Why residents quit: Prevalence of and reasons for attrition among anaesthesia residents in a single sponsoring institution

Daphne Moo, Wei Shyan Siow and Ee Teng Ong

Abstract

Background: The SingHealth Anaesthesiology Residency Programme (SHARP) is a 5-year postgraduate training programme in Singapore. Since its inauguration in 2011, SHARP has taken in the largest number of anaesthesia residents in Singapore. However, we noticed significant attrition over the years. As attrition is a costly and disruptive affair, both to the individual and the programme, we seek to investigate the prevalence of and reasons for separation, in order to determine ways to minimize attrition.

Methods: An online anonymous survey was conducted among all residents who have separated from SHARP. The questionnaire comprised questions regarding demographic data, reasons behind separation, obstacles faced during residency, and potential ways to reduce attrition.

Results: From 2011 to 2018, 22 out of 127 residents have separated from the programme, giving an overall attrition prevalence of 17%. Nineteen (86%) of the separated residents responded to our questionnaire. The most common reason for separation was due to difficulties in juggling childcare and training commitments. Of the residents who have separated, more than half of them would consider rejoining the programme if a less than full time (LTFT) option was available.

Conclusion: One out of every six residents in the SHARP quits residency training. The reasons behind separation are often varied due to each resident’s unique social circumstances. An individualized training programme with a LTFT option that allows for flexibility may boost retention in the programme.

Keywords

Anaesthesia, residency, less than full time training

Introduction

SingHealth is the largest sponsoring institution (SI) for Residency Programmes providing postgraduate training in Singapore. The SingHealth Anaesthesiology Residency Programme (SHARP) is governed by the policies of the Accreditation Council Graduate Medical Education – International (ACGME-I) – and has been taking in the largest number of residents in the country since 2011. The SHARP curriculum extends over 5 years. In addition to the ACGME-I requirements, junior residents are required to pass the two-part Master in Medicine (MMed) Anaesthesiology examinations before they can progress to Senior Residency (SR), the final 2 years of the programme. At the end of their second year in SR, residents must pass an exit examination before they can be accredited as specialists. All the above requirements must be met within 8 years. Currently, only full-time training is available.

A significant amount of resources is invested into recruiting and training every resident. The premature loss of every resident is disruptive and costly to the programme. On top of the increased work load and call duties for the remaining residents, the overall morale of the residency is also lowered. Additional time and effort is also required to reshuffle manpower to minimize the impact on patient care and duty rosters.

As General Surgery (GS) residency programmes are known to have the highest rates of attrition, several studies have investigated the prevalence and causes of attrition. Several studies have investigated the prevalence and causes of attrition of GS
residents.\textsuperscript{7,8} However, there are no similar studies for anaesthesia residency programmes in the literature. Hence, we decided to look into the overall prevalence and causes of attrition, from the perspectives of those who have left, with the aim of gaining additional insight into ways to boost retention.

**Methods**

Before beginning the study, an application was submitted to the SingHealth Centralized Institutional Review Board (IRB) for review. The IRB decided that no further ethical deliberation was required as an anonymous survey was used. An anonymous online survey was carried out using a self-administered questionnaire. The survey was made available for 6 months from March to August 2019. The questionnaire comprised 39 questions divided into three main sections: (a) Demographic information, (b) Training progress in residency, and (c) Reasons for separation from the programme and what could have prevented the departure.

The first section, on demographic information, included questions about gender, age, undergraduate medical education and number of years spent practicing anaesthesia before starting residency training. In view of the small number of participants, this section was made optional to allay fears that their responses may be identifiable from certain data. We also asked whether the respondent's current practice was still related to anaesthesia.

The second section collected data on the resident's training progress, such as whether they passed any examinations, if there was a need for remediation during training and the reasons behind remediation. In the third section, information was collected on the primary and all other secondary contributing reasons that led to separation. We included options such as unpredictable working hours, need for stay-in calls, change in family dynamics, unsupportive training environment or faculty, unsuccessful attempts at examinations and change of interest. Respondents could choose one primary reason and all secondary reasons that they felt were relevant to their circumstances. A free-text box was available for all other reason(s). There was also a separate section for residents who were parents, focusing on information with regards to childcare and the struggles they faced while juggling training requirements with parental responsibilities.

