Working as a newly appointed consultant: a study into the transition from specialist registrar

Practising for the first time as a consultant can be extremely challenging. This study explored the experiences of 45 physicians and surgeons who had made the transition from specialist registrar to hospital consultant.

This study, exploring the experiences of newly appointed consultants, was conceived and designed following a large scale study conducted between 2000 and 2005 which investigated the transition from medical student to doctor (Brown, 2005; Brown et al, 2007). During the previous study a number of senior consultants, in face to face interviews, recalled not only their own experiences of making the transition into professional practice but also the challenges they faced when making the transition from specialist registrar (SpR) to their first post as a consultant. These experiences formed the basis of this study which investigates the notion of transition from the end of specialist training to the beginning of practice as a consultant.

The purpose of this study was to inform those managing specialty programmes as well as individual trusts on how best to prepare SpRs for the consultant role and also how to support new consultants during the first months in post. Previous studies have suggested that formal mentoring programmes would benefit some consultants (Roberts et al, 2002; McKinstry et al, 2005).

Methods

This mixed method case study focused on 45 newly appointed consultants working in 12 NHS trusts in one deanery between May and December 2007. For the purpose of this study newly appointed consultants were defined as those first appointed in May 2006 or later. By taking an interpretative approach this study drew on the experiences of the participants to form a better understanding of the transition from SpR to hospital consultant.

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There were three phases of data collection. Initial themes were raised during phase 1 (P1) where seven participants across six NHS trusts took part in open-ended interviews (undertaken by JB). These themes were investigated in phase 2 (P2) through an online piloted questionnaire with open and closed questions distributed to all participants across 12 NHS trusts. Phase 3 (P3) explored specific issues raised in the previous data collection phases through six semi-structured interviews (undertaken by JB) with participants from six separate NHS trusts (four of the sites were different to those involved in P1). This case study design allowed a clearly defined group of participants to raise the relevant issues surrounding their transition rather than the researchers setting the investigative framework (Golby, 1994; Cresswell, 2003; Yin, 2003).

Recruitment to the study

Programme directors were asked via e-mail to supply a list of consultants who were first appointed in or after May 2006. Forty-five consultants were identified and were offered the opportunity via e-mail to take part in the study.

Consent and confidentiality

Participation was voluntary and participants were informed that they could withdraw from the study at any stage. Information sheets were distributed to participants at every stage in the data collection process. Interviews took place at a time and venue convenient to the participant with each interviewee signing a consent form and agreeing to the tape-recording of the interview. Online questionnaire links were distributed via e-mail. The questionnaires were completed electronically with the online system providing anonymized responses. Specialties and specific trusts were not discussed to allow consultants working within smaller clinical areas to remain unidentifiable, thus confidentiality was assured throughout the process.

The relationship between each of the data collection phases

The aim of the open-ended interviews was to inform the design of the questionnaire to be distributed to the wider study population in P2. Responses to the questionnaire were invited on either a five-point Likert rating scale or on a yes/no/unsure basis with opportunities to expand answers using free text. The questionnaire findings in turn informed the design of a semi-structured interview schedule that investigated the key themes in more depth.

Data analysis

Descriptive statistics were used to analyse quantitative data with qualitative data analysed using thematic framework analysis (Ritchie and Lewis, 2003). This rigorous and transparent data management process allowed for the systematic 'scaffolding' of key concepts and themes.

Results

The findings from all three phases of data collection are summarized below. *Table 1* reports the questionnaire response rate, the relationship between the key findings and where these themes emerged in the data collection phases.

Preparation for the consultant role

Twenty eight participants completed or partially completed the questionnaire phase of the study (P2). As shown in *Figure 1* 25 of the 26 respondents (96%) believed that they were prepared or very well prepared for the clinical aspects of their role with 21 (81%) of the 26 reporting they felt prepared or very well prepared for team working. However, 15 out of the 26 respondents (58%) felt they were not prepared for dealing with trust management issues and 21 (81%) felt they were not prepared for the financial management aspects of the role. Although the majority (85%) of respondents felt prepared or moderately prepared for leadership – a key component of the consultant role – it is of concern that 15% (4/26) felt they were not prepared.

