: Trainee views of the overall quality of induction to the clinical environment, by type of clinical site



There was also significant variation in trainee view by type of site for individual aspects of induction.

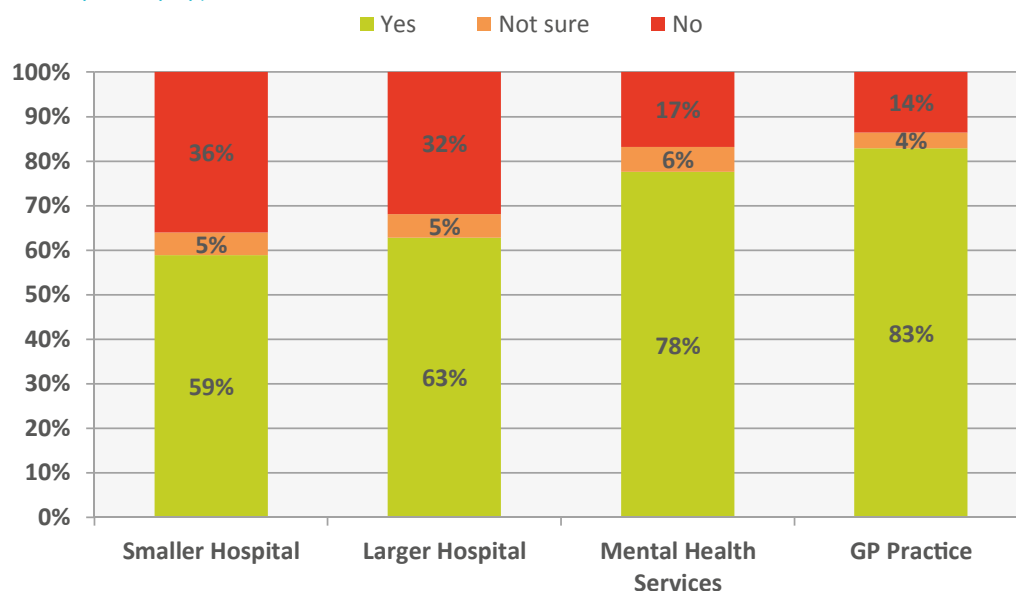
Trainees in larger hospitals (48%) and smaller hospitals (46%) were less likely to say that they had received all the information they needed about their workplace than trainees in GP practices (72%) or mental health services (67%); this difference was significant (χ^2 (6, N = 1526) = 53.84, $p < 0.001$). This is illustrated in Figure 27.

Figure 27: “Did you get all the information you needed about your workplace when you started working in this post?” Analysed by type of clinical site



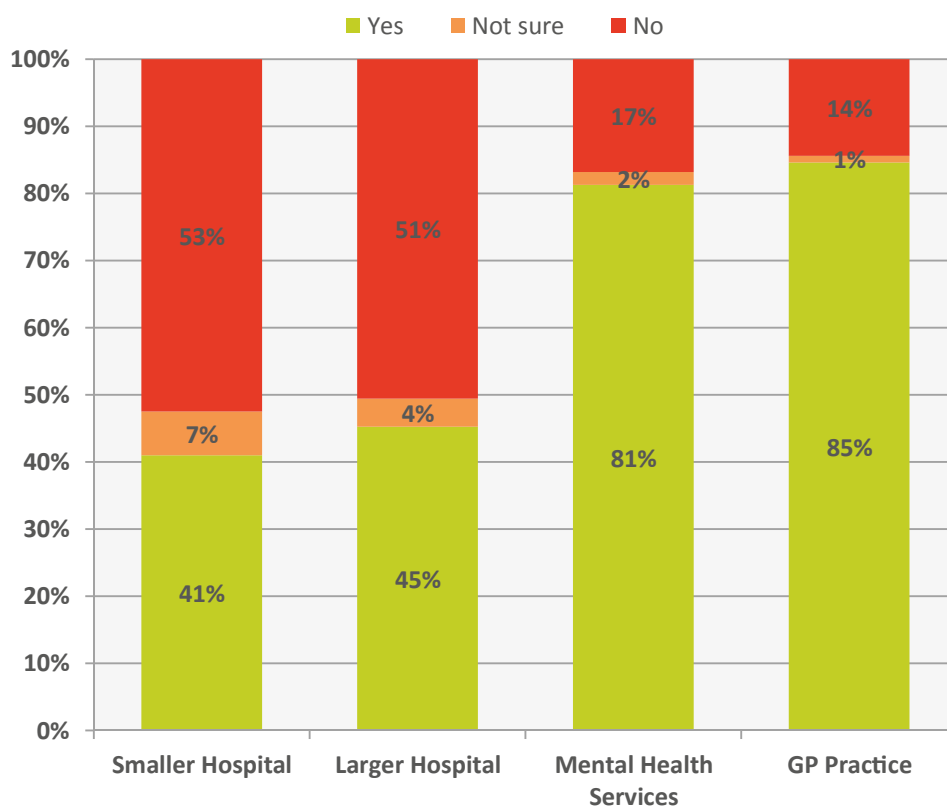
Trainees in larger hospitals (63%) and smaller hospitals (59%) were less likely to say they had their role and responsibilities explained to them at the start of their post than trainees in GP practices (83%) or mental health services (78%); this was also a significant difference, (χ^2 (6, N = 1525) = 43.78, $p < 0.001$). This is illustrated in Figure 28.

Figure 28: “Did someone explain your role and responsibilities in your unit or department at the start of this post?” Analysed by type of clinical site



Finally, trainees in larger hospitals (45%) and smaller hospitals (41%) were less likely to say they had discussed educational objectives with an educational supervisor than trainees in GP practices (85%) or mental health services (81%); this was also a significant difference (χ^2 (6, N = 1531) = 156.04, $p < .001$). This is illustrated in Figure 29.

Figure 29: “Did you sit down with your educational supervisor and discuss your educational objectives for this post?” Analysed by type of clinical site



3.5 Trainee views of their preparedness for transitions

What did we find?

- Almost 9-in-10 trainees completing specialty training felt they had been well prepared for their next role.
- In contrast, approximately 3-in-10 interns reported that their previous medical education and training did not prepare them well for intern training. The prevalence of this issue among trainees in Ireland is 2-3 times greater than among their UK counterparts.
- For 5-in-10 interns who reported that preparedness was an issue, lack of preparedness was a 'medium-sized' or 'serious' problem. Again, for those who felt under-prepared, compared with their UK counterparts, trainees in Ireland were 2 times more likely to report that this was a problem.
- Among interns, while feeling unprepared was less commonly reported with respect to clinical knowledge and interpersonal skills, the problem more commonly arose with regard to administrative duties and the physical/emotional demands of clinical work as an intern.
- It is important to note that the prevalence of feeling underprepared was not associated with trainee-related characteristics. Critically, the problem was no more or less common for interns depending on their medical school of graduation or the intern training network overseeing their intern learning experience.
- Interns who rated the quality of induction to the clinical environment positively were more likely to also report that they felt well prepared for intern training.
- Trainees who felt less well prepared for intern training reported a poorer experience of the clinical learning environment; for those who reported the problem to be more serious, their experience of the clinical learning environment was worse.

What does this mean?

At the end of specialty training, doctors completing a specialty training programme overseen by a recognised postgraduate training body in Ireland receive a certificate of completion of specialty training and can be registered as a specialist. An important outcome of specialty training in Ireland is that trainees feel they have been prepared for their next role. However, while it is an intuitive and attractive global measure for training effectiveness and future performance, "preparedness" needs to be interpreted judiciously since feeling prepared doesn't always predict future performance as a doctor.⁵⁸ Nevertheless, it is positive to note that most trainees completing specialty training felt they had been well prepared for their next role. Variation in perceptions of preparedness across different specialities could potentially provide useful feedback to training bodies on the strengths and weaknesses of their training programmes. Given the relatively small numbers of trainees completing training each year, such variation would be most robustly assessed by examining trends across a number of years. This is an area for the Medical Council to monitor in future.

Despite acknowledged limitations,⁵⁸ feeling prepared for internship and its relationship with undergraduate medical education and early postgraduate clinical experience is a well-recognised and well-researched issue. In many health systems, improving preparedness for transition from medical school to clinical practice has been a key focus of reform in medical education and training.⁵⁹

This report, for the first time on a comprehensive and national basis, describes intern views on preparedness for intern training and identified a high prevalence of self-perceived under-preparedness. It is important to note that perceptions of under-preparedness are not uncommon among medical graduates making the transition to internship: the problem has been described in studies conducted in the UK, US and Australia.⁶⁰⁻⁶² However, it is notable that in this study the issue was significantly more prevalent and serious among interns in Ireland than it was among their UK counterparts. Preparedness for internship was studied by the Medical Council on a national basis in 2003.⁶³ In that study, 68% of interns disagreed that undergraduate medical education had prepared them well for internship. Comparison with the results from *Your Training Counts* 2014 would suggest that the issue of interns feeling under-preparedness has improved. It would be disappointing if that were not the case, given the wide range of measures that have been put in place at an undergraduate and intern level; however, the scale used to ascertain trainee views in 2003 was different (a 4-point scale with no response available for 'neither agree nor disagree' responses), so progress is difficult to track with confidence.

Feeling under-prepared was no more and no less common across different categories of intern (e.g. age, route of entry to medical school) and, importantly, the issue was similar across graduates of different medical schools. While the issue of trainee perception of under-preparedness is significant, it is positive to note that there does not appear to be systematic variation. There are differences in curricular approaches across different medical schools, and the lack of systematic variation in feelings of preparedness suggests that there are no particular curriculum features in place any school that might be contributing to a perception of under-preparedness for intern training. This finding contrasts with evidence from the UK, where variation in intern perception of preparedness was noted across different medical schools.⁶⁴ Similarly, it is positive to note that trainee perception of under-preparedness did not vary across intern training network, nor did it vary between smaller and larger hospitals. This finding would suggest that there is no particular feature of the role requirements facing interns that systematically contributes to a perception of trainee under-preparedness for the intern year.

Why do some interns feel under-prepared for the transition from medical school to intern training? The results of this study show that clinical knowledge is not a cause for concern; and it is positive to note that trainees generally felt well prepared with regard to interpersonal skills. Some trainees reported difficulty with clinical procedures. This is an issue that warrants further consideration, given that any deficit in this domain should be amenable to specific and focussed educational interventions.

Overall, it is significant that domains where intern perception of under-preparedness was greatest were related to emotional/physical demands and administrative tasks. While this sort of quantitative analysis is a useful way to begin to understand the issue of perceived under-preparedness, qualitative methods are well placed to understand why perceptions of under-preparedness arise. Such methods were used by Illing et al., who were commissioned by the General Medical Council to explore the issue of perceptions of under-preparedness for intern training in the UK in response to findings from the early 2000s similar to those presented in this report.^{65, 66} They found that perceptions of being under-prepared tended to arise for areas of practice that required previous participation in the workplace, like the emotional demands of prioritising and managing time on a busy clinical service, being on-call, prescribing, and administrative skills such as dealing with paperwork for patient discharge. These findings led them to suggest a number of possible interventions to address under-preparedness: enriching undergraduate clinical placement to provide for greater experiential learning; ensuring medical students play a greater active role on clinical teams, including a more central role closer to graduation; providing for shadowing experiences before internship, which provide the correct balance between necessary formal induction activities and time spent practising tasks for which students will

shortly become responsible as interns. The authors also made specific recommendations in the area of supporting development of prescribing skills. The findings and recommendations of this important study, and the emphasis on learning to become an intern through deep and meaningful participation in the workplace before making the transition, has a strong grounding in current perspectives on how doctors learn.⁹

The findings and recommendations made by Illing et al. resonate with other commentary on the issue of preparedness. In the US, the same issue has been framed as a “process-management problem” in medical education, which demands a “systems approach”, and which recognises the continuum of professional development and the need to manage transitions as well as focusing on discrete elements or stages of medical education and training.⁶⁷

It is important to note that the issue of trainee perception of under-preparedness for intern training is remediable. Comparative data with UK demonstrates that the proportion of interns in the UK reporting under-preparedness has reduced over time in that health system. Simple preparation courses for those finishing medical school and beginning internship have been shown to be effective.⁶⁸ The results of *Your Training Counts 2014* also indicate that an experience of effective induction and orientation is associated with feeling prepared. It should be possible to make progress with the challenge of intern perception of under-preparedness in Ireland, which is highlighted in this report. However, it will require leadership and commitment to collaboration across a range of important stakeholders.

What are the implications of not addressing intern perceptions of under-preparedness?

The transition from medical student to intern is an exciting but challenging step for doctors in training. Studies have demonstrated that it can be a stressful time and a perception of under-preparedness may contribute to this.^{65, 66} *Your Training Counts* has collected trainee views on their health and wellbeing as well as their engagement with work. The relationship between these issues and trainee perception of under-preparedness will be explored in a separate report.

