The training needs and career intentions of staff grade and associate specialist doctors

This article outlines the results of a study which used an online survey to explore the career intentions of staff grade and associate specialist doctors in one region and their training needs to inform those managing the continued professional development of staff grade and associate specialist doctors.

Introduction

Staff grade and associate specialist (SAS) doctors are experienced and senior career grade doctors working within the NHS. They work across all specialties, both in clinical and non-clinical areas. Previously, SAS doctors have focused almost entirely on service delivery. Training has not been part of the SAS doctor contract and often continuing professional development has not always been facilitated.

However, a new contract for SAS doctors was agreed in 2008 (Department of Health, Social Services and Public Safety, 2010). One aim of this contract was to avoid confusion around the then many titles given to doctors in the SAS grades and bring them into a single category with a single pay spine. Hence the term 'specialty doctor' replaced the older terms 'staff grade' and 'associate specialist'. Entry to the associate specialist grade was closed and specialty doctors were offered an incremental pay scale with the potential to progress through a series of pay 'thresholds' provided certain performance expectations were met. The proposals introduced a new grade called 'specialty doctor' and a new contract for existing associate specialists but, paradoxically, no option for specialty doctors to progress to the higher paid associate specialist grade. Specialty doctors were now able to stay in the grade and progress via the pay thresholds but promotion to another grade would only be possible by re-entering training or by securing recognition via the Certificate of Eligibility for Specialist Registration. The SAS doctor is a unique role that does not have an equivalent outside the UK.

A fundamental element of the new contract is the requirement for doctors to undertake regular appraisals while developing a portfolio to record their progress in the job. This allows SAS doctors to progress to the top of their grade while gaining experience and expanding their skills. Many regions (deaneries) have now appointed associate postgraduate deans with a responsibility for SAS doctors and their continuing professional development (Medical Careers, 2010).

The Tooke Report recommended that 'Doctors in these posts should have access to training overseen by Postgraduate Deaneries and CPD [continuing professional development] opportunities' (Tooke, 2008). There are different career pathways within the SAS role. Some SAS doctors aim to gain entry to specialty training programmes, others are keen to remain within the SAS grade. What seems clear is that many SAS doctors teach medical students (Medical Careers, 2010). The creation of these posts has led to localized development opportunities for SAS doctors that were previously very limited (Phazey et al, 2012).

Although many SAS doctors aim to gain a place on specialty training programmes, others make a clear choice to remain in this grade (British Medical Association Staff and Associate Specialist Committee, 2009). The British Medical Association study (2009) highlighted the differences in career intentions of SAS doctors. This clearly has an impact on how regions (deaneries) and local NHS hospital trusts facilitate the most appropriate continuing professional development opportunities and manage career expectations.

This study explored the career intentions and training needs of an often overlooked population, and investigated whether there were any significant factors that influenced their career goals and training needs. The findings will help inform those managing and facilitating the continuing professional development of SAS doctors. The article also emphasizes the need for those in educational roles to consider the individual requirements of SAS doctors under their direct supervision as well as informing trainees of the potential for career progression within this SAS pathway.

Methods

All SAS (467) grade doctors in one region within north west England were invited to participate in the study. They were identified by the individual NHS trust human resources details held by the administrative lead (or SAS lead) in each NHS hospital trust. This identification process was done independently by each trust as the research team did not have access to this information. The survey was distributed by e-mail to all trust SAS administrative leads who then forwarded the online survey to all trust SAS doctors. The email contained a link to the online questionnaire via Survey Monkey and an information sheet which described the study in detail and assured respondents of confidentiality. Two reminder emails

Dr Jeremy Brown *is Senior Lecturer in the Evidence-based Practice Research Centre / Mersey Deanery, Faculty of Health and Social Care, Edge Hill University, Ormskirk,* **Mrs Jennifer Kirton** *is Research Assistant in the Faculty of Health, Edge Hill University, Ormskirk, Lancashire L39 4QP,* **Professor Nigel J Shaw** *is Consultant Neonatologist in the Department of Neonatal Medicine, Liverpool Women's NHS Foundation Trust, Liverpool, Professor in the Evidence-based Practice Research Centre, Edge Hill University, Ormskirk, and Honorary Associate Dean, Mersey Deanery,* **Dr Philip Murphy** *is Reader in the Evidence Based Practice Research Centre and Department of Social and Psychological Sciences, Edge Hill University, Ormskirk, and* **Mr Raymond Clarke** *is Consultant ENT Surgeon at Royal Liverpool Childrens Hospital, Alder Hey and Associate Dean, Mersey Deanery, Liverpool*

Correspondence to: Mrs J Kirton (Jennifer.kirton@edgehill.ac.uk)

were sent to maximize the opportunity to complete and submit the questionnaire.