These perceived gaps in their preparation for the financial and managerial aspects of the role were confirmed at all stages of the data collection process:

'You know even from SpR to consultant it's not much of a transition in clinical, but lets say from administration and management there's a lot of big, big change.' (P1: interviewee 1)

'Our training prepares us much better for the clinical challenges than for the managerial ones.' (P2: questionnaire 5)

Participants had undertaken SpR training across various deaneries in the UK. When asked to identify one area of the training that could be improved (or added) to ease the transition, financial and trust management were again the key areas that were identified:

'I kind of felt my SpR training was lacking in the management and administration aspect of things. How the NHS works was only introduced to me in my fourth year.' (P1: interviewee 1)

Although the majority of participants felt they were unprepared for the financial and managerial aspects of the role it proved difficult to identify a way of addressing this gap during SpR training. Many of the financial issues were trust specific so generic management training would not necessarily prepare new consultants for these financial and managerial challenges:

'With management issues I think it's just experience, being around and seeing how it works, I don't think you can train any more.' (P3: interviewee 4)

'Financial and management issues need to be incorporated into our training. The deanery does run a fantastic management course for final year registrars but we need to

Table 1. Overview of the research process (May to December 2007)

Data collection	No. of responses or interviews	Aim	Brief summary of findings from each data collection phase
Phase 1 (P1) Open-ended interviews (May–July 2007)	7 (4 physicians, 3 surgeons; 6 male, 1 female)	To inform questionnaire design	The interviewees felt: Clinically well prepared
			Trust management issues were the biggest challenge
			Taking over from outgoing consultants can result in taking on highly complex longstanding cases
			Previous experience of working in a department also eased the transition and attracted them to post
Phase 2 (P2) Questionnaire to newly appointed consultants (October–November 2007)	28 out of a total sample of 45 (response rate 62.2%)	To inform the semi-structured interview	Questionnaire findings: Nineteen (68%) males and nine (32%) females completed the questionnaire
			Twenty-one were physicians and seven were surgeons. There were no significant differences in responses between physicians and surgeons
			Twenty (71%) were UK graduates, eight (29%) were non-European graduates. There were no significant differences in responses between UK and non-European graduates
			Seventeen (63%) respondents were filling newly established posts. Ten (37%) were replacing outgoing consultants. One did not answer. There were no significant differences in responses between those filling new posts or replacing outgoing consultants
			Clinically well prepared
			Not prepared for managerial and financial aspects of the role
			The first few months in post were very challenging and at times for some very stressful
			Informal support mechanisms in place and valued
			Fifteen (60%) felt the transition involved 'a re-examination of who or what they are', e.g. questioning career choice, suitability for role, choice of appointment, location
Phase 3 (P3) Newly appointed consultant semi-structured interviews and focus groups (November–December 2007)	6 (5 physicians, 1 surgeon; 4 male, 2 female)	Investigate further the issues raised in questionnaire	Managerial aspects of role were very challenging but there was no consensus on how this could be addressed in specialist registrar training
			Concerns that generic management training could not prepare specialist registrars for the transition
			Shadowing managers or consultants may be of some use but it could also prove irrelevant
			Informal support was highly valued, much more so than any formal structures of support

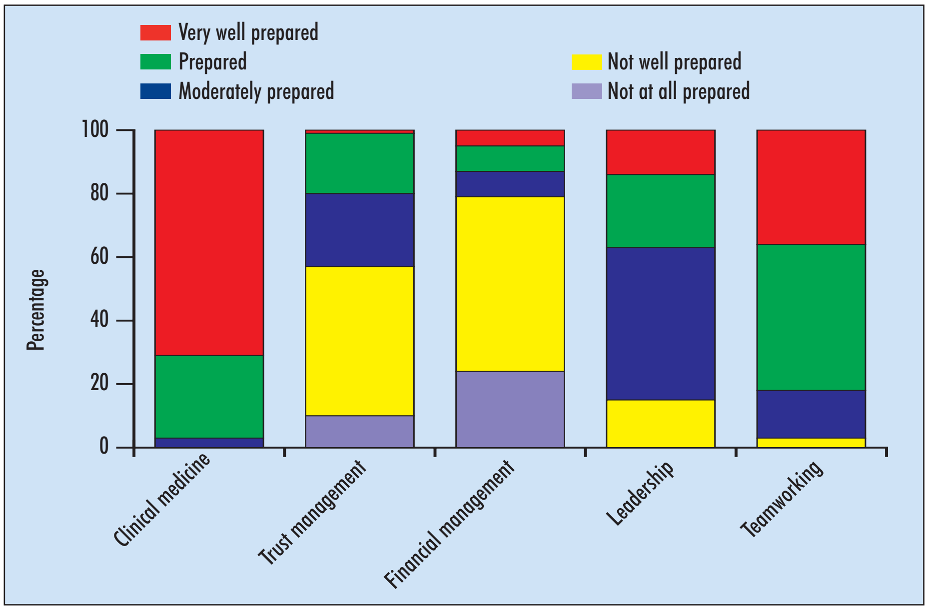

Figure 1. Please rate how well your specialist registrar training prepared you for the following aspects of your consultant post? (n=26).

attend the meetings at the trust where we train to understand what the issues are.' (P2: questionnaire 4)

'You can never be prepared for this change. I still feel strongly that final year SpRs should attend the meetings in the Trust they are seconded to. However, this is usually difficult because of manpower issues.' (P2: questionnaire 2)

Transition from specialist registrar to consultant

Fifteen (60%, *n*=25) agreed that their transition from SpR to consultant grade had involved a re-examination of who and what they were (Wilkie and Raffaelli, 2000). The remaining ten (40%) felt they did not go through this re-examination process.