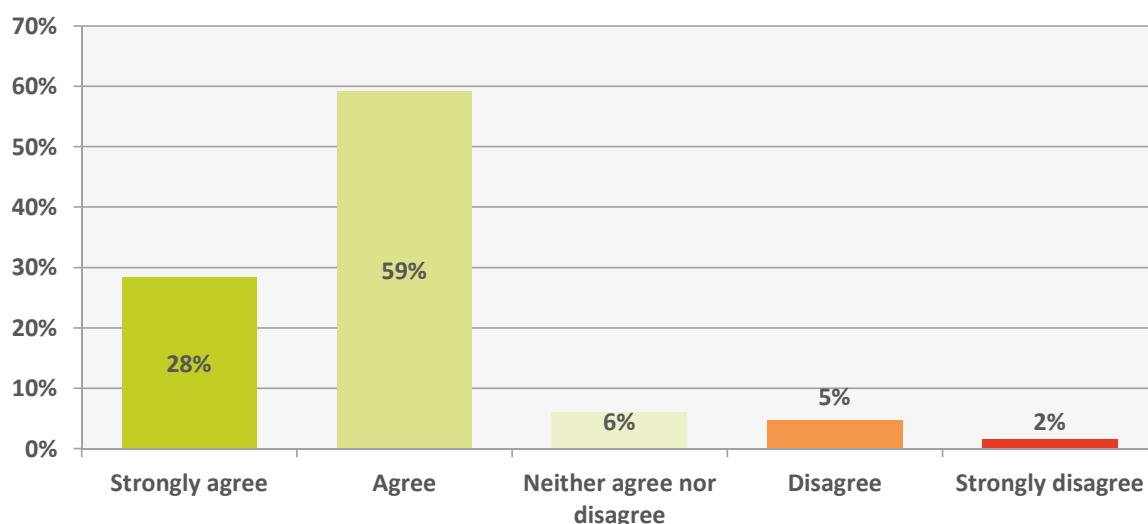
Albeit that a causal relation cannot be inferred given the nature of this study, it is significant to note that interns reporting under-preparedness reported poorer views of their overall experience of the clinical learning environment. It is possible that issues such as self-confidence may relate to both trainee perception of preparedness and perception of the clinical learning environment. However, it is also possible that interns who feel less prepared, and who are struggling with the demands of work as an intern, may not be as able to navigate the clinical site to secure positive learning experiences as their more prepared colleagues. Enabling interns to feel more prepared for intern training may also improve their experience of the clinical learning environment; although it is recognised that moving from feeling under-prepared to feeling confident in the role of intern is in itself a learning experience.

Finally, addressing trainee perception of under-preparedness also has a patient safety and quality of care dimension. Trainees can and do provide good care to patients.⁵⁵ Interns play a critical role in clinical service delivery. Healthcare organisations must address this and plan arrangements to support them when they are new in post so as to manage recognised risks associated with periods of significant clinical staff changeover in the healthcare system.^{56, 57}

3.5.1 Trainees completing specialty training and preparedness for next role

Trainees due to shortly complete specialty training were asked how well prepared they felt to take up their next role. Most trainees (87%) due to complete specialist training agreed or strongly agreed that specialty training had prepared them well for the next stage of their career; however, a small minority (7%) disagreed or strongly disagreed. The views of trainees completing specialty training on preparedness are shown in Figure 30. We will need to monitor this over future surveys to identify whether or not the perception of trainees completing specialist training about preparedness for their next role is different in different specialties. One year's findings are insufficient to draw conclusions, but this is an important issue to follow-up in future.

Figure 30: “My experience of specialist training has prepared me well for the next stage in my career”, views of trainees completing specialty training



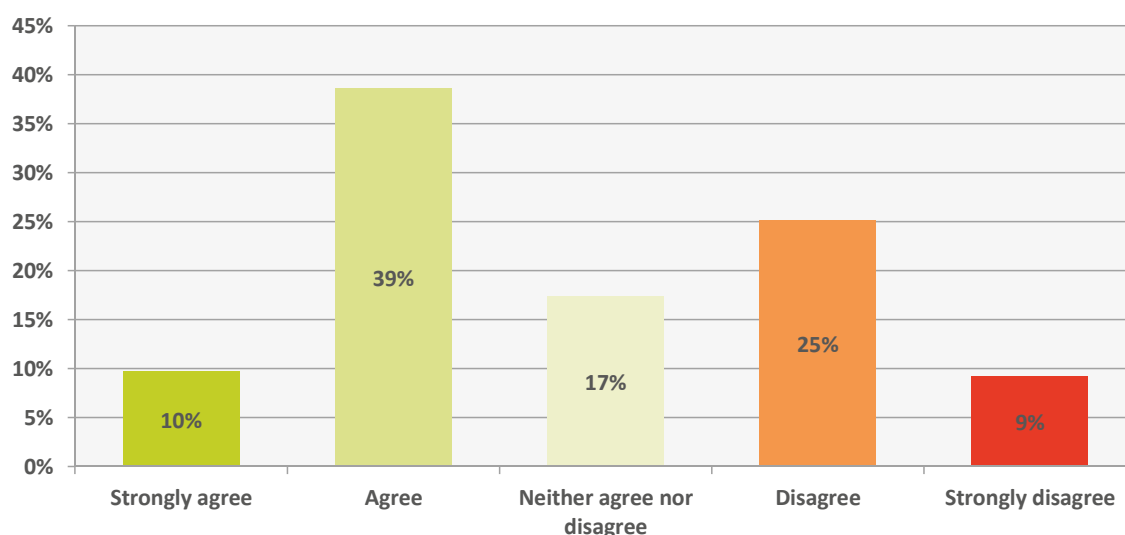
3.5.2 Interns and preparedness for intern training

Trainees who had entered intern training from medical schools approximately 10-12 months before the time of the survey were invited to share views regarding how well, in retrospect, they felt their previous education and training had prepared for this important transition.

Intern views on overall and domain specific preparedness

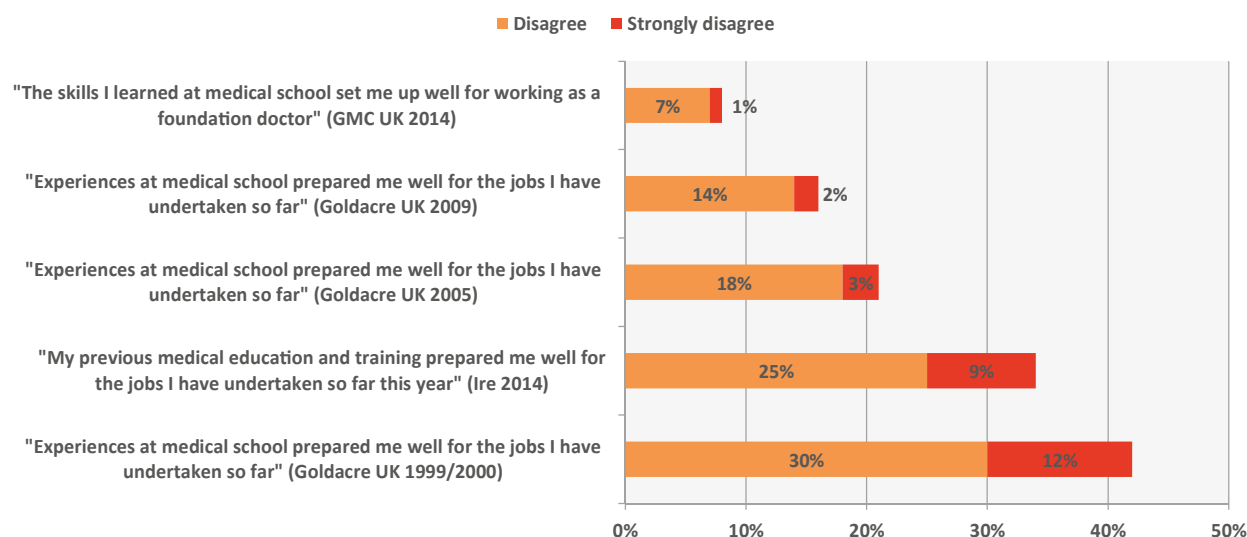
Overall, 49% of interns agreed that their previous medical education and training prepared them well for the jobs they had undertaken as an intern; however, 34% did not feel well prepared. This is illustrated in Figure 31.

Figure 31: "My previous medical education and training prepared me well for the jobs I have undertaken so far this year"



To place this in context, responses from interns in Ireland were compared with responses to a similar question in surveys conducted by the GMC and Goldacre et al. involving doctors in the UK at the same stage of training.⁶⁹ This is illustrated in Figure 32. In 2014, a higher proportion of interns in Ireland felt unprepared for intern training compared with their contemporary UK counterparts.

Figure 32: Benchmarking views of under-preparedness for intern training, comparison of trainees in UK and Ireland



Interns who reported that they did not agree that their previous medical education and training had prepared them well for the jobs they had undertaken during their intern year were asked to identify the scale of lack of preparation. For interns who did not feel prepared, while 45.7% reported that lack of preparedness was a 'minor problem', for 45.7% the problem was 'medium-sized' and for a further 8.6% the problem was 'serious' (Figure 33). Figure 34 compares the scale of the problem of unpreparedness between interns in the UK and Ireland; 25.6% of UK interns who felt unprepared said the problem was 'medium-sized' to 'serious' problem compared with 54.3% of interns in Ireland.

Figure 33: "Was a lack of preparation for this year a serious, medium-sized or minor problem for you?"

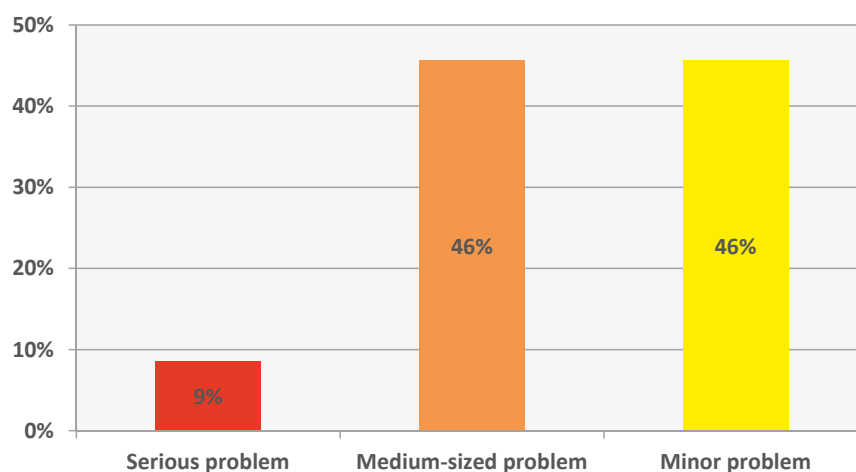
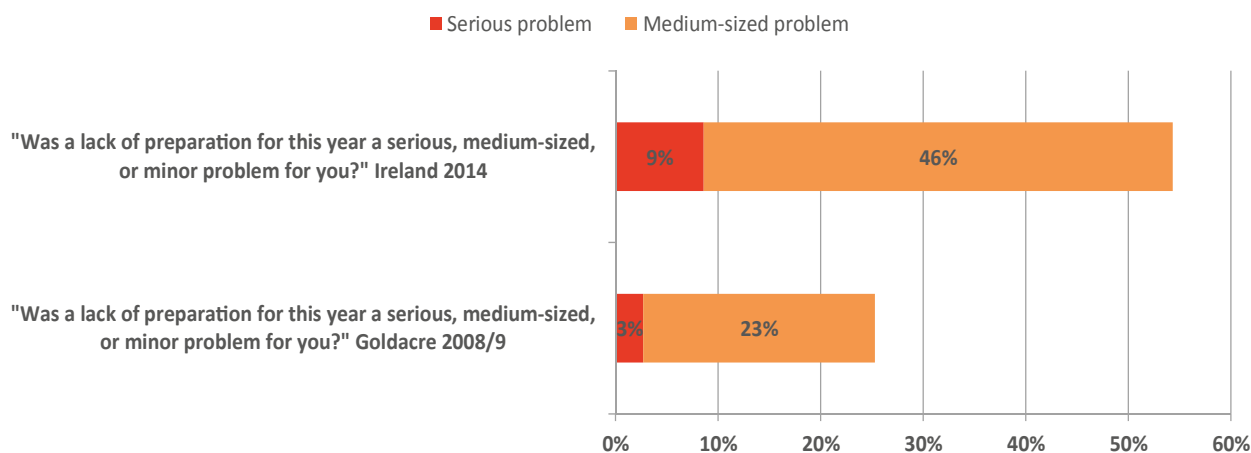
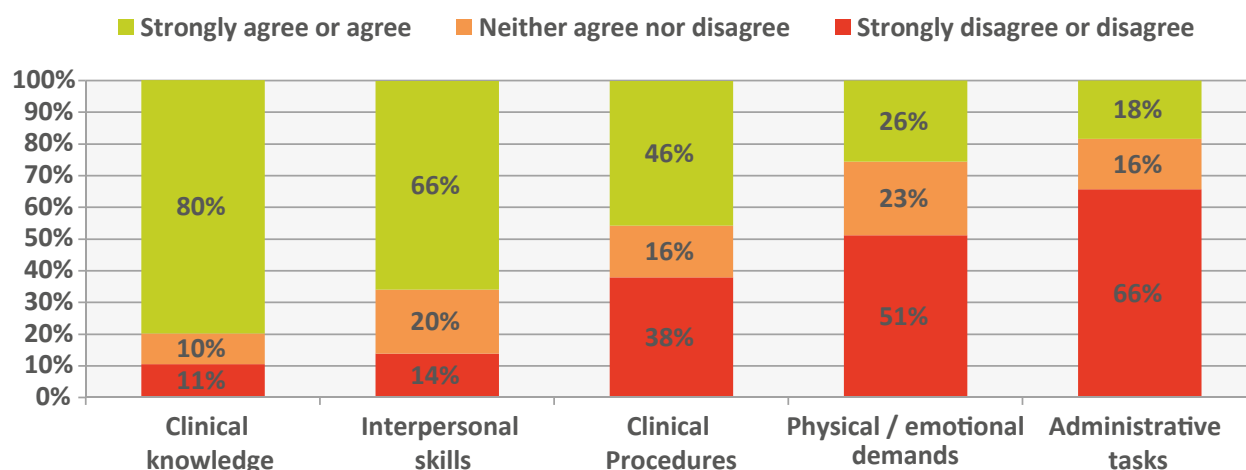


Figure 34: Benchmarking views on seriousness of self-perceived unpreparedness for intern training, comparing trainees in UK and Ireland



Interns were also asked to provide their views on how well their previous medical education and training had prepared them with necessary skills across a number of different domains. The results are illustrated in Figure 35. While a high proportion of interns agreed that they were well prepared in the domain of clinical knowledge (79.8%), in the domains of physical/emotional demands (25.6%) and administrative tasks (18.4%), only a minority of interns agreed that they were well prepared.