Online survey questions were informed by a systematic literature search and by informal interviews with SAS doctors who attended a regional training event. The questions were based on demographic information, previous education including training posts, details of their present role, access to job planning, training needs and careers goals. The study took both a quantitative approach to measure group opinions and attitudes and a qualitative approach to gather individual accounts and observations. The questionnaire was piloted by all SAS leads and administrative leads within the region's trusts. The research team reviewed these comments and made some subsequent modifications.

Quantitative data analysis

All quantitative data was stored and analysed using Statistical Package of the Social Sciences (SPSS 18). Preliminary descriptive analyses concentrated upon the number and percentage of respondents occupying the various demographic and career categories examined. In order to explore the associations between career-related variables, and gender and ethnicity respectively, chi-squared analyses were performed, with observed (O) and expected (E) values being compared. Where necessary, some categories were combined in order to produce valid analyses, with regard to cell size.

Qualitative analysis

The qualitative elements of the questionnaire were designed to explore individual experiences and motivations around decision making to practice as an SAS as well as career ambitions. These qualitative comments made by respondents were analysed using a thematic analysis approach incorporating the four stages of organization, familiarization, reduction and analysis (Miles and Huberman, 1994; Polit and Beck, 2009).

Transcriptions were analysed independently by two researchers to add inter-rater validity to the findings (Cohen et al, 2007). The data were coded into themes. Theme descriptors were defined and re-defined until all data were fully represented (Polit and Beck, 2009). The final themes were then discussed by the researchers.

Ethics

University ethical approval was granted by the Faculty of Health's Research Ethics Committee. The Chair of North Liverpool Research Ethics Committee categorized this study as service evaluation. NHS North West Strategic Health Authority Research and Development Committee approved the study.

Results

Requests for participation were sent out by trust administration leads to 467 SAS doctors, and 251 respondents completed the online survey, giving a response rate of 53.8%. Responses were received from 17 out of the 18 NHS trusts in the deanery. Any questionnaire survey relies on the goodwill of participants, and so the findings can only represent those who have participated. Not all questions were compulsory and some respondents chose to omit answers to some questions so the totals reported will not always be the same.

Participants

The majority of respondents were male (155, 61.8%) with only 38.2% (96) being female. The modal age range of participants was from 36–40 years old (19.5%, 49). Respondents gained their first medical qualifications between 1975 and 2004. Ethnicity was selected by respondents based on 16 standardized categories. The majority of respondents were of Asian ethnic origin (130, 51.8%). Seventy were white British (27.9%) and 21 (8.4%) were other white origin. Forty eight (19.1%) respondents required a work permit to work in the UK.

Career variables

Fifty nine different sub-specialties were represented in the survey with most respondents in anaesthetics (28, 11.2%), emergency medicine (20, 8.2%), ophthalmology (18, 7.2%), orthopaedics (11, 4.4%) and psychiatry (9, 3.6%).

The majority of respondents (111, 44.2%) had undertaken between 2 and 5 years in training posts. Sixty four (25.5%) respondents had 5 years or more in training posts and 22 (8.8%) had spent under 2 years in training posts.

Respondents reported their current job titles within the SAS grade: associate specialists (90, 35.9%), specialty doctor (45, 17.9%), staff grade (54, 21.5%), other (27, 10.8%). Other titles of posts that SAS doctors stated that they were working under included acting consultant, clinical assistant, clinical fellow, junior clinical fellow, senior clinical fellow, hospital practitioner, staff doctor (trust grade) and trust doctor.