We asked if and how a temporary interruption from training might have been helpful in mitigating separation, and if they would consider re-entering the programme if a part-time training option was made available to them. A free-text box for alternative responses was included in all questions. At the end of the questionnaire, an opportunity was given for the respondents to share any suggestions on how they felt the programme could be improved, in order to reduce attrition in future.

The survey was developed by two main study investigators, and was then sent to the Programme Director and Assistant Director for feedback on content validity, relevancy and readability. The survey was then pretested on a senior resident before it was sent out to all the participants.

All 22 residents who have separated were contacted via email to participate in the anonymous online survey. Anonymized responses were collected and reminders were sent every 2 weeks to boost the response rate until the survey was closed. Participation in the survey was on a voluntary basis and no incentives were given.

**Results**

From 2011 to 2018, the SHARP recruited a total of 127 residents, of which 22 residents have separated from the programme, giving an overall attrition prevalence of 17%. Among the separated residents, 17 (77%) were females while five (23%) were males. As the programme had more female (69%) than male (33%) residents, we also calculated the attrition rates according to gender. Some 19% of female residents, as compared with 13% of their male counterparts, left the programme.

Of the 78 residents recruited from 2011 to 2014, only 33 (42%) completed their training on time. Within this cohort, 13 (17%) of them separated; 14 (18%) extended their training by 4 months to 2 years due to reasons such as maternity leave, no pay leave, national service or unsuccessful attempts at examinations. The remaining 18 (23%) residents are still in training (Figure 1).

Subsequently, 49 residents were recruited into the programme from 2015 to 2018. Among them, 29 (59%) of them are on track to completion within the stipulated 5 years. 11 (22%) residents have been delayed in their progress and nine residents (18%) have separated from the programme (Figure 2).

Nineteen out of 22 separated residents responded to our survey (86%); 16 (84%) respondents were females and three (16%) were males. In total 17 (90%) of these residents joined the programme when they were 30 years old or younger; and two (10%) were recruited when they were above 30 years old. Eight (42%) of them went to an overseas medical college, while 11 (58%) of them graduated from local medical schools. The majority of the respondents (84%) had no more than 2 years of anaesthesia exposure before residency training, while three (16%) had more than 2 years of experience in anaesthesia before becoming a trainee.

Eleven residents did not achieve any success with the MMED examinations, whereas four of them passed the first part, and the remaining four residents completed both parts. Fifteen of the respondents (79%) considered separation within the first 3 years of training, while four (21%) only entertained that thought after 3 years. Only two of the separated residents (11%) required remediation. Separation was voluntary and initiated by the resident for majority of the cases (89%). However, two (11%) residents reported that the faculty brought up the idea of separation first.

Table 1 shows the primary reasons that respondents chose for separation. The top three primary reasons were: (a) addition of a newborn in their family nucleus and childcare issues; (b) options with more attractive remuneration were available; (c) irregular working hours including the need for stay-in calls. Other primary reasons chosen include unsupportive training environment; a change of interest; the lack of
inspiring role models; unsuccessful attempts at examinations; and the fact that our local examinations were not recognized internationally. Respondents then indicated all secondary factors that contributed to separation. Their responses are listed in Table 2.

We collected data on the subgroup of residents who were working parents. A total of 11 responses were collected. Seven residents had family support with regards to childcare but four had to rely entirely on external help, including foreign domestic workers, childcare or infant care. For this subgroup, the most important deciding factor that contributed to separation is presented in Table 3. The most common reason cited was difficulty in juggling examination preparations on top of parental responsibilities. All other contributing factors are listed in Table 4.

Eleven (58%) residents felt that a temporary interruption of training for at least 6 months might have been helpful in avoiding their separation. They postulated that it would give them more time to resolve personal issues relating to childcare or health, and figure out ways to achieve better work–life balance. Ten (53%) of the respondents indicated that they would consider rejoining the programme if a part-time option was made available. However, six (31%) of them stated that this would not change their minds, and three (16%) residents

**Table 1.** Primary Reasons for Separation.

| Reason                                                        | Count (Percentage) |
|---------------------------------------------------------------|--------------------|
| Addition of a newborn and childcare issues                    | 5 (26%)            |
| Options with better remuneration were available                | 4 (21%)            |
| Irregular working hours including the need for stay-in calls   | 3 (16%)            |
| Unsupportive training environment                              | 2 (11%)            |
| Change of interest                                             | 2 (11%)            |
| Lack of inspiring role models                                  | 1 (5%)             |
| Unsuccessful attempts at the examinations                      | 1 (5%)             |
| The MMed Examinations was not recognized internationally (free text) | 1 (5%)             |
| Inability to take no pay leave                                 | 0 (0%)             |
| Need for remediation                                           | 0 (0%)             |
| Inability to get along with colleagues                        | 0 (0%)             |