Figure 35: “My previous medical education and training prepared me well” - domain specific responses



Variations in interns' views on preparedness

A number of different trainee and environment characteristics were examined for relationships with intern views on preparedness for intern training.

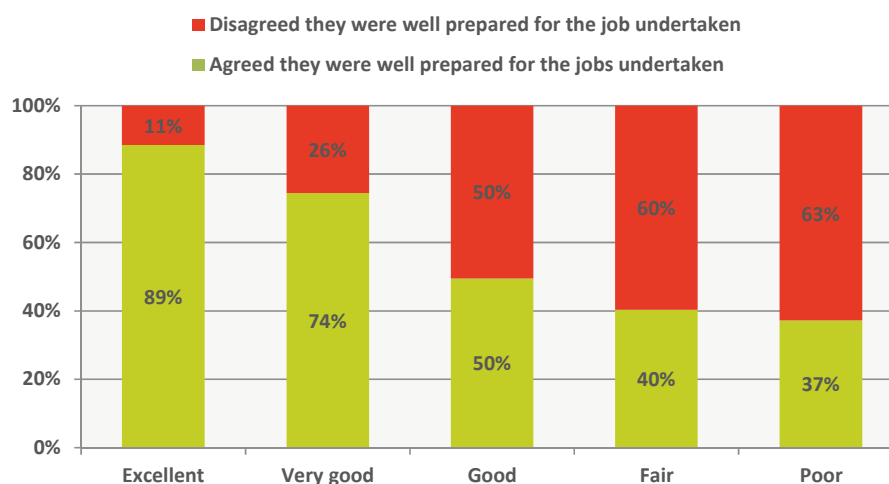
Views of preparedness were similar between males and females and across different age groups. There was no difference in views of preparedness between interns who took a direct-entry or graduate-entry route to medical school.

Interns were asked to identify the medical school where they completed their medical education, and views on preparedness for intern training were examined by medical school of qualification. Importantly, there was no significant variation in views on preparedness by across medical school of qualification ($\chi^2(10, N = 204) = 12.86, p = 0.232$). The relationship between intern views on preparedness and body overseeing training was also explored; there was no significant variation in intern views across intern training networks ($\chi^2(10, N = 203) = 6.21, p = 0.797$). Finally, the views of interns on preparedness were similar between those training in smaller hospitals and those training in larger hospitals, ($2(2, N = 204) = 0.429, p = 0.807$).

Interns' views of preparedness and induction to the clinical environment

Interns' views of preparedness were further explored to examine the relationship with their experience of induction. As shown in Figure 36, in general, a higher proportion of interns who rated their induction positively perceived that they were well-prepared for internship; the differences in perceptions of preparedness across views on quality of induction were significant ($\chi^2(4, N = 176) = 16.47, p = 0.002$).

Figure 36: Intern perception of preparedness for intern training, variation across ratings of the quality of induction



Interns' views of preparedness and overall experience of the clinical learning environment

The views of interns on the clinical learning environment have already been described. The relationship between these views and their views on preparedness was examined.

Trainees who agreed that their previous medical education prepared them well for intern year also had significantly higher total D-RECT scores (161.9) than trainees who disagreed that they felt well prepared (138.1) (Figure 37, $F(2,197) = 14.72$, $p < 0.001$). For trainees who felt unprepared, those who reported this as a more serious problem tended to have poorer views of the clinical learning environment; however, differences were not significant (Figure 38, $F(2,97) = 2.93$, $p = 0.058$).

Figure 37: "My previous medical education and training prepared me well for the jobs I have undertaken in the intern year", relationship with mean total D-RECT scores

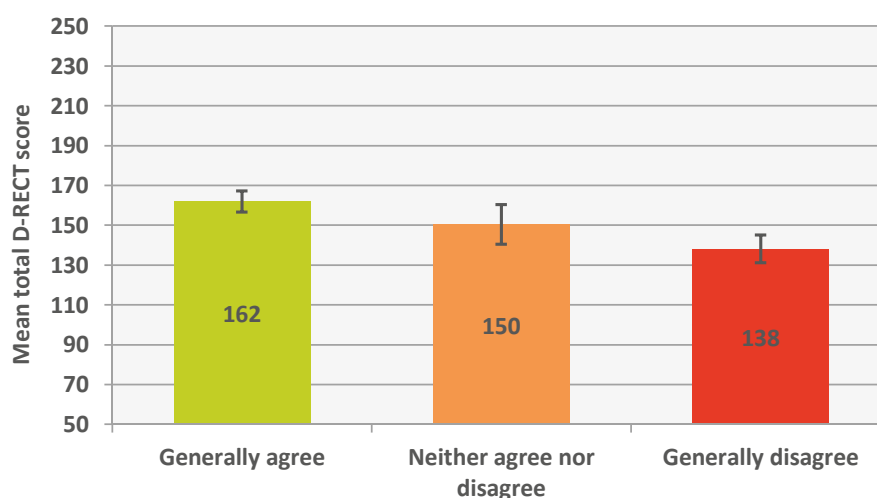
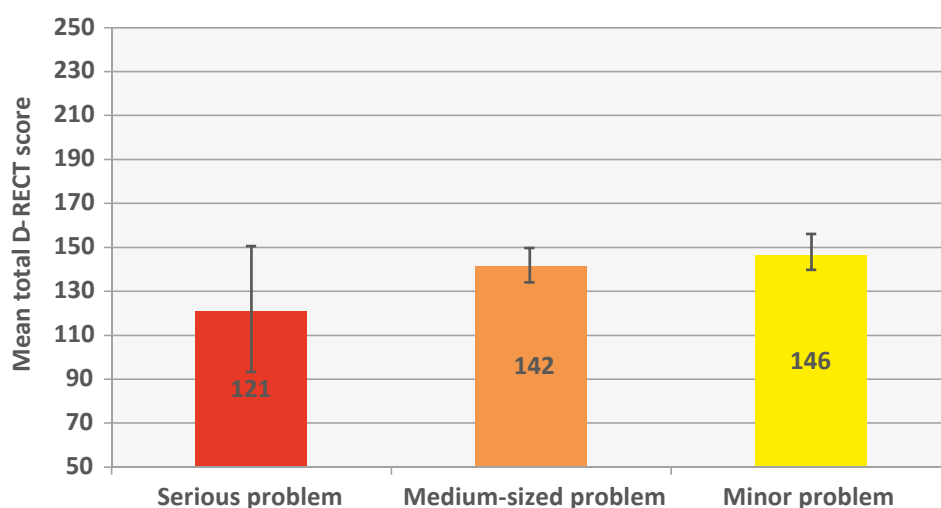


Figure 38: “Was a lack of preparation for this year a serious, medium-sized or minor problem for you?”
Relationship with mean total D-RECT scores



3.6 Trainee views of bullying and undermining behaviour

What did we find?

- Based on trainee-reported experience, bullying and undermining behaviours were endemic in the clinical learning environment. In total, approximately 3-in-10 trainees reported personal experience of bullying and undermining behaviour, and this experience was over 2 times more prevalent than their UK counterparts. Where bullying and undermining behaviour was experienced, the frequency was greater among trainees in Ireland compared with their UK counterparts.
- The prevalence of trainee-reported personal experience of bullying and undermining behaviours was greater among younger trainees and among those at the intern stage of training.
- Type of clinical site was relevant: the prevalence of trainee-reported personal experience of bullying and undermining behaviours was greater among trainees at hospitals than among trainees at GP practices.
- Experience of bullying and undermining behaviours was associated with a poorer trainee view of the clinical learning environment.

What does this mean?

We found that the experience of being bullied in the workplace, of observing others being bullied, and of experiencing undermining behaviour from a senior doctor is endemic among trainees in Ireland. This is not surprising, in that bullying and undermining are well recognised features in medical education and training, with a large number of studies in places like the UK, Canada, Australia and USA finding that the experience is common among trainees. A recent systematic review and meta-analysis found that, across published studies, 59.4% (95% CI 52.0%-66.7%) of trainees experienced at least one form of harassment or discrimination.⁷⁰ Verbal harassment was the most common form of harassment and senior doctors were the most common source, followed by patients or their families. The issue of bullying was examined with interns previously by the Medical Council in 2003, and 61% of interns reported an experience of being bullied.⁶³

What is striking about the results in this study is that the problem appears more common among trainees in Ireland than among their UK counterparts. It is positive to note that significant factors – like gender and country of qualification – do not appear to affect the prevalence of experience of bullying behaviours. However, it is concerning that bullying is more common among interns, who are at the earliest stages of training.

Bullying and undermining are complex phenomena, which are perceived differently by different people. It is acknowledged as a limitation that the findings in this study relate to perceived experiences. However, bullying and undermining are well-recognised features of the workplace across different countries and different settings. Work undertaken by Eurofound has established that 5% of workers reported experiencing bullying in the last 12 months. The prevalence of bullying varied across countries and was higher than average in Ireland; across sectors, the prevalence was higher in health and social care.⁷¹ A recent report by the Economic and Social Research Institute in Ireland reported that the prevalence of bullying was 7.9% in 2007, and had risen from 7.0% in 2001. Across sectors, bullying tended to be common in health and social work (13.0%), which was close to education, the sector where bullying was most common (14.0%).⁷²

The relationship between the prevalence of bullying and organisational factors is well-established.⁷¹ ⁷² It is important to note that the prevalence of trainee-reported personal experience of bullying and undermining behaviours was greater among trainees at hospitals than among trainees at mental health services or GP practices. Trainees who reported an experience of bullying or undermining more commonly reported poorer views of the clinical learning environment.

What are the implications for trainees? The experience of bullying can have health implications for trainees.⁷⁰ *Your Training Counts* invited trainees to share views regarding their health, the these results will be published in the next report.

While a cause-and-effect relationship cannot be established in this study, it is important to note that trainees who reported experience of bullying also had poorer views of the clinical learning environment. Their experience of bullying may have consequences for their learning experience and learning outcomes.

The prevalence of bullying and undermining behaviours has wider implications for the medical profession and for medical professionalism. Workplace learning is a process of socialisation which affects learner outcomes across the domains of knowledge, skills and attitudes.⁹ In the clinical environment, through a process of enculturation, trainees learn what is required of them and form their identity as medical professionals.⁷³ Both experiencing bullying and perceiving others being bullied or undermined is corrosive to the development of medical professionalism.

3.6.1 The prevalence of trainee-reported bullying and undermining behaviours

Trainees were invited to provide their views on bullying and undermining behaviours in the clinical environment.

As illustrated in Table 4, 33.7% of trainees reported being the victim of bullying and harassment in their post and 51.5% reported witnessing someone else being the victim of bullying and harassment; 43.8%

had experienced undermining behaviours. Compared with their UK counterparts, trainees in Ireland more commonly reported bullying and undermining behaviours in the clinical workplace, and more commonly reported that they occurred with greater frequency.⁶⁹

Table 4: The prevalence of trainee-reported bullying and undermining behaviour in the clinical environment, comparing trainees in the UK and Ireland

	How often, if at all, have you been the victim of bullying and harassment in this post?		How often, if at all, have you witnessed someone else being the victim of bullying and harassment in this post?		In this post, how often if at all, have you experienced behaviour from a consultant/GP that undermined your professional confidence and/or self-esteem?	
	UK, 2013	Ireland, 2014	UK, 2013	Ireland, 2014	UK, 2013	Ireland, 2014
Never	86.8%	66.4%	80.5%	48.5%	73.5%	56.2%
At least once	13.4%	33.7%	19.6%	51.5%	26.5%	43.8%
Every day	0.2%	1.2%	0.3%	2.5%	0.3%	7.4%
At least once per week	1.0%	5.1%	1.4%	8.2%	1.4%	3%
At least once per fortnight	1.0%	2.5%	1.4%	5.4%	1.6%	3.7%
At least once a month	2.0%	5.7%	3.5%	9.5%	4.1%	0.8%
Less than once per month	9.2%	19.2%	13.0%	25.9%	19.1%	28.9%

Footnote: In the subsequent analyses, frequency was re-categorised. "Never" was converted to "never bullied"; "Less often than once per month" was converted to "infrequently bullied" and "At least once per month", "At least once per fortnight", "At least once per week", and "Every day" were converted to "frequently bullied".