One hundred and eighty nine (75.3%) respondents were on a permanent contract and 27 (10.8%) were on a temporary contract. One hundred and eighty (71.7%) respondents worked full time, and 36 (14.4%) worked part time.

Length of service in current post

One hundred and three (41.3%) respondents had been in their current post for 5 years or more. Forty eight (19.1%) had been in post for between 2 and 5 years and 65 (25.9%) had been in post for less than 2 years.

Career goal

Fifty five (21.9%) intended to remain at their present grade, 93 (36.8%) intended to become a consultant, 17 (6.8%) intended to change their present grade, and 26 (10.4%) were uncertain at the time the survey was conducted.

Gender and career variables

A significant association was found between gender and career goal (χ^2 [4, n=202] = 10.738, P=0.030). *Table 1* shows the observed (O) and expected (E) values for each cell of the analysis. Fewer men aspire to remain in their current post than

Table 1. Observed (O) and expected (E) values (in brackets) for the association between gender and career goal

Gender	To remain at your present grade	To become a consultant	To change your grade	To move overseas	Uncertain	Totals
Male	25 (34.3)	64 (58.0)	10 (10.6)	9 (6.9)	18 (16.2)	126
Female	30 (20.7)	29 (35.0)	7 (6.4)	2 (4.1)	8 (9.8)	76
Totals	55	93	17	11	26	202

would be expected by chance, while more aspire to consultant posts than would be expected. For women, this relationship was reversed.

The association between gender and time in current post was on the borderline of statistical significance (χ^2 [2, n=216] = 5.871, P=0.053). The largest cell disparities between O and E values for men showed that more men than would be expected by chance had been in their current post for between 2 and 5 years (O = 36, E = 29.3), but fewer had been in their current post for 5 years or more than would be similarly expected (O = 56, E = 62.9). For women, this relationship was reversed with regard to having been in their current post for between 2 and 5 years (O = 12, E = 18.7) and for 5 years or more (O = 47, E = 40.1). The association between gender and contract type (i.e. permanent or temporary) in current post was not significant (χ^2 [1, n=216] = 2.182).

Ethnicity and career variables

The 16 original categories for encoding ethnicity produced an unacceptably high number of very low E values in initial chi-squared analyses. Therefore ethnic categories were combined into 'white', 'Asian', and 'other' (*Table 2*). Ethnicity did not have a significant association with either time in current post (χ^2 [4, n=216] = 5.899), or contract type in current post (χ^2 [2, n=216] = 1.193).

However, the association with gender was highly significant (χ^2 [2, n=251] = 26.109, P<0.000), with the largest cell disparities for men being in the 'white' (O = 38, E = 56.8) and 'Asian' (O = 95, E = 78.4) categories. Contrasting disparities were evident for women in both the 'white' (O = 54, E = 35.2) and Asian (O = 32, E = 48.6) categories.

The association between ethnicity and career goal was highly significant (χ^2 [4, n=202] = 16.979, P=0.002). *Table 2* shows that the major component of the association between ethnicity and stated career goal was that more respondents identifying themselves as white endorsed the goal of staying at their present grade than would be expected by chance, while fewer endorsed the goal of becoming a consultant than would be similarly expected. For respondents identifying themselves as Asian, this relationship was reversed.

Decision to become an SAS doctor

There were different rationales for choosing to become an SAS doctor but thematic analysis of the qualitative comments highlighted several key reasons for deciding to become an SAS doctor. The quotations below are verbatim and are the best exemplars from all responses received. The most common reason given was the influence of lifestyle and personal circumstances:

'Family commitment needed a stable and permanent position to function in life. This I would say was the most important factor in taking my decision.' (Q210)

'The options were either to work as locum consultant or settle with a family life in one place as SAS. I don't regret my decision as I feel I am better off and better trained than so many newly trained and recently appointed consultants.' (Q191)

'Much better work life balance when I started although this has now changed within emergency medicine.' (Q134)

'Stability in work place and life/ realization that can still work and have a life and sustain livelihood.' (Q30)

'A stable job and also equally enjoying all the shared responsibilities with my consultant colleagues in the development of the department to deliver a high standard of care to the patients.' (Q35)