**Table 2.** Secondary Reasons for Separation.

| Reason                                                        | Count |
|---------------------------------------------------------------|-------|
| Irregular working hours including the need for stay-in calls  | 14    |
| Unsupportive training environment                              | 6     |
| Addition of a newborn and childcare issues                    | 4     |
| Lack of inspiring role models                                  | 3     |
| Options with better remuneration were available                | 3     |
| Inability to take NPL                                          | 2     |
| Unsuccessful attempts at the examinations                      | 2     |
| Environment was not stimulating or challenging anymore (free text) | 1     |
| Lack of family support (free text)                            | 1     |
| Change of Interest                                             | 0     |
| Need for remediation                                           | 0     |
| Inability to get along with colleagues                        | 0     |
were undecided. Among the 19 respondents, six (33%) of them are currently still pursuing a career related to anaesthesia, in non-training positions.

We also asked these separated residents what they felt would reduce attrition in the programme (Table 5). A free-text section for additional suggestions was provided and their thoughts have been summarized in Table 6.

**Discussion**

Over a 7-year period from 2011 to 2018, the SHARP had an overall attrition prevalence of 17%. This is comparable to the attrition prevalence of 18% described among GS residents, with uncontrollable lifestyle quoted as the most common reason for attrition. Given the close working relationship
between anaesthetists and surgeons, and hence similar unpredictable working hours, this comparable attrition rate is not unexpected.

The top primary reason for attrition was the addition of a newborn and childcare issues. All five residents who cited this as their primary reason were females. This is consistent with the literature reviewed, where female residents were significantly more likely to leave the programme for family reasons when compared with their male counterparts. The authors postulated that this is because postgraduate specialty training often coincides with the child-bearing years of most residents. In Singapore, the responsibility for child-rearing activities still typically falls on mothers rather than fathers. Female residents are often also the main caregivers of elderly or sick family members.

In light of the growing percentage of women in the medical workforce, it would be myopic to simply avoid the recruitment of female residents. Moreover, many studies have shown that female physicians have greater empathy, and produce better patient outcomes. Instead, this should highlight an urgent need for more flexibility in the programme, in order to accommodate and retain female doctors with family responsibilities in the residency.

In the United Kingdom, postgraduate specialty training on a less than full time (LTFT) basis is well established and fully supported by the Royal College of Anaesthetists. More than 10% of anaesthesia trainees work LTFT for at least part of their career. LTFT training has been shown to retain doctors in the workforce and is not hurdle to successful completion of training. Evidence has shown that female doctors do subsequently return to full-time work when they have fewer childcare responsibilities. LTFT training creates a viable option for them to complete their training and is an important part of building a diverse and sustainable workforce. Although majority of LTFT trainees in the UK are females, the demand for LTFT training has increased over the years. As the current generation of physicians is known to place more value on work–life balance, LTFT training is expected to become a lifestyle choice in the future, regardless of gender.

A unique flexible option (FO) is also offered by the Paediatric Residency Programme in the University of California, San Francisco. FO residents work 6–8 months each year and can take up to 5 years to complete the 33 months of training required. A 10-year review done by the programme showed encouraging results – none of the FO residents left the programme, and specialty board scores were similar across FO and regular schedule residents. Two of the FO residents also went on to become chief residents. The study concluded that the FO was a powerful tool in recruiting and retaining residents who are truly passionate about the values embraced by the specialty, hence improving the overall morale of the residents.

In this study, the majority of the separated residents indicated that they would consider rejoining the programme if a part-time option was available. Although there is currently no LTFT residency training available in Singapore, it may be timely for the programme leadership to recognize that the traditional model of a “one size fits all” training pathway may no longer be the best possible use of resources. Instead, LTFT training should be given full consideration as a viable option. In the long run, it may be worthwhile to invest additional time and effort to develop individualized training plans tailored to suit the evolving needs of both the programme and the trainees.

