Staff grade doctors and the consultant ladder: falling off or stepping off?

Maureen Baker, Jacky Williams, Roland Petchey, Andy Flett

The majority of the doctors in staff grade posts surveyed had qualified overseas and a substantial proportion were dissatisfied with their posts. Very few doctors had received adequate careers counselling before starting their post and many were concerned at the lack of opportunities for career development.

INTRODUCTION

Lord Moran, the personal physician to Winston Churchill, famously described the medical career structure as a ladder. Hospital consultants stood in triumph at the