3.6.2 Variation in trainee views of bullying and undermining behaviours

The relationship between trainee-reported personal experience of bullying and undermining behaviour and trainee and environment-related characteristics was explored.

The prevalence of trainee-reported personal experience of bullying and undermining behaviour was similar for male and female trainees (χ^2 (2, N = 1380) = 1.74, p = 0.419). The prevalence was also similar for trainees who had taken a direct route into medical schools and those who had taken a graduate route (χ^2 (2, N=1112) = .06, p = 0.971). There was no association between the prevalence of trainee-reported personal experience of bullying and undermining behaviour and country of qualification (χ^2 (2, N=1380) = 4.77, p = .092).

Compared with older trainees, trainee-reported personal experience of bullying and undermining behaviours was more prevalent among younger trainees; this difference was significant (χ^2 (8, N = 1380) = 16.74, p = 0.033). This is illustrated in Figure 39. Stage of training was also a relevant factor in the prevalence of trainee-reported personal experience of bullying and undermining behaviours (Figure 40). The prevalence was higher among interns, and lower among trainees in GP training and higher specialist training; these differences were significant (χ^2 (10, N = 1379) = 59.78, p < 0.001).

Figure 39: Prevalence of trainee-reported personal experience of bullying and undermining, compared across age groups

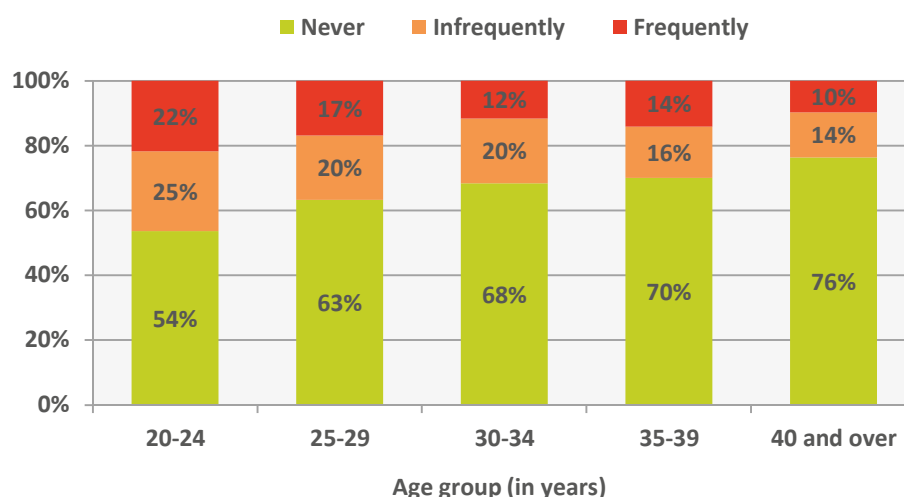
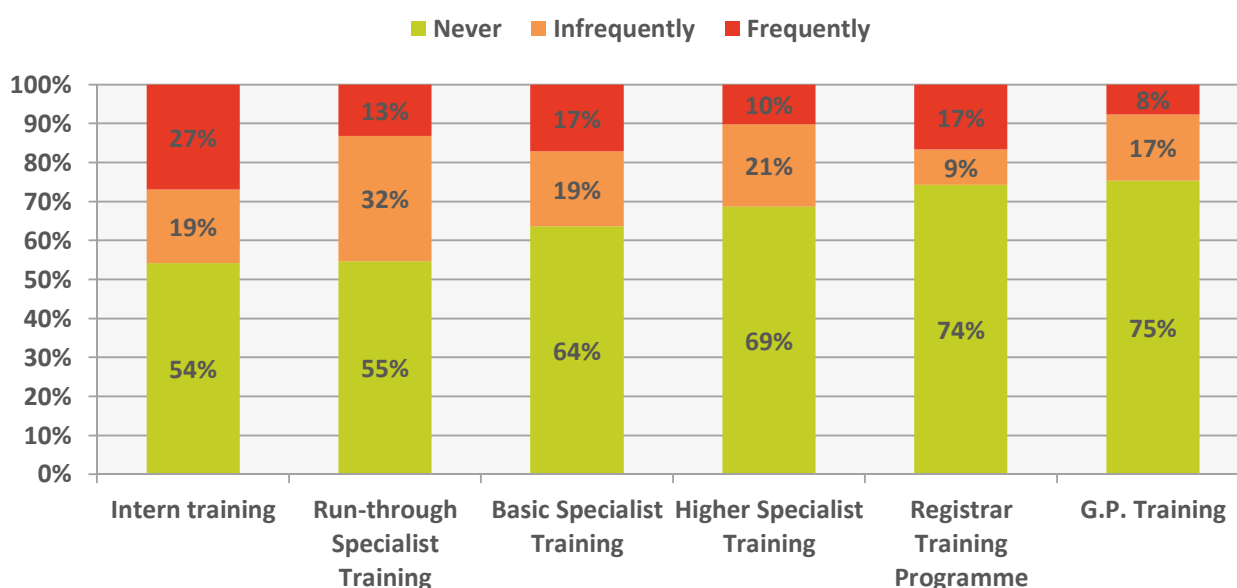
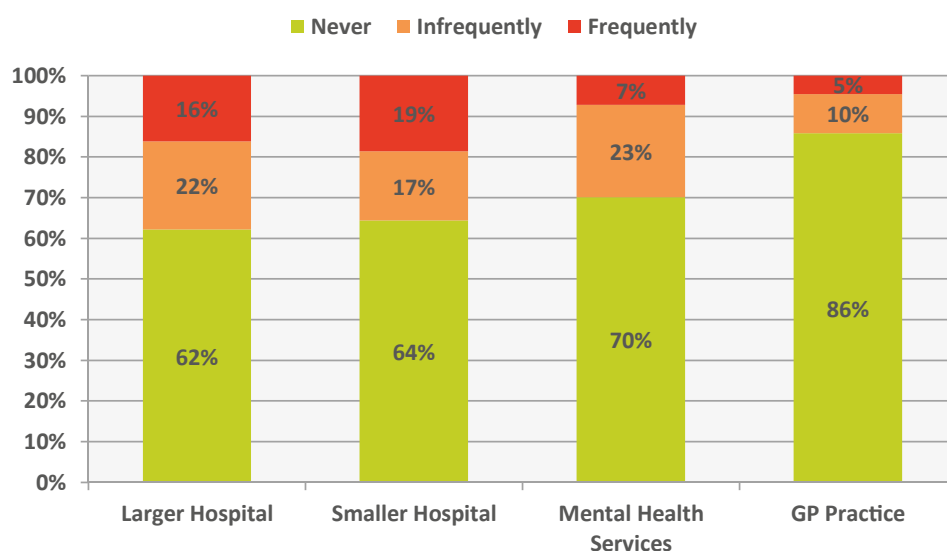


Figure 40: Prevalence of trainee-reported personal experience of bullying and undermining, compared across stage of training



Finally, the prevalence of trainee-reported personal experience of bullying and undermining behaviour varied across clinical site type (Figure 41). Trainees in GP practices (4.5%) and mental health services (7.2%) were less likely to have been frequently bullied than trainees in larger hospitals (16.1%) and smaller hospitals (18.6%), and these differences were significant ($\chi^2(6, N = 1357) = 44.99, p < 0.001$) and remained significant for specialist trainees only ($D2(6, N = 1146) = 34.1, p < 0.01$).

Figure 41: Prevalence of trainee-reported personal experience of bullying and undermining, compared across type of clinical site

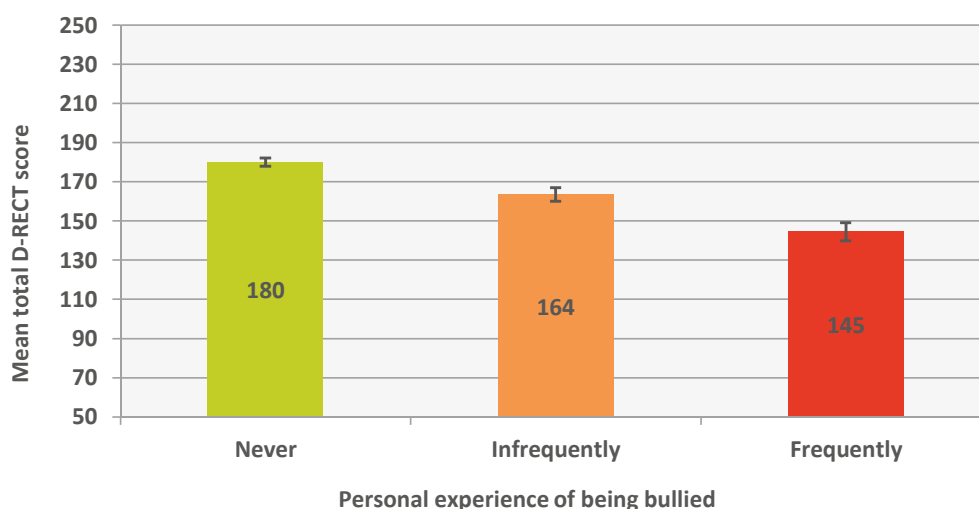


3.6.3 Trainee views on bullying and the overall clinical learning environment

The relationship between trainee-reported personal experience of bullying and undermining behaviour and trainee view of the overall clinical learning environment was examined.

As illustrated in Figure 42, compared with trainees who did not report personal experience of bullying and undermining behaviour, trainees who experienced bullying and undermining reported lower total D-RECT scores; as the frequency of trainee-reported personal experience of bullying and undermining behaviour increased, the view of the clinical learning environment became poorer. These differences were statistically significant ($F(2,1235) = 123.79, p < 0.001$).

Figure 42: Trainee views of the clinical learning environment, compared by frequency of trainee-reported personal experience of bullying and undermining behaviour



3.7 Trainee views of safety and quality of care at clinical sites

What did we find?

- Over 8-in-10 trainees felt physically safe at the clinical site where they trained; just over 1-in-20 did not.
- Trainees with poorer views of the quality of induction at the clinical site were more likely to report that they did not feel safe.
- Trainees who reported that they did not feel safe at the clinical site also reported poorer views of the clinical learning environment.
- Over 8-in-10 trainees rated the quality of care at the clinical site where they trained as good or very good.
- Compared with other trainees, interns had a poorer view on quality of care; trainees at smaller hospitals also had poorer views on the quality of care.
- Trainees who reported a positive experience of induction at the clinical site were also more likely to rate the quality of care as good or very good; interns who felt prepared for intern training were also more likely to positively rate the quality of clinical care.
- Trainees who rated the quality of care at the clinical site as good or very good reported most positive views of the clinical learning environment.

What does this mean?

It is fundamental that trainees feel physically safe at the place where they work and learn. It is positive to note that the vast majority of trainees questioned in *Your Training Counts* did feel safe. The importance of feeling safe is underscored by the relationship between feeling safe and trainees' overall view of the clinical learning environment. The finding that trainees at GP practices may feel less safe requires monitoring. By their nature, GP practices are small clinical sites, dispersed in different settings across the country, where trainees may find themselves more exposed than at larger clinical sites like hospitals.

Put simply, the best way for doctors to develop the knowledge, skills and attitudes necessary to provide safe, high-quality care is for them to learn at places that provide safe, high-quality care.⁷⁴ It is positive to note that most trainees rated the quality of care at the place they were learning as good or very good. This environment provides a good basis for the future of healthcare delivery.

There was some variation in views on quality of care. Interns reported a more negative view on the quality of care at clinical sites than trainees at other stages; interns who felt less prepared for intern training also reported more negative views of the quality of care. These factors may be related – the experience of feeling underprepared may affect interns' perception of quality of care.