Notably, one-third of the separated residents are still pursuing a career related to anaesthesia, implying that separation was not due to a wrong choice of specialty, but a training environment that was not sustainable for residents with additional responsibilities outside work. We noticed that majority of the separated residents did not require remediation and were not dismissed by the programme because of unsatisfactory performance. This suggests that they were clinically competent, and their premature departure was possibly a loss to the training programme and the public healthcare system.

The third highest primary reason for separation was irregular working hours, including the need for stay-in calls (16%). Taking into consideration the nature of the practice of anaesthesia, unpredictable hours form an integral part of the work involved and is unlikely to be modifiable. Hence, managing the expectations of residents is key in reducing attrition due to this reason. Without adequate work experience in the specialty, residents may have unrealistic expectations of training and working hours, leading to increased inclination towards attrition. Hence, we suggest making prior work experience in anaesthesia a prerequisite before application to the programme, so as to better prepare prospective residents for the rigorous reality of postgraduate training.

A significant number of responses cited the absence of a supportive training environment and the scarcity of role models as a contributory factor for leaving. A qualitative study that conducted in-depth interviews among those who left their residency programme found that even when protected time was given for formal educational sessions, these residents felt that their absence from clinical duties was still perceived to be frowned upon by their seniors. Moving forward, a qualitative follow-up study involving interviews with our separated anaesthesia residents may be helpful in finding out whether there was a similar experience locally. Meanwhile, it would be important to reassure residents that protected educational sessions will be supported by all staff in teaching hospitals.

It is also crucial to note that having an assigned mentor does not automatically lead to a constructive and supportive relationship. Positive faculty–resident interactions have been associated with increased resident satisfaction and decreased desire to leave prematurely. However, this will require effort from the programme to recruit faculty members who are genuinely interested in nurturing junior doctors, on top of ensuring that they are remunerated appropriately and have sufficient administrative time set aside to discharge their residency-related duties.

The main limitation of our study is the small sample size, as only separated residents from one programme in a single SI were included. It would be more informative if similar studies were conducted in other residency programmes nationwide. Second, our survey was done on a voluntary basis and is hence subject to response bias. There may be unknown systemic differences between the respondents and non-respondents.
which can limit the generalizability of our results. Non-
respondents may have had a more unpleasant experience dur-
ing their time in residency, hence their refusal to participate in the questionnaire. Despite reassurances given to ensure ano-
nymity of the responses, the possibility of inaccurate answers from those who feared career repercussions remains unavoid-
able. As we did not conduct any in-depth interviews to explore individual experiences in detail, precise qualitative data could not be collected. Nevertheless, we had a robust response rate of 86%. This questionnaire was specifically designed to focus on the circumstances leading to attrition, as described by for-
er residents. We understand that experiences can be multi-
faceted, and we recognize that this study did not explore the perspectives of the faculty on the separated residents, which may be vastly different.

Conclusion
The separation of a resident is a costly and disruptive affair. This is the first study since the inauguration of the SHARP that seeks to gain a deeper understanding of the factors responsible for attrition, from the viewpoints of the sepa-
rated residents.

Female residents were more likely to leave, citing childcare responsibilities as the most common primary reason. A flex-
ible training system with the option of LTFT training may be a feasible intervention that can boost retention within the programme.

Our survey findings also suggested multiple areas for improvement within the training programme, therefore pro-
viding fertile grounds for future research to qualitatively investigate the reasons behind attrition.

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Author contributions
Dr Daphne Moo, Dr Wei Shyan Siow and Dr Ee Teng Ong were involved in the literature review, data collection, data analysis and paper write-up.

Availability of data
The datasheets generated and analyzed during the study are availa-
ble from Dr Daphne Moo.

Ethical approval
Singhealth Centralised Institutional Review Board (CIRB) has reviewed and determined that the application does not require fur-
ther deliberation because this project aims to find out the reasons of separation from the Anaesthesia Residency Program using an anon-
ymous survey.

Informed consent
Written informed consent was not obtained because this project aims to find out the reasons of separation from the Anaesthesia Residency Program using an anonymous survey.

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**Reasons for separation from SHARP**

* Required

**Did you take no pay leave (NPL) during your training?** *

Mark only one oval.

- Yes
- No
- I requested for NPL but was not granted
- Other: __________ (Free Text)

**What was the main reason behind taking NPL?** *

Mark only one oval.

- Health reasons
- Childcare issues
- To study for exams due to previous unsuccessful attempt(s)
- To resolve other outstanding personal issues
- To explore other interests
- Other: __________ (Free Text)

**Choose all other reasons behind taking NPL** *

Check all that apply.