Some respondents were less positive about their career choice as an SAS grade doctor. They felt that they were left with no other option after being unsuccessful in obtaining a training post or being unable to gain another job:

'Unable to enter training after leaving GP as I did not have an MRCP [requirement for training post in UK].' (Q7)

'Lack of alternative career options.' (Q41)

'To avoid unemployment.' (Q47)

'I was denied entry into SPR [specialist registrar] programme.' (Q129)

'Not able to progress in training.' (Q171)

However, some respondents who had felt forced to take on an SAS position reported mixed views on their experiences:

'Honestly, initially it was disappointment after completing GP training and realizing it wasn't for me. Post grad careers advice was woefully inadequate back then so chose a staff grade post to buy me thinking time, then stayed as had a family etc. However, latterly, it suits me very well.' (Q57)

A very small minority of respondents commented about their concerns of possible discrimination in the career structure:

'Forced. Look at the data, how many overseas doctors were appointed as senior registrars.' (Q19)

'In the name of keeping standard for patients' safety, there were artificially created difficulties and obstacles for people like us to get allocated training to become consultants. If possible I would have used my experience and skills in consultant position rather than associate specialist.' (Q14)

Some respondents decided to take up an SAS post to focus on clinical rather than management and administrative issues:

'Remaining doing a clinical job rather than having to spend a lot of time on managerial issues.' (Q134)

The role was seen by some as an opportunity to gain further experience before further career progression:

Table 2. Observed (O) and expected (E) values (in brackets) for the association between ethnicity and career goal

Ethnicity	To remain at your present grade	To become a consultant	Other	Totals
White	31 (21.2)	24 (35.9)	23 (20.9)	78
Asian	23 (28.3)	55 (47.9)	26 (27.8)	104
Others	1 (5.4)	14 (9.2)	5 (5.3)	20
Totals	55	93	54	202

'Senior post with responsibility and independence, in absence of a specialist registration and possible career progression to become a consultant.' (Q166)
'To settle down at one place and then improve my career by learning from my senior colleagues who will understand my abilities and appreciate my work.' (Q3)

Professional development

Respondents were questioned about their access to departmental job planning (*Table 3*). Although at least 60% of respondents have had a recent appraisal, a personal development plan, a portfolio and a clinical supervisor, only 34.7% of respondents have an educational supervisor. There was wide inter-trust variation in the results reported. Owing to sensitivities around the potential risk of identifying trusts no breakdown of data is reported here.

Study leave

Two hundred and five (81.7%) respondents said that they had access to study leave, but only 98 (38.9%) respondents reported using their full study leave entitlement. Respondents gave a variety of reasons to explain the underuse of study leave including a lack of appropriate courses, locations of courses, difficulties hearing about courses in time for the 6-week imposed deadlines for study leave requests enforced by many trusts, and family and work commitments.

Importance of specific professional development opportunities

Respondents were asked to indicate how important they deemed specific professional development opportunities to be for them personally on a five-point scale from 'of no importance' to 'vital'.

Top-up training for certification to prove eligibility for entry onto the specialist training programme is seen to be most vital (27.1%, 68) followed by specialty-specific education (26.6%, 66). It should also be noted that teaching skills training was viewed as being vital or very important by 113 respondents (45.4%).

Table 3. Access to departmental job planning

	Yes	No
Recent appraisal	65.7% (165)	17.5% (44)
Personal development plan	59.8% (150)	23.5% (59)
Portfolio	59.5% (149)	23.9% (60)
Clinical supervisor	63.3% (159)	19.9% (50)
Educational supervisor	34.7% (87)	48.6% (122)

Discussion

The response rate for this study was good, 53.75% compared to 26% generated by the British Medical Association survey published in 2009. The findings demonstrate, like the previous British Medical Association (2009) study, that the SAS grade covers a diverse group of doctors at different stages in their medical career with very different career outlooks.

Within this grade, the present study found that career goals had significant associations with gender and ethnicity, whereby there was a lower representation of women and of respondents identifying their ethnicity as white among those aspiring to consultant positions than would be expected under an assumption that career goals were unrelated to these variables.