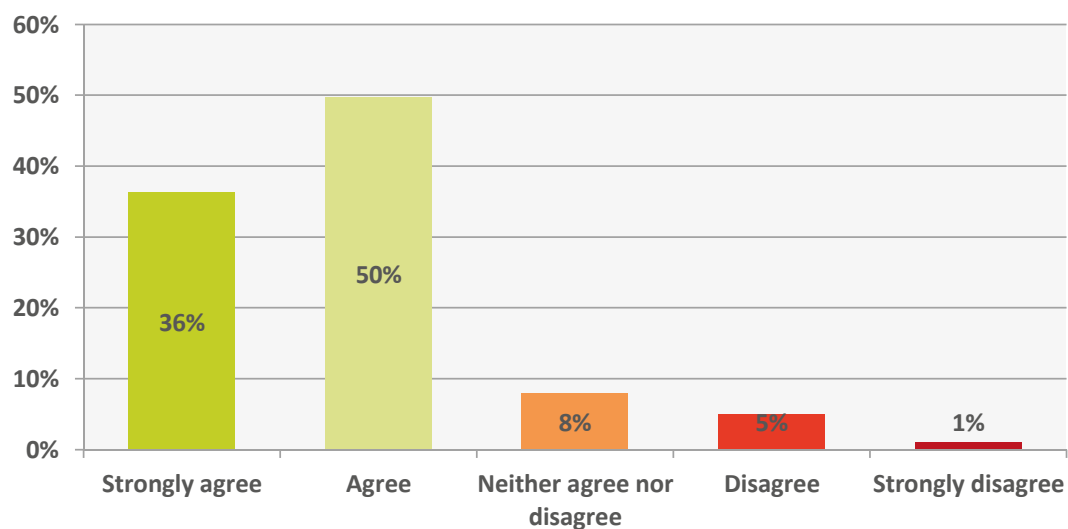
The finding of poorer trainee perceptions of quality of care at smaller hospitals is consistent with the challenges that have been identified in sustaining safe delivery of services to the requisite standard at these sites and the need to address the overall configuration of acute hospital services in Ireland.^{75, 76}

It is noteworthy that trainees who had a poorer experience of induction at a clinical site were more likely to rate the quality of care negatively than trainees who had a better experience of induction. It is also noteworthy that trainees who had more negative views on the quality of care at the place where they trained also viewed the clinical training environment more poorly than trainees with positive views on the quality of care. These inter-related factors raise questions about how the overall climate or culture at an organisation is constructed and how this supports safe, high-quality care. The General Medical Council have explored these factors further and demonstrated that a number of factors about trainees' experience of healthcare organisations as places to learn also predict a range of measures of the quality and safety of care at the same healthcare organisations. While the inter-relationship of factors like this need to be cautiously interpreted, they support the view that robust integrated governance of healthcare organisations benefits trainee experience as well as service delivery.

3.7.1 Trainee views of safety at clinical site

Trainees were asked to consider whether or not they felt physically safe within the environment where they worked and learned. In total, 86% of trainees agreed or strongly agreed that they felt physically safe (Figure 43).

Figure 43: Trainee views of their physical safety at the clinical site



The view of physical safety at the clinical site was assessed across a number of trainee characteristics and no difference was identified across gender (χ^2 (1, N =1377) = 2.61, p = 0.106), age group (χ^2 (4, N =1377) = 7.29, p = 0.121), route of entry to medical school (χ^2 (1, N =1082) = 0.985, p = 0.321) or country of basic medical qualification (χ^2 (1, N =1377) = 0.090, p = 0.764).

The relationship with type of site was examined. Compared with trainees at other types of sites, more trainees at GP practices reported that they did not feel physically safe (8%); this difference was significant (Figure 44, χ^2 (3, N =1355) = 10.96, p = 0.012). Trainees with more negative views of the quality of their induction to the clinical site were also more likely report not feeling physically safe; this difference was also significant (Figure 45, χ^2 (1, N =1361) = 6.73, p = 0.009).

Figure 44: Trainee view of their physical safety at the clinical site (% disagreed or strongly disagreed), comparison by type of site

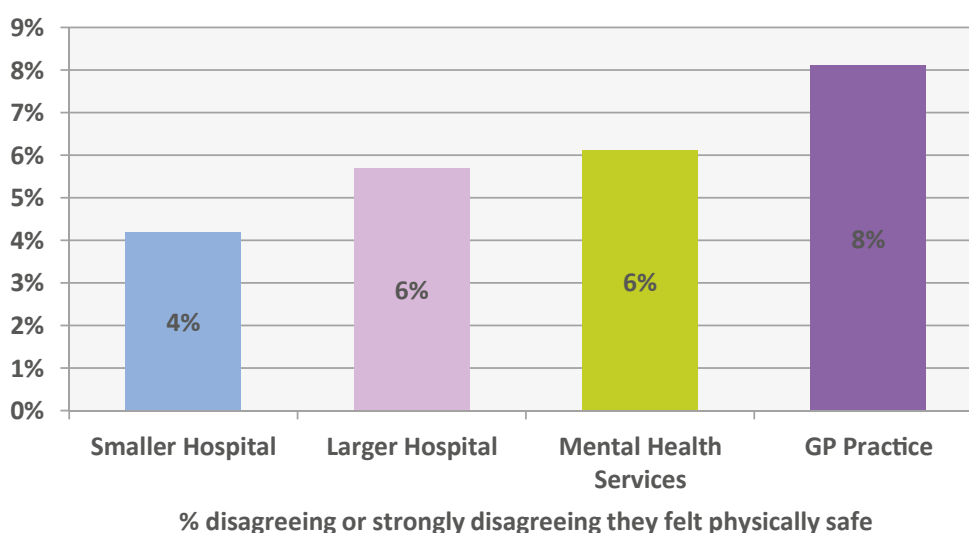
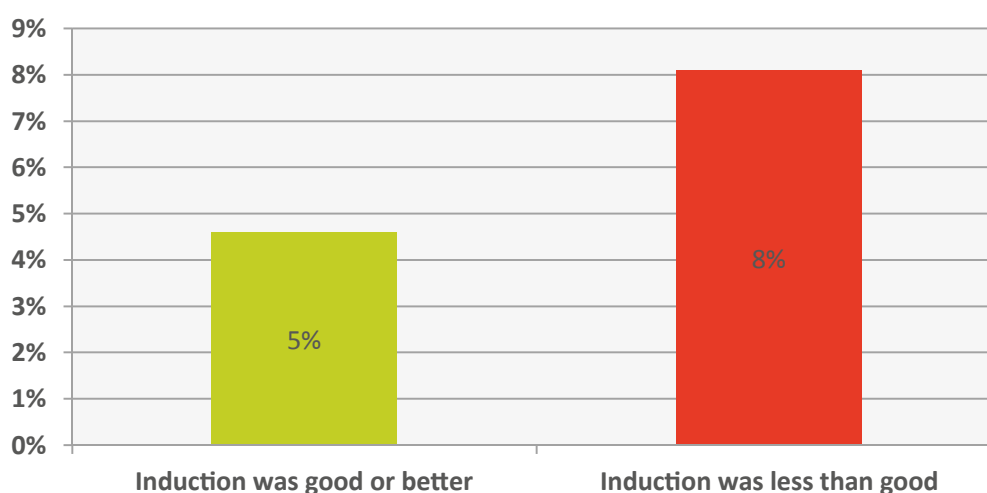
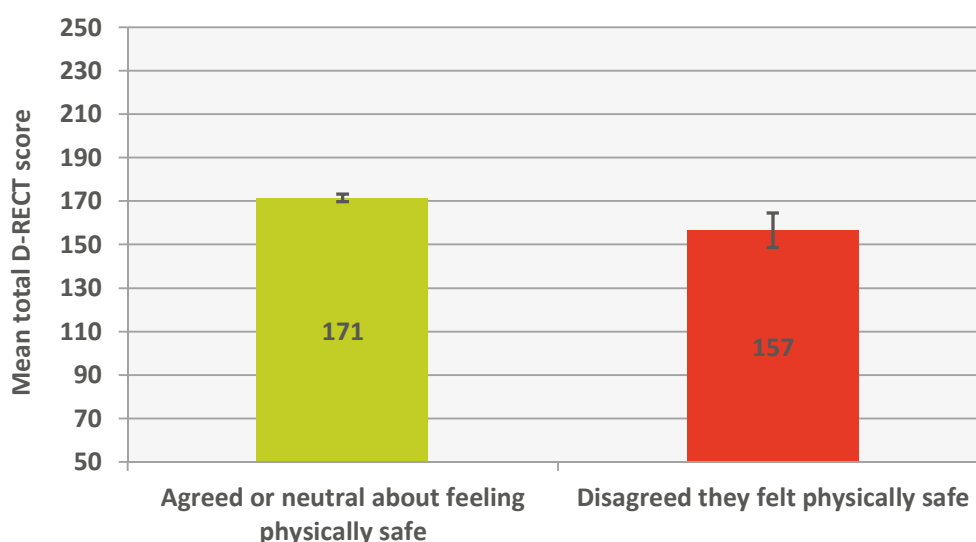


Figure 45: Trainee view of their physical safety at the clinical site (% disagreed or strongly disagreed that they felt safe), comparison by view of induction



Trainee views on the clinical learning environment varied depending on whether or not they felt physically safe at the clinical sites; those who disagreed that they felt physically safe reported lower total D-RECT scores than those who did not (Figure 46, $t(1283) = 3.99$, $p < 0.001$).

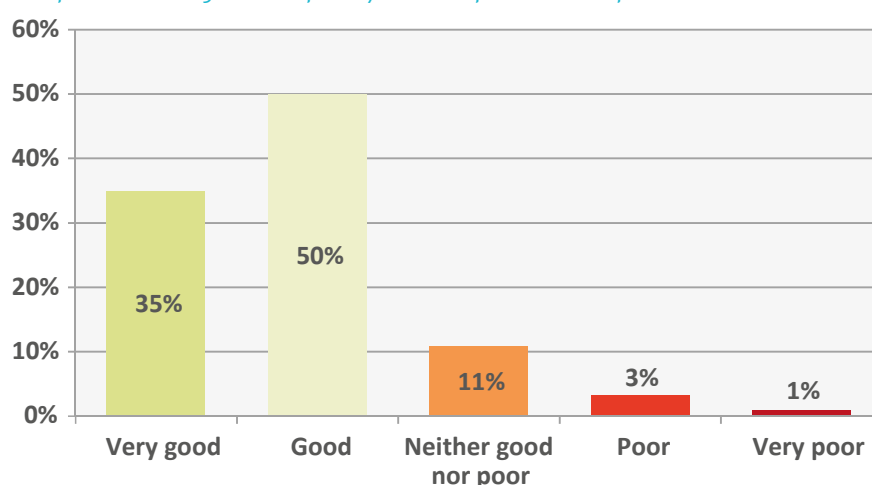
Figure 46: Trainee view of the clinical learning environment, comparison by views on physical safety



3.7.2 Trainee views of the quality of patient care at clinical sites

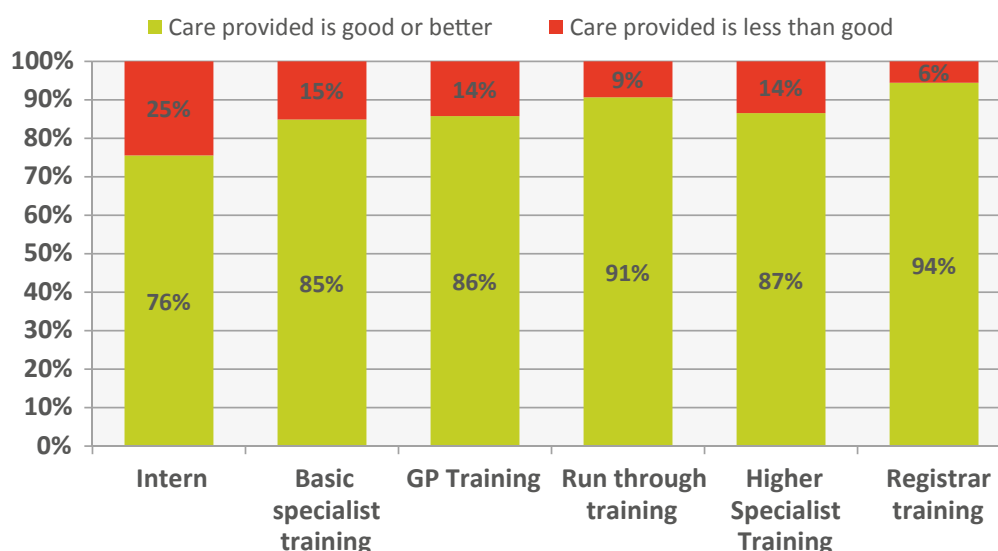
Trainees were asked to consider their view on the quality of care provided to patients at the clinical site where they worked and learned. In total, 85% of trainees reported that they rated the quality of care at the clinical site as 'good' or 'very good'; 4% reported it was 'poor' or 'very poor' (Figure 47).