It was recognized that transition involved coming to terms with the fact that they were now perceived differently by colleagues and patients:

'Starting as a consultant and feeling you are a consultant, mentally you've got to change the way you think about the role. It was quite a big stress for me starting off, you still felt like an SpR, it's other people who see you in a different light, that's the hard thing, people seeing you differently.' (P3: interviewee 5)

'"Looking like a consultant" rather than an SpR.' (P2: questionnaire 8)

'You are still the same person inside but you must realise you are regarded differently by others. When you say something, it's been said by a consultant. I kept telling myself I was the same person but I eventually realised that in terms of position I am not.' (P2: questionnaire 6).

Getting used to 'being a consultant' also involved accepting the fact that as the clinical lead of a team they had ultimate responsibility for their staff. The actual undertaking of overall leadership in practice was one of the key challenges new consultants faced:

'One of my consultant colleagues said that one of the hardest things to get used to is people doing things in your name, and you are not being aware of it, and I think he's right actually.' (P3: interviewee 3)

'It's just the realisation of how much direct clinical contact you have and I think training experience you are really protected and you realise the implications of being there for everybody everywhere.' (P3: interviewee 2)

'I think it's a mental thing rather than a training issue, getting used to be a consultant, the buck stops with you, but until you do the job you can't prepare for that.' (P3: interviewee 4)

Despite the many years in postgraduate training posts and being prepared to fulfil the role of consultant, the first months in post proved for many to be stressful:

'I think it's taken me about a year. Clinical responsibility takes over, you can't really do much more than worry about the patients.' (P3: interviewee 6)

'Took three months to return to normal levels of stress. Thereafter was much easier.' (P2: questionnaire 5)

For one participant, taking over from an outgoing consultant raised some unexpected clinical challenges:

'I completely underestimated the effect of taking over from a senior consultant because I was left with some horrendous cases that you felt really ill equipped to deal with in your first few months.' (P1: interviewee 2)

Specialist registrar training

Although becoming a consultant is perceived by many as the pinnacle of their medical career, it is perceived by some as the beginning of another hierarchical system to work in:

'As a consultant you're meant to be an autonomous practitioner and have a degree of independence commensurate with your fellow consultants. They love to preserve the sort of senior registrar, registrar, house officer type approach to new consultants. You know there is that hierarchy.' (P1: interviewee 6)

'This transition is still ongoing for me. I have watched friends struggle with it so felt a little prepared for the difficulties. I have benefited from not rushing through the system having trained part-time. Being a consultant is not the end of the ladder that I once thought I was climbing – it is, as most things in life, the beginning of yet another ladder.' (P2: questionnaire 4)

Support

The vast majority of participants relied on their own informal support networks rather than any formal structures within their trust:

'Yes, I mean that was the main reason for taking this job. The informal network here is great. Everybody really gets on.' (P1: interviewee 2)

'There is a previous consultant I worked with who is always there for me, I just pick up the phone and say I just need to know I'm doing the right thing.' (P3: interviewee 2)

These support mechanisms are important, especially as some consultants feel they are less likely to receive feedback now they are in a senior position:

'I think this has been one of the most challenging periods in my life. I wonder how I'm doing all the time, and also feel that people are less likely to tell me now compared to when I was an SpR.' (P2: questionnaire 2)

'Feeling lonely – can't ask for help!' (P2: questionnaire 28)

Consultant colleagues are a main source of support. Twenty (77%, *n*=26) respondents felt very well supported by the consultants in their department. Four (15%) felt they had limited support, one (4%) felt he/she had no support and one (4%) gave no comment.

The vast majority of respondents had already previously worked in their department either as a junior doctor or as a locum consultant. Therefore many had already established informal support networks before taking on the consultant role.

Career choice

Twenty (77%) participants made their career choice after medical school with six (30%) of these making career choices during specialist training.

Discussion

This study demonstrates that practising as a consultant in the first year of appointment is often a challenging experience which can in some cases test an individual's commitment to working within a particular department. Preparation for the clinical aspects of being a consultant is extensive but the managerial and financial aspects of the role are not addressed during specialist training to the same extent.