- Health reasons
- Childcare issues
- To study for exams due to previous unsuccessful attempt(s)
- To resolve other outstanding personal issues
- To explore other interests
- Other: __________ (Free Text)

**In which way did taking NPL contribute to your decision for separation?** *

Mark only one oval.

- No, taking NPL did not contribute in any way.
- Taking NPL actually gave me time to resolve some of my issues and hence delayed my decision for separation.
- It gave me some time to explore other options and interests which convinced me that I did not want to pursue a career in Anaesthesia
- It allowed me to take time off work to prepare for exams but I was still unsuccessful
- It made me realize that spending time with my child/children is my top priority instead of becoming a specialist
- Other: __________ (Free Text)
When did you start considering separation from residency after joining? *
Mark only one oval.
☐ Less than 1 year
☐ 1 to 2 years
☐ >2 years to 3 years
☐ > 3 years to 4 years
☐ > 4 years

Did you require remediation? *
Mark only one oval.
☐ Yes
☐ No
☐ Other: __________ (Free Text)

Questions related to remediation (Skip if no remediation required)
How long was your remediation? *
___________ (Free text)

What was the outcome of your remediation? *
Mark only one oval.
☐ Pass.
☐ No need for further remediation.
☐ Did not meet expectations and required further remediation.
☐ Others: __________ (free text)

How did remediation contribute to your decision for separation? *
Mark only one oval.
☐ No it did not.
☐ Separation was due to other reasons.
☐ I felt that it was unfair and unjustified.
☐ It was a needless waste of my time. I felt that the faculty was not interested in helping me address my weaknesses.
☐ It gave me time to reflect on my priorities in life and I realized I was not really interested in anaesthesia
☐ Others: __________ (free text)

Who first brought up the idea of separation? *
Mark only one oval.
☐ Me
☐ The residency programme
☐ Others: __________ (Free Text)

Choose the primary reason that best described your decision for separation *
Mark only one oval.
☐ Options with more attractive financial remuneration were made available
☐ Health concerns
Long working hours
Unpredictable working hours
Need for stay-in calls
Unsuccessful attempt(s) at examinations and lack of other options besides MMED
Change of interest in specialty
Unsupportive training environment
Inability to get along with colleagues
Lack of family support
Addition of a newborn in my family nucleus and change of priorities in life
Addition of a newborn in my family nucleus and lack of a trustworthy alternate caregiver
Lack of role models in the faculty leading to disillusionment about the specialty and what it entails
Need for remediation
Inability to take NPL to resolve some of my other outstanding issues
Other: __________ (Free Text)

Choose all other contributing factors *

Check all that apply.

- Options with more attractive financial remuneration were made available
- Health concerns
- Long working hours
- Unpredictable working hours
- Need for stay-in calls
- Unsuccessful attempt(s) at examinations and lack of other options besides MMED
- Change of interest in specialty
- Unsupportive training environment
- Inability to get along with colleagues
- Lack of family support
- Addition of a newborn in my family nucleus and change of priorities in life
- Addition of a newborn in my family nucleus and lack of a trustworthy alternate caregiver
- Lack of role models in the faculty leading to disillusionment about the specialty and what it entails
- Need for remediation
- Inability to take NPL to resolve some of my other outstanding issues
- Others: __________ (Free text)

What resource(s), if present during your time as a trainee, may have prevented you from separation? You may choose more than 1 option. *

Check all that apply.

- More financial remuneration for extended working hours
- Possibility of an extended part time training programme with shorter working hours
- Avoidance of stay in calls during certain periods i.e. recent loss in the family, health issues, pregnancy, 1 year after child is born
- Less academic requirements
☐ More support for examination candidates, especially during the examination period
☐ Better welfare for trainees i.e. study room, pantry for juniors
☐ Alternative options of reliable childcare at workplace at a subsidized rate
☐ Possibility of interrupting training (NPL or working at a slower pace) after giving birth and restarting at a later time when my child is older
☐ More family support
☐ More clarity and details about the training programme and its requirements disclosed during open house
☐ Others: __________ (Free text)

If convenient and comfortable, can you share with us what you think may reduce the separation rate of the singhealth anaesthesia residency programme

________ (Free text)

Are you still pursuing a career related to anaesthesia? *
Mark only one oval.
☐ Yes
☐ No
☐ Others: __________ (Free text)