Figure 47: Trainee reported rating of the quality of care provided to patients



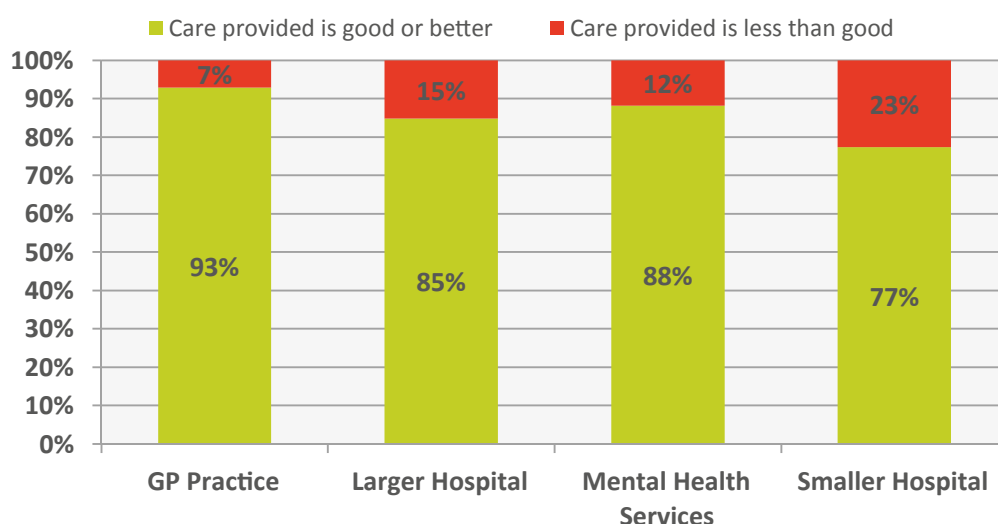
There was no variation in trainee views on the quality of care at clinical sites across gender ($\chi^2(1, N = 1434) = 0.299, p = 0.584$), age group ($\chi^2(4, N = 1434) = 3.37, p = 0.499$), route of entry to medical school ($\chi^2(1, N = 1134) = .221, p = 0.638$) or country of qualification ($\chi^2(1, N = 1434) = 3.33, p = .068$). However, compared with trainees at other stages, interns were much more likely to rate the quality of care as less than good (25%); this difference was significant (Figure 48, $\chi^2(5, N = 1431) = 22.05, p = 0.001$).

Figure 48: Trainee reported rating of the quality of care provided to patients, variation across stage of training



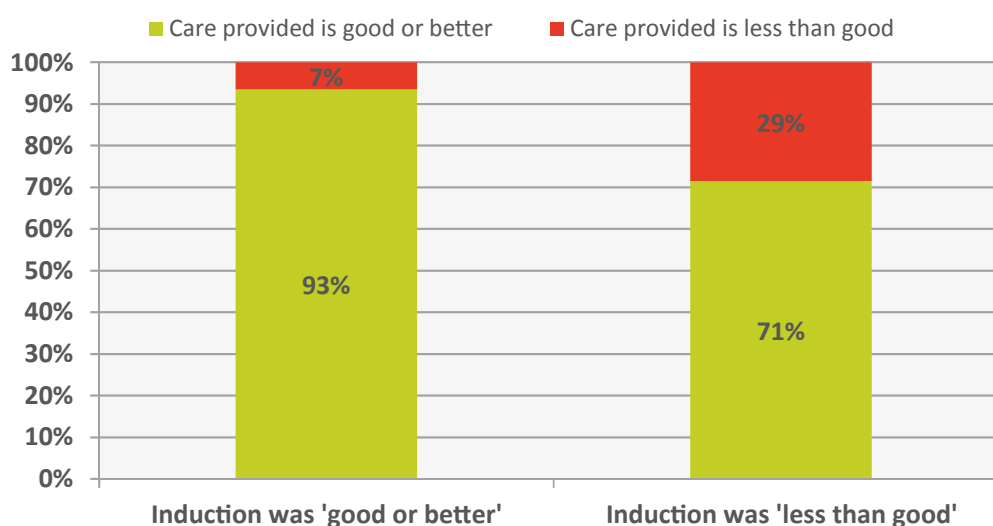
Trainee perceptions of quality of care varied across different types of clinical site (Figure 49). A higher proportion of trainees at GP practices rated care as good or better (93%), while a higher proportion of trainees at smaller hospitals rated the quality of care as less than good; the variation in trainee rating across types of site was significant ($\chi^2(3, N = 1411) = 20.81, p < 0.001$) and remained significant for specialist trainees only ($\chi^2(3, 1199) = 10.9, p = 0.012$).

Figure 49: Trainee reported rating of the quality of care provided to patients, variation across type of clinical site



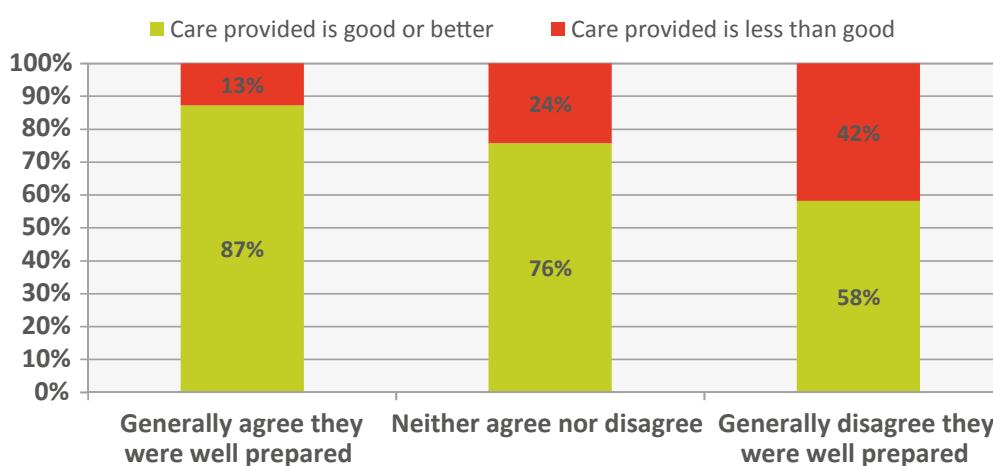
The relationship between experience of induction and rating of quality of care was explored (Figure 50). Compared with trainees who had more positive views on their experience of induction, trainees who reported that induction was less than good were more likely to rate the quality of care as less than good as well; this difference was significant ($\chi^2(1, N = 1420) = 126.05, p < 0.001$).

Figure 50: Trainee reported rating of the quality of care provided to patients, variation by trainee views of induction



For interns, those who felt more prepared for intern year were more likely to rate quality of care more positively than interns who felt less prepared; this variation in views was significant (Figure 51, $\chi^2(2, N=207) = 19.02, p < 0.001$).

Figure 51: Trainee reported rating of the quality of care provided to patients, variation by intern views of preparedness



Finally, trainee views on the overall clinical learning environment were compared with their rating of the quality of care provided at the clinical site. Trainees who rated the quality of care at the clinical site as good or better had a more positive view of the clinical learning environment (177.3) than trainees who rated the quality of care at the clinical site as less than good (139.1); this difference was significant (Figure 52, $t(1288) = 17.62, p < 0.001$).

Figure 52: Trainee views of the clinical learning environment, comparison by rating of the quality of care at the clinical site.



SECTION 4:

CREATING SUPPORTIVE LEARNING ENVIRONMENTS

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4.1 Key themes and emerging agenda from *Your Training Counts* 2014

Looking across the results from *Your Training Counts* 2014, it is possible to identify a number of key themes and an emerging agenda for continuous improvement.

4.1.1 Establishing an evidence-base and monitoring progress

Your Training Counts 2014 collected views regarding over 100 different issues from 1,636 trainees in Ireland at different clinical sites, in various specialities and at all stages of training. This report helps establish a valuable evidence-base to inform our understanding of postgraduate training in Ireland. It comes at a time of debate and discussion about medical education, training and career structures in Ireland, when the issue of medical graduate retention is in focus and in the context of an ambitious programme of health system review. This debate and discussion should be based on information and be learner-focussed. *Your Training Counts* provides evidence about the needs and experiences of doctors in training to inform this debate.

Emerging agenda

Policy and practice in postgraduate training in Ireland cannot be strengthened without robust and comprehensive arrangements for monitoring and evaluation. The national mean total D-RECT score, and the mean total D-RECT scores across a number of different categories of trainee and different settings, provide a useful baseline against which progress with continuous improvement of the clinical learning environment in Ireland can be monitored.

Your Training Counts will be an annual survey of trainee experience in Ireland. With baselines defined in 2014, it will be possible to track progress with the continuous improvement of the clinical learning environment for postgraduate training through subsequent surveys. Having a system in place to monitor progress ensures accountability and supports improvement.⁷⁷

4.1.2 Appreciating strengths and sharing lessons for good practice

Many trainees are enjoying a positive experience of the clinical learning environment in Ireland. This is a strong and clear message emerging from *Your Training Counts* 2014. Their experience must not be overlooked, not least since contained within it may be important lessons for improvement. Furthermore, the clinical learning environment is a complex entity comprising many interlinked attributes. It is also important not to overlook the many facets of their experience which trainees, on average, rated positively. For example, team working and peer collaboration are vital competencies for doctors to learn and the best way to learn these is through participation in the workplace. These competencies are critical for patient safety and it is positive to note that these are strengths of the clinical learning environment in Ireland.

Emerging agenda

An overview of any system will identify strengths and weaknesses. It is easy to focus on deficits, and undoubtedly this report highlights issues that need to be addressed. However, *Your Training Counts* offers the opportunity to better understand what is working well, where, and for whom. For example, what could acute hospitals learn from mental health services and GP practice? Examining good practices and sharing lessons across the system of postgraduate training in Ireland is an important basis to improving every trainee's experience and to reducing unnecessary variation.

4.1.3 Valuing clinical teachers

Trainee recognition of the role of their clinical teachers stands out in *Your Training Counts* 2014. Consultants, GPs and other clinical teachers face multiple competing demands in the delivery of increasingly busy clinical services. Yet it is clear that they are providing strong leadership to doctors in training, and this is to be commended.

Emerging agenda

Formalisation of medical education and training has, undoubtedly, helped improve quality for the benefit of the public and the profession alike. However, the importance of apprenticeship should not be lost.⁷⁸ There is a need to better understand how consultants, GPs and other clinical teachers can be supported in this critical role. For example, the results of *Your Training Counts* 2014 show that feedback is an area where significant and achievable progress could be made. Faculty development arrangements need to be in place to help consultants, GPs and other doctors involved in training to maintain the critical skills needed to be effective teachers, mentors and role models for trainees. Healthcare organisations, policymakers and other stakeholders must support consultants, GPs and other clinical teachers in balancing the demands of delivering clinical services with the important role they fulfil in shaping the next generation of medical professionals.

4.1.4 Addressing variation and ensuring reliability through educational governance

Your Training Counts 2014 also points to areas for improvement.

Across the attributes of the clinical learning environment, it is clear that some basic educational processes – like feedback, educational supervision and adjustment of responsibility to fit the trainee's competence – are working less well than others. Changes in these areas are achievable through explicit procedures to manage learning in the clinical environment, such as proper use of learning portfolios. Weaknesses regarding patient handover need to be addressed not just for the benefit of trainees but in the interest of patient safety. While the individual role of clinical teachers is acknowledged, the style of working between clinicians may not always set positive examples for trainees.

There is also wide variation in the clinical learning environment across clinical sites, which needs to be reduced. Variation is not just random, it is systematic. For example, trainees at acute hospital sites reported poorer experience than trainees at other healthcare facilities. Some variation is to be expected. And nobody – not even the experts surveyed in this study – expect that clinical sites challenged to deliver busy clinical services will consistently deliver an optimum clinical learning environment. But it is reasonable to expect that a greater number of trainees would more reliably experience a satisfactory clinical learning environment. “High-reliability” is a concept which has been used to understand how healthcare organisation can more consistently deliver safe, high-quality care in the context of the challenges which they face.⁷⁹ Extending this concept, wide variation in trainee views of the clinical learning environment needs to be comprehensively addressed so that the quality of the training experience becomes more reliable.

Emerging agenda

Overall, the findings from *Your Training Counts* 2014 point to a need for healthcare organisations to address a number of inter-related issues regarding the governance and management of the clinical site – both as a place for trainees to learn and a place for them to work. The variation in trainee experience must be tackled, first and foremost, through organisational commitment and leadership to improvement. While there is a role for individual clinical teachers, evidence suggests that the educational leadership of

individual clinicians cannot be effective in driving change without broader organisational support.⁸⁰ These changes relate to the clinical site as a learning environment; however, the findings in this report are not simply a problem for educationalists. Good human resource management practices are required to improve trainee experience. Educational governance at clinical sites needs to be strengthened, and an integrated approach adopted, which joins up corporate areas that have responsibility for the safety and quality of clinical care and those that have responsibility for management of the learning environment.

4.1.5 Getting early experience right for interns

The most significant and systematic variation in trainee experience to emerge through *Your Training Counts* 2014 is the challenge facing interns. They reported poorer experiences across the range of domains examined this year and their challenges may be interlinked, beginning with the issue of feeling under-prepared for intern training. Transitions in professional development will never be easy and a step change will present a stretch for trainees – indeed that very stretch is rich in learning experience. But it is difficult to accept that trainees at the earliest stage of their professional development should face a challenge of the scale and scope described in *Your Training Counts* 2014.