These findings confirm those reported in previous studies (McKinstry et al, 2005; Beckett et al, 2006; Kite and Salt, 2006). For example Beckett et al (2006) reported that the trust management challenges new consultants face can add stress to an already pressurized role. However, the difficulty is trying to incorporate an effective and relevant way of preparing SpRs for this aspect of the job with many of the difficulties faced being trust-specific issues that generic training cannot always cover. Shadowing consultants, hospital managers or attending hospital management meetings during specialist training may be useful for some, especially those who take up a consultant post in the same trust. However, such a process may prove irrelevant to some and may even be prohibited in some trusts.

Findings suggest that participants were often still coming to terms with the fact that they were now a 'consultant'. There was recognition that other people's perception of them had changed. Interviewees found it difficult to articulate the realization of being a leader. As previously reported by Brown et al (2007), transition often raises feelings of anxiety and insecurity because of the fear of not knowing fully how to adapt to a new professional role.

Any transition, according to Wilkie and Raffaelli (2005), involves a fundamental re-examination of who and what we are, even if this processing is occurring at a largely unconscious level. It may therefore be argued that despite at least 7 years of postgraduate training the transition from SpR to consultant may be characterized by a period of natural uncertainty. If there is natural uncertainty it is important that support mechanisms are in place. A previous study identified similar concerns: 'I think in medicine there is a hierarchy you steadily climb up and even when you reached what you think is the top there is always some sense of insecurity' (educational supervisor interviewee) (Brown, 2005).

The pressure that many new consultants feel that they are under may at times be great (Houghton et al, 2002; Naeem et al, 2005; Vassilas, 2005). However, any stresses appear to be dealt with and ease over time, especially when working in a supportive environment. Difficulties seem to emerge when departments, or in some cases individuals, do not offer the consultant the informal support required. For example, as reported there were some consultants who were beginning to question their career choice and these were often in conjunction with a perceived lack of support within their particular department.

It was apparent throughout each data collection phase that these consultants felt they were clinically prepared for the role. This is a positive finding. However, it could be argued that the consultants themselves may not be in the best position to gauge their own clinical performance. Robinson et al (2007) argue that new consultants should not assume their clinical training is complete and that they need to be aware of knowledge gaps. Further research could investigate the perceptions of senior colleagues of the preparedness of new consultants for the clinical aspects of the role.

It is particularly relevant to highlight the late career choices made by many of the study participants in light of the changes in postgraduate training through Modernising Medical Careers (Watmough et al, 2007). As medical students and newly graduated doctors are under pressure to make earlier career choices these findings demonstrate the importance of postgraduate experience in influencing such decisions.

The completion of the study coincided with several initiatives to enhance clinical leadership and engagement throughout undergraduate and postgraduate medicine. These include the NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges (2008) jointly developing a curriculum across undergraduate and postgraduate medicine to encourage doctors to become actively engaged in the delivery and management of health services. The Kings Fund (Levenson et al, 2008) has also outlined the importance of leadership in the NHS, by making a strong argument that the medical profession needs doctors with both management and leadership skills. The initiatives fit in with Lord Darzi's vision of local communities with particular reference to clinicians and patients taking more control in planning and delivering services (Department of Health, 2008).

Conclusions

New consultants are highly skilled and experienced professionals but may still need a prescriptive support system, therefore support must be made available if required. The findings from this study suggest that support mechanisms are ideally developed by the individual him-/herself and these can take the form of guidance from friends and colleagues as reported in an earlier study by Brown (2005). However, the difficulty with such informal processes is these support channels may not exist for some consultants. A more structured induction process and mentoring system that is consistently offered across all trusts would help to address potential problems during the first few months in post. Although this study has highlighted the potential limitations of shadowing because of the trust-specific issues reported by participants it may still be a useful strategy to offer final year SpRs the chance to shadow an existing consultant from their own specialty.

In order to investigate whether 'learning on the job' as a consultant means the new consultant will eventually fulfil their potential in the role over time, the same cohort of consultants will be invited to participate in further data collection phases in 2010 which will focus on their reflections of the transition 3 or 4 years following appointment. BJHM

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KEY POINTS

- Despite at least 7 years of postgraduate training the transition from specialist registrar to consultant may be characterized by a period of natural uncertainty.
- Preparation during specialist registrar training for the clinical aspects of the consultant's role is extensive but managerial and financial components are not fully addressed as they are often issues specific to individual trusts.
- The first year of a consultant's appointment is often a challenging experience which can in some cases test the individual's commitment to work within that particular department or even specialty.
- The leadership role of the new consultant with its responsibilities and influences on the team and working environment can only be fully appreciated once in post.
- Informal support mechanisms rather than formal processes seem to work effectively for new consultants. The difficulty with informal support mechanisms is these support channels may not exist for some consultants who most need them.