The development of equitable career pathways for doctors in this grade may be facilitated by further research examining these associations, and by a consultative process to overcome possible barriers to career aspirations among those who may perceive themselves to be at a disadvantage. Findings seem to imply that some SAS doctors who have been unable to gain entry to a specialty programme view the SAS role as an alternative pathway to accreditation. This was never the intention of those creating the new contract in 2008.

It must be a concern that some doctors may have unrealistic expectations of what the SAS role may lead to in terms of opportunities to progress onto specialty training programmes. For a foundation year 1 trainee considering his/her career options it is important to have a clear understanding of the role and responsibilities of the SAS doctor and how these differ from those on specialty programmes. This will inform decisions on which type of post to apply for that best suits the trainee's own personal circumstances and career goals. The advice to a foundation doctor who wants to progress to a certificate of completion of training must be to compete for a place on a training programme and not to see the specialty grade as an alternative means of training.

Many respondents cited family commitments, responsibilities and stability as a reason for choosing the grade and yet few decide to work less than full-time. This suggests that the SAS role is attractive for those who want to remain in the same locality with an element of permanence to their working environment. Another influence may be that the SAS role does not have the same management and leadership responsibility of a hospital consultant. Evidence suggests that specialist registrars entering their first post as a hospital consultant face real challenges and arguably stresses that may even overlap to some extent with family life (Brown et al, 2009). The SAS doctor may value the opportunity to have a fulfilling career practicing as a hospital doctor and focusing on the clinical work without having to manage and lead teams and take such responsibility 'home with them'.

These findings suggest that regions and trusts must continue to develop strategies to facilitate the educational progression of SAS doctors in the same way as they offer doctors in training grades. The majority of respondents did not take up their full entitlement of study leave but this may be consistent with other doctors.

Although the majority of respondents had taken part in a recent appraisal, just under a quarter had not. Similar numbers reported having a personal development plan, a clinical supervisor and a portfolio. More worryingly, less than half of SAS doctors had an educational supervisor. As regions implement strategies to facilitate the continued professional development of SAS doctors it is clear that trust appraisal processes must be at the heart of any educational policy.

In 2008, Stubbing argued that SAS doctors need to be treated on the same 'educational footing' as colleagues in run-through training posts. This suggests that if SAS doctors are to take part in continued professional development and have the opportunity, if they want to, to work towards a specialist training post, the deaneries should be appointing allocated educational supervisors who have the necessary training

and experience to facilitate the educational needs of SAS doctors. Indeed, it is of fundamental importance that all SAS doctors have an educational supervisor.

Even though this group of doctors are not in a run-through specialty training post they still need a named individual within their trust who can oversee and advise on their continued professional development. The Gold Guide (Modernising Medical Careers, 2010) sets out the role of the educational supervisor for specialty trainees. Although SAS doctors will have more individualized needs and working circumstances they still need that same focal point to manage their learning needs and opportunities and their e-portfolio.

Where the role will differ for the educational supervision of an SAS doctor compared to a specialty trainee is managing with a sense of realism the professional developmental opportunities of a doctor who is likely to be working on a more permanent basis in a trust compared to a specialty trainee (Modernising Medical Careers, 2010).

It is clear from this study's responses that some SAS doctors are very senior indeed so their relationship with their named educational supervisor may be quite different to a more junior member of the grade. The vast difference in experience within the grade is quite surprising. Findings suggest that there are some relatively inexperienced doctors with between 2 and 5 years postgraduate experience in quite senior SAS grades. So issues around further training and ongoing support for some junior members of staff have to be considered at the same time as catering for very experienced doctors quite late on in their medical career, and thus the relationship between an SAS doctor and an educational supervisor may be very different from one case to another. The relationship between the SAS doctor and educational supervisor may go on for a number of years and its success will hinge on the ability of the educational supervisor to offer appropriate advice that remains achievable, useful and relevant.

The educational supervisor needs to be flexible and gauge individual needs. This may range from managing false expectations to offering and facilitating worthwhile and necessary continuing professional development opportunities for those who have been in place for many years.