Emerging agenda

Progress made with improving intern training in Ireland is to be acknowledged. However, the multiple and inter-related challenges facing interns need to be addressed as a priority. This will require multiple actions and involve multiple stakeholders. Commitment and coordination of effort will be required. These actions will need to be guided by further research, but some simple actions can be started in time for July 2015 – like a more robust, consistent and systematic approach to induction and orientation across intern training networks. The fact that all interns are employed in organisations operated or funded by the Health Service Executive is an opportunity. An outcome-focused approach will be required which clarifies the milestones to be achieved and which takes a process management approach across the continuum from medical school, through the intern year and to the commencement of specialist training.⁶¹

4.1.6 Building good places to work, to learn and to care

Reading across a number of areas examined by *Your Training Counts*, it is evident that more can be done in some places to make the clinical environment a better place to work and learn. While the focus of the Medical Council is on trainees' experience as learners, it is clear that many enablers of a good learning experience in the clinical environment relate to good human resource management practices.

Standing out amongst these issues is trainees' experience of bullying.

That a culture of bullying was endemic in the clinical learning environment in Ireland should not be surprising given that the phenomenon is well described internationally and may be accepted as part of the culture of learning. But the scale of the issues and the systematic variation in trainee experience of this culture is concerning. Added to this, there are implications arising from learning in this culture for the future of medical professionalism.

The relationship of some of the issues identified in *Your Training Counts* – like patient handover, induction and orientation, a sense of under-preparedness among the most junior trainees – to patient safety and quality of care cannot be overlooked. *Your Training Counts* points to opportunities to better ensure that clinical sites are not only good places to learn, but are also good places to work and to provide care to patients.

Emerging agenda

The clinical environments where trainees work, where they learn and where patients receive care are the same place. Action is needed to support trainees as workers in the clinical environment and to build cultures which ensure these are good places to work, to learn and to care. The findings in *Your Training Counts* support the interconnection between these aspects of the clinical environment. The response to the agenda set by *Your Training Counts* cannot be seen simply as the responsibility of the Medical Council, medical education and training bodies and individual clinical teachers. Taking forward this agenda will strengthen the health system today and into the future for the benefit of patients.

4.2 Who is responsible for taking forward this agenda?

As described in Section 1, a number of stakeholders need to be involved to take forward a continuous improvement agenda for the clinical learning environment in Ireland.

At the clinical site, there is a role for clinical teachers, other healthcare professionals, healthcare management and, ultimately, the board overseeing each healthcare organisation. Put simply, clinical sites have a responsibility to control the quality of the clinical learning environment. In the context of the reform to structures in the Irish health system, Chief Academic Officers will need to take a leadership role in placing concern for the quality of the clinical learning environment and the voice of trainees on the agenda for new hospital groups. Within these groups and in other healthcare organisations, specific responsibilities may be delegated to educational leads who can work more closely with issues at the level of specific specialities, departments or associated clinical sites.

The Health Service Executive has a role, above its role in respect of the management of individual training sites. As the organisation that makes proposals of posts to the Medical Council for doctors to be registered as interns and trainee specialists, the Health Service Executive's Medical Education and Training function must be assured that it is making proposals of posts at clinical sites which have effective systems and processes in place to control the quality of the clinical learning environment. To do otherwise would be to fail in its responsibility under the Medical Practitioners Act 2007 to promote the development of specialist medical education and training.

The bodies overseeing intern and postgraduate training already demonstrate commitment to the highest standards of medical education and training in Ireland. As these bodies embed the standards set by the Medical Council, they will continue to take a role in managing the quality of postgraduate training through, for example, selection and training of clinical teachers and through review of the quality of clinical sites from a specialty-specific perspective.

The Medical Council has defined expectations for clinical sites where interns and specialist trainees learn. It already has a programme of intern training site inspection in place and will shortly be commencing a programme of specialist training site inspections. Under the Medical Practitioners Act 2007, it has powers to remove training status from clinical sites if concerns for the quality of the clinical learning environment cannot be in any other way ameliorated. Through its approval of bodies that oversee training, it will also ensure that these bodies are effectively managing the quality of clinical learning environments. Through defining what is required, through monitoring, and through taking action where standards are not met, the Medical Council will quality assure the clinical learning environment.

Finally, while this report focusses on the clinical learning environment, the issues it raises link with good human resource management and governance of the quality and safety of care. Organisations like the Health Information and Quality Authority and the Health and Safety Authority have roles in ensuring robust and effective workforce governance at clinical sites for the benefit of patients and healthcare professionals alike.

4.3 Supportive learning environments – an agenda for continuous improvement

In summary, *Your Training Counts* 2014 sets an agenda for continuous improvement which can help create supportive learning environment in Ireland which will benefit trainees and will ultimately benefit patients.

4.3.1 For healthcare organisations and the Health Service Executive

- We expect healthcare organisations to have in place educational governance arrangements so as to discharge the responsibility for the control of the quality of the clinical learning environment and to have an accountable person delegated with this responsibility. That person should have a plan in place which describes the actions being taken to manage the clinical learning environment in line with Medical Council criteria for clinical sites; the plan should be monitored and progress should be reported to the board or equivalent overseeing management of the organisation. This accountable person and that plan will be the initial point of interaction with the Medical Council when inspections of clinical sites take place in 2015.
- We expect the Health Service Executive, in its annual proposals of intern and specialist training posts to the Medical Council for the purpose of registering trainees, to provide assurance that the quality of the clinical learning environment at the sites where these posts are located is being controlled in line with Medical Council criteria.
- We expect healthcare organisations who employ trainees to ensure that good human resource management practices are in place to deal with simple matters like induction and orientation at the clinical site.
- We expect healthcare organisations who employ trainees to ensure that necessary policies and procedures are defined and embedded to ensure that the clinical environment is a safe place for them to work and learn. This includes a strategy to reduce the prevalence of bullying and undermining behaviours.
- We expect healthcare organisation to work collaboratively with the Medical Council and with medical education and training bodies, recognising the connection between their educational governance arrangements and the overall safety and sustainability of the health system.

4.3.2 For education and training bodies

- We expect all bodies involved in medical education and training to identify and share good practices with regard to management of the clinical learning environment.
- We expect all bodies involved in medical education and training to identify actions, which they will take from 2015 onwards, that are informed by *Your Training Counts* and which specifically address weaknesses in the clinical learning environment. We will track these actions through our monitoring of their approval as training bodies.
- We expect all bodies involved in medical education and training to continue to work with clinical sites to help ensure - through quality management processes - that they consistently provide a good clinical learning environment for trainees. We expect postgraduate training bodies to pay particular attention to aspects of the clinical learning environment relevant to their individual specialty.
- We expect engagement and cooperation from all bodies involved in medical education and training to address challenges set out regarding intern training.

- We expect all bodies involved in medical education and training to work collaboratively to better manage safer and smoother progression between different stages of doctors' professional development.

4.3.3 For policymakers and other stakeholders

- We expect the Department of Health to support the Medical Council's role quality assurance of medical education and training. This means enabling us to develop requisite capacity and capability to effectively assure that quality issues highlighted by *Your Training Counts* 2014 are addressed.
- We expect other organisations with roles involving the governance of healthcare organisations (that are complementary to the role of the Medical Council in quality assuring the clinical learning environment) to ensure the clinical environment is a good place to work for trainees, for the benefit of patients and trainees alike.

4.3.4 For the Medical Council

- We will continue to monitor the training experience of postgraduate training in Ireland through *Your Training Counts* and will share results with trainees and with all relevant stakeholders.
- Through our Student and Trainee Consultative Panel we will seek to better understand that issues facing medical students and trainees so as to better inform our decisions about medical education and training and to ensure that these are learner-centred.
- We will set out a strategy for our role in Medical Education, Training and Professional Development 2015-2020, which will identify areas of focus and priority objectives for the Medical Council.
- Recognising the specific challenges faces by interns, we will review intern training in Ireland to see how interns can be better prepared to make this transition and better supported to benefit from this rich and important stage of professional development.
- In 2015, we will begin a programme of clinical site inspections to understand progress being made on the ground with embedding the criteria set by the Medical Council for places where doctors learn.
- In 2015, we will work with the Health Service Executive Medical Education and Training function to ensure that, in respect of places where posts it proposes to the Medical Council for trainee specialist registration are located, it is satisfied that robust and effective systems and processes are in place to quality control the clinical learning environment.
- We will continue to work with other stakeholders who have a role in the governance of the quality agenda in medical education and training, especially the bodies overseeing training whose role we approve against defined standards.
- In 2015, we will publish a framework for research to enable us to better understand medical education and training in Ireland and to support informed decision-making about quality-assurance.



APPENDICES

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Appendix 2 Specialty groups and overseeing training body

Anaesthesia

College of Anaesthetists of Ireland

- Anaesthesia

Paediatrics

Faculty of Paediatrics - a constituent body of the Royal College of Physicians in Ireland

- Paediatric Cardiology
- Paediatrics

Pathology

Faculty of Pathology - a constituent body of the Royal College of Physicians in Ireland

- Chemical Pathology
- Haematology (Clinical & Laboratory)
- Histopathology
- Immunology (Clinical & Laboratory)
- Microbiology
- Neuropathology

General Practice

Irish College of General Practice

- General Practice

Medicine

Irish Committee on Higher Medical Training -
a constituent body of the Royal College of Physicians in Ireland

- Cardiology
- Clinical Genetics
- Clinical Neurophysiology
- Clinical Pharmacology & Therapeutics
- Dermatology
- Endocrinology & Diabetes Mellitus
- Gastroenterology
- General (Internal) Medicine

- Genito-Urinary Medicine
- Geriatric Medicine
- Infectious Diseases
- Medical Oncology
- Nephrology
- Neurology
- Palliative Medicine
- Pharmaceutical Medicine
- Rehabilitation Medicine
- Respiratory Medicine
- Rheumatology
- Tropical Medicine

Emergency Medicine

Royal College of Surgeons of Ireland

- Emergency Medicine

Psychiatry

College of Psychiatrists of Ireland

- Psychiatry
- Child & Adolescent Psychiatry
- Psychiatry of Learning Disability
- Psychiatry of Old Age

Public Health Medicine

Faculty of Public Health Medicine in Ireland - a constituent body of the Royal College of Physicians in Ireland

- Public Health Medicine

Radiology

Faculty of Radiology

- Radiation Oncology
- Radiology

Obstetrics & Gynaecology

Institute of Obstetrics and Gynaecology - a constituent body of the Royal College of Physicians in Ireland

- Obstetrics & Gynaecology

Surgery

Royal College of Surgeons in Ireland

- Cardiothoracic Surgery
- General Surgery
- Neurosurgery
- Ophthalmic Surgery*
- Oral & Maxillo-Facial Surgery
- Otolaryngology
- Paediatric Surgery
- Plastic, Reconstructive & Aesthetic Surgery
- Trauma and Orthopaedic Surgery
- Urology

Occupational Medicine

Faculty of Occupational Medicine - a constituent body of the Royal College of Physicians in Ireland

- Occupational Medicine

Ophthalmology

Irish College of Ophthalmology

Appendix 3: D-RECT - Original and amended questionnaire

Attribute Subscale (number of items)	Question (<i>amendment for use in Ireland</i>)
Supervision (3 items)	The guidelines clearly outline when to request input from a supervisor
	The amount of supervision I receive is appropriate for my level of experience
	It is clear which attending (<i>consultant</i>) supervises me
Coaching and assessment (8 items)	I am asked on a regular basis to provide a rationale for my management decisions and actions
	My attendings (<i>consultants</i>) coach me on how to communicate with difficult patients
	My attendings (<i>consultants</i>) take the initiative to explain their actions
	My attendings (<i>consultants</i>) take the initiative to evaluate my performance
	My attendings (<i>consultants</i>) take the initiative to evaluate difficult situations I have been involved in
	My attendings (<i>consultants</i>) evaluate whether my performance in patient care is commensurate with my level of training
	My attendings (<i>consultants</i>) occasionally observe me taking a history
	My attendings (<i>consultants</i>) assesses not only my medical expertise but also other skills such as teamwork, organisation or professional behaviour
Feedback (3 items)	My attendings (<i>consultants</i>) give regular feedback on my strengths and weaknesses
	Observation forms (<i>such as Mini-CEX, DOPS etc.</i>) are used to structure feedback
	Observation forms (<i>such as Mini-CEX, DOPS etc.</i>) are used periodically to monitor my progress
Teamwork (4 items)	Attendings (<i>consultants</i>), nursing staff, other allied health professionals and residents (<i>trainees</i>) work together as a team
	Nursing staff and other allied health professionals make a positive contribution to my training
	Nursing staff and other allied health professionals are willing to reflect with me on the delivery of patient care
	Teamwork is an integral part of my training
Peer collaboration (3 items)	Residents (<i>trainees</i>) work well together
	Residents (<i>trainees</i>), as a group, make sure the day's work gets done
	Within our group of residents (<i>trainees</i>) it is easy to find someone to cover or exchange a call (an on-call shift)