The findings reported suggest that SAS doctors saw training opportunities as being important and relevant. Specific top-up training for certification to prove eligibility onto specialist training programmes was perceived as the most vital training opportunity. This is training in the process that gives doctors who have not completed UK specialist training programmes the opportunity to apply for eligibility for the General Medical Council's Specialist Register (Postgraduate Medical Education and Training Board, 2006). This gives doctors the opportunity to take honorary or fixed term positions as a consultant in the NHS.

Over half saw the development of teaching skills as either vital or very important. This suggests that many SAS doctors are undertaking teaching in their role. This may be both in formal and informal educational settings. Although no data were collected on teaching commitments, a survey conducted in London deaneries found that 70% of SAS doctors taught medical students (Medical Careers, 2010).

Conclusions

The findings demonstrate that SAS doctors in this one deanery share a common characteristic: the commitment to progress and develop their skills as doctors whatever their personal circumstance or career intention. The vast majority made informed decisions to undertake an SAS role, decisions that they remain relatively happy with as long as they take advantage of their educational opportunities. Deaneries and trusts therefore need to tailor the diverse training needs of individual doctors. This can only happen if every SAS doctor has an identifiable educational supervisor who can undertake regular appraisals and set out individual job plans. The findings here demonstrate that the vast majority have clinical supervision in place. However, 41% do not have an educational supervisor and this must be addressed. **BJHM**

This research was funded by Mersey Deanery. The authors would like to thank all staff and associate specialist administrators and leads for their assistance with recruitment and advertisement of the study.
Conflict of interest: none.

British Medical Association Staff and Associate Specialist Committee (2009) *BMA Survey of SAS doctors' workload and career progression.* British Medical Association, London

Brown JM, Ryland I, Shaw NJ, Graham DR (2009) Working as a newly appointed consultant: an investigation into the transition from specialist registrar to hospital consultant. *Br J Hosp Med* **70**(7): 410–14

Cohen L, Manion M, Morrison K (2007) *Research Methods in Education.* Routledge, New York

Department of Health, Social Services and Public Safety (2010) Staff and Associate Specialists (SAS) Doctors Contract. www.dhsspsni.gov.uk/index/hrd/pay_and_employment/pay_and_employment-sas_dr_contract.htm (accessed 20 July 2012)

Medical Careers (2010) Career Progression for SAS Doctors. www.medicalcareers.nhs.uk/postgraduate_doctors/specialty_doctors/career_progression_for_special.aspx (accessed 20 July 2012)

Miles MB, Huberman AM (1994) *Qualitative data analysis: An expanded sourcebook.* 2nd edn. Sage Publications, California

Modernising Medical Careers (2010) *A Reference Guide for Postgraduate Specialty Training in the UK* (Gold Guide). Modernising Medical Careers, London

Phazey G, Agius S, Hayden J (2012) SAS doctors' perceptions of their role in the NHS. *BMJ Careers* 26 Apr (http://careers.bmj.com/careers/advice/view-article.html?id=20007147 accessed 20 July 2012)

Polit DF, Beck CT (2009) *Essentials of Nursing Research Appraising Evidence for Nursing Practice.* 7th edn. Lippincott William & Wilkins, Philadelphia

Postgraduate Medical Education and Training Board (2006) *Routes to the Specialist Register for SHOs, Trust Grade and NCCG Doctors.* www.gmc-uk.org/Routes_to_the_Specialist_Register_for_run_through_training___461.pdf_30872336.pdf (accessed 20 July 2012)

Stubbing J (2008) Education and the SAS doctor. *BMJ Careers* 15 Oct (http://careers.bmj.com/careers/advice/view-article.html?id=3096 accessed 20 July 2012)

Tooke J (2008) *Aspiring to excellence. Final report of the independent inquiry into Modernising medical careers.* Aldridge Press, London: 57

KEY POINTS

- The findings demonstrate that staff and associate specialist doctors in this deanery share a common characteristic: the commitment to progress and develop their skills as doctors.
- The majority of staff and associate specialist doctors made informed decisions to undertake an staff and associate specialist role, and are relatively happy the role as long as they take can take advantage of educational opportunities.
- Deaneries and trusts need to tailor the diverse training needs of individual doctors by the allocation of an individual educational supervisor for each staff and associate specialist doctor.