Attribute Subscale (number of items)	Question (amendment for use in Ireland)
Professional relations between attendings (<i>consultants</i>) (3 items)	Continuity of care is not affected by differences of opinion between attendings (<i>consultants</i>)
	Differences of opinion between attendings (<i>consultants</i>) about patient management are discussed in such a manner that is instructive to others present
	Differences of opinion are not such that they have a negative impact on the work climate
Work is adapted to resident's (<i>trainee's</i>) competence (4 items)	The work I am doing is commensurate with my level of experience
	The work I am doing suits my learning objectives at this stage of my training
	It is possible to do follow up with patients
	There is enough time in the schedule for me to learn new skills
Attendings' (<i>consultants'</i>) role (8 items)	My attendings (<i>consultants</i>) take time to explain things when asked for advice
	My attendings (<i>consultants</i>) are happy to discuss patient care
	There is/are NO attending physician(s) (<i>consultants</i>) who have a negative impact on the climate
	My attendings (<i>consultants</i>) treat me as an individual
	My attendings (<i>consultants</i>) treat me with respect
	My attendings (<i>consultants</i>) are all in their own way positive role models
	When I need an attending (<i>consultants</i>) I can always contact one
	When I need to consult an attending (<i>consultants</i>), I can always contact one
	When I need to consult an attending (<i>consultants</i>) they are readily available
Formal education (4 items)	Residents (<i>trainees</i>) are generally able to attend scheduled educational activities
	Educational activities take place as scheduled
	Attendings (<i>consultants</i>) contribute actively to the delivery of high-quality formal education
	Formal education and training activities are appropriate to my needs

Attribute Subscale (number of items)	Question (amendment for use in Ireland)
Role of the specialty tutor (<i>educational supervisor</i>) (6 items)	The specialty tutor (<i>educational supervisor</i>) monitors the progress of my training
	The specialty tutor (<i>educational supervisor</i>) provides guidance to other attending's when needed
	The specialty tutor (<i>educational supervisor</i>) is actively involved in improving the quality of education and training
	In this rotation evaluations are useful discussions about my performance
	My plans for the future are part of the discussion
	During evaluations, input from several attendings (<i>consultants</i>) is considered
Patient sign out (<i>patient handover</i>) (4 items)	When there is criticism of a management plan I have developed in consultation with my attending physician (<i>consultant</i>), I know the attending physician (<i>consultant</i>) will back me up
	Sign out (<i>patient handover</i>) takes place in a safe climate
	Sign out (<i>patient handover</i>) is used as a teaching opportunity
	Attendings (<i>consultants</i>) encourage residents to join in the discussion during sign out

Appendix 4: Other questions in *Your Training Counts 2014*

Induction and Orientation

Please say how much you agree, or disagree, with the following statements:

- Did you get all the information you needed about your workplace when you started working in this post?
- Did someone explain your role and responsibilities in your unit or department when you started working in this post?
- Did you sit down with your educational supervisor and discuss your educational objectives for this post?
- How would you rate the quality of the induction in this post (this refers to the induction to the organisation in which you worked)?

Preparedness

Please say how much you agree, or disagree, with the following statements:

- "My previous medical education and training prepared me well for the jobs I have undertaken so far this year"
- "My previous medical education and training prepared me well with the clinical knowledge I needed for this year"
- "My previous medical education and training prepared me well with the interpersonal skills I needed for this year"
- "My previous medical education and training prepared me well for the clinical procedures I carried out this year"
- "My previous medical education and training prepared me well for the administrative tasks I carried out this year"
- "My previous medical education and training prepared me well for the physical/ emotional/ mental demands of this year"

Bullying and Undermining

- How often, if at all, have you been the victim of bullying and harassment in this post?
- How often, if at all, have you witnessed someone else being the victim of bullying and harassment in this post?
- In this post, how often if at all, have you experienced behaviour from a consultant/GP that undermined your professional confidence and/or self-esteem?

Safety and Quality of Care

- Please say how much you agree, or disagree, with the following statement:
 - "I feel physically safe within the hospital environment"
- Overall, how would you rate the quality of care provided to patients in this post?

Appendix 5: More detailed and additional analyses

Overview of responses to D-RECT

Items	N	Mean	Standard Deviation
"Observation forms (such as Mini-CEX, DOPS etc.) are used periodically to monitor my progress"	1495	2.49	1.23
"My consultants occasionally observe me taking a history"	1494	2.50	1.23
"Observation forms (such as Mini-CEX, DOPS etc.) are used to structure feedback"	1494	2.51	1.24
"There are NO consultants who have a negative impact on the climate"	1421	2.73	1.28
"Patient handover is used as a teaching opportunity"	1329	2.92	1.15
"My consultants give regular feedback on my strengths and weaknesses"	1561	2.93	1.20
"There is enough time in the schedule for me to learn new skills"	1507	2.93	1.20
"Continuity of care is not affected by differences of opinion between consultants"	1417	3.01	1.10
"During evaluations, input from several consultants is considered"	1330	3.01	1.11
"The educational supervisor provides guidance to other consultants when needed"	1334	3.10	1.04
"My consultants coach me on how to communicate with difficult patients"	1534	3.13	1.19
"The guidelines clearly outline when to request input from a supervisor"	1559	3.16	1.10
"My consultants take the initiative to evaluate difficult situations I have been involved in"	1549	3.19	1.18
"I am asked on a regular basis to provide a rationale for my management decisions and actions"	1569	3.23	1.11
"The educational supervisor monitors the progress of my training"	1419	3.25	1.15
"My consultants take the initiative to evaluate my performance"	1562	3.27	1.16
"The educational supervisor is actively involved in improving the quality of education and training"	1388	3.30	1.08
"Differences of opinion between consultants about patient management are discussed in such a manner that is instructive to others present"	1404	3.31	0.99

Items	N	Mean	Standard Deviation
"Consultants encourage trainee doctors to join in the discussion during patient handovers"	1267	3.31	1.07
"Patient handover takes place in a safe climate"	1337	3.32	1.08
"In this rotation evaluations are useful discussions about my performance"	1423	3.34	1.07
"Consultants contribute actively to the delivery of high-quality formal education"	1449	3.36	1.08
"My consultants evaluate whether my performance in patient care is commensurate with my level of training"	1550	3.37	1.08
"Formal education and training activities are appropriate to my needs"	1470	3.37	1.16
"Within our group of trainee doctors it is easy to find someone to cover or exchange an on-call shift"	1385	3.40	1.13
"Differences of opinion are not such that they have a negative impact on the work climate"	1458	3.41	0.97
"It is possible to do follow up with patients"	1466	3.41	1.07
"Trainee doctors are generally able to attend scheduled educational activities"	1463	3.45	1.20
"My consultants assess not only my medical expertise but also other skills such as teamwork, organisation or professional behaviour"	1559	3.47	1.14
"My consultants take the initiative to explain their actions"	1560	3.54	1.09
"My plans for the future are part of the discussion"	1422	3.55	1.05
"When there is criticism of a management plan I have developed in consultation with my consultant, I know the consultant will back me up"	1393	3.56	0.93
"The work I am doing suits my learning objectives at this stage of my training"	1509	3.59	1.09
"Nursing staff and other allied health professionals are willing to reflect with me on the delivery of patient care"	1481	3.62	1.00
"Nursing staff and other allied health professionals make a positive contribution to my training"	1491	3.69	1.04
"The work I am doing is commensurate with my level of experience"	1509	3.69	0.98
"Educational activities take place as scheduled"	1467	3.69	1.04
"My consultants are all in their own way positive role models"	1455	3.71	1.01

Items	N	Mean	Standard Deviation
"When I need to consult a consultant, they are readily available"	1452	3.71	1.06
"The amount of supervision I receive is appropriate for my level of experience"	1571	3.81	1.05
"Consultants, nursing staff, other allied health professionals and trainee doctors work together as a team"	1490	3.86	0.95
"When I need a consultant I can always contact one"	1449	3.91	1.03
"My consultants treat me as an individual"	1456	3.92	0.88
"It is clear which consultant supervises me"	1554	3.96	1.14
"My consultants treat me with respect"	1458	4.04	0.81
"Trainee doctors work well together"	1471	4.05	0.78
"My consultants take time to explain things when asked for advice"	1456	4.06	0.81
"Trainee doctors as a group, make sure the day's work gets done"	1459	4.15	0.83
"Teamwork is an integral part of my training"	1507	4.17	0.86
"My consultants are happy to discuss patient care"	1446	4.17	0.73

Variation in view on attributes of clinical learning environment by stage of training

Subscale: Supervision	N	Mean	Lower 95% CI	Higher 95% CI
Intern Training Programme	238	3.3	3.2	3.4
Basic Specialist Training Programme	401	3.5	3.4	3.6
G.P. Training Programme	339	3.7	3.6	3.8
Run-through Specialist Training Programme	53	3.7	3.5	3.9
Registrar Training Programme	84	3.8	3.6	4.0
Higher Specialist Training Programme	425	3.9	3.8	3.9

Subscale: Coaching and assessment	N	Mean	Lower 95% CI	Higher 95% CI
Basic Specialist Training Programme	392	3.6	3.5	3.7
Run-through Specialist Training Programme	53	3.7	3.4	4.0
G.P. Training Programme	340	3.8	3.7	3.9
Higher Specialist Training Programme	376	4.0	3.9	4.1
Registrar Training Programme	82	4.0	3.8	4.2

Subscale: Feedback	N	Mean	Lower 95% CI	Higher 95% CI
Intern Training	222	1.9	1.8	2.0
Run-through Specialist Training	51	2.5	2.2	2.7
G.P. Training	319	2.6	2.5	2.7
Basic Specialist Training	392	2.7	2.6	2.8
Higher Specialist Training	419	2.9	2.8	3.0
Registrar Training	80	3.0	2.8	3.2

Subscale: Teamwork	N	Mean	Lower 95% CI	Higher 95% CI
Intern Training Programme	231	3.46	3.3403	3.5796
Basic Specialist Training Programme	389	3.7763	3.699	3.8537
G.P. Training Programme	316	3.8758	3.795	3.9566
Run-through Specialist Training Programme	52	3.8894	3.6924	4.0865
Higher Specialist Training Programme	401	4.0125	3.9449	4.08
Registrar Training Programme	79	4.0443	3.8909	4.1977

Subscale: Peer collaboration	N	Mean	Lower 95% CI	Higher 95% CI
Basic Specialist Training Programme	384	3.8	3.8	3.9
Higher Specialist Training Programme	386	3.8	3.8	3.9
G.P. Training Programme	256	3.8	3.8	3.9
Run-through Specialist Training Programme	53	3.9	3.7	4.1
Intern Training Programme	225	4.0	3.9	4.1
Registrar Training Programme	75	4.0	3.8	4.2

Subscale: Professional relations between consultants	N	Mean	Lower 95% CI	Higher 95% CI
G.P. Training Programme	261	3.1	2.9	3.2
Intern Training Programme	224	3.1	3.0	3.2
Run-through Specialist Training Programme	52	3.2	2.9	3.4
Basic Specialist Training Programme	378	3.3	3.2	3.4
Higher Specialist Training Programme	389	3.3	3.2	3.4
Registrar Training Programme	77	3.5	3.3	3.7

Subscale: Work being adapted to trainees' competence	N	Mean	Lower 95% CI	Higher 95% CI
Intern Training Programme	228	2.9	2.7	3.0
Basic Specialist Training Programme	384	3.3	3.2	3.4
Run-through Specialist Training Programme	51	3.4	3.2	3.7
Higher Specialist Training Programme	390	3.6	3.5	3.7
G.P. Training Programme	330	3.6	3.5	3.7
Registrar Training Programme	77	3.6	3.5	3.8

Subscale: Consultants' role	N	Mean	Lower 95% CI	Higher 95% CI
Intern Training Programme	219	2.9	2.7	3.0
G.P. Training Programme	304	3.0	2.9	3.1
Run-through Specialist Training Programme	53	3.1	2.8	3.4
Basic Specialist Training Programme	381	3.2	3.1	3.3
Higher Specialist Training Programme	411	3.3	3.2	3.4
Registrar Training Programme	73	3.4	3.1	3.7

Subscale: Formal Education	N	Mean	Lower 95% CI	Higher 95% CI
Basic Specialist Training Programme	218	3.1	3.0	3.2
G.P. Training Programme	378	3.4	3.3	3.5
Higher Specialist Training Programme	73	3.5	3.2	3.7
Intern Training Programme	413	3.6	3.5	3.7
Registrar Training Programme	307	3.6	3.5	3.7
Run-through Specialist Training Programme	53	3.7	3.5	4.0

Subscale: Role of the Educational Supervisor	N	Mean	Lower 95% CI	Higher 95% CI
Basic Specialist Training Programme	204	2.9441	2.8354	3.0528
G.P. Training Programme	347	3.0906	2.9974	3.1838
Higher Specialist Training Programme	272	3.3382	3.237	3.4395
Intern Training Programme	48	3.3458	3.069	3.6227
Registrar Training Programme	386	3.4725	3.3919	3.5531
Run-through Specialist Training Programme	71	3.4953	3.2854	3.7052

Subscale: Patient handover	N	Mean	Lower 95% CI	Higher 95% CI
Basic Specialist Training Programme	195	2.8	2.7	3.0
G.P. Training Programme	345	3.3	3.2	3.4
Higher Specialist Training Programme	222	3.3	3.2	3.4
Intern Training Programme	49	3.4	3.1	3.6
Registrar Training Programme	338	3.5	3.4	3.6
Run-through Specialist Training Programme	68	3.6	3.4	3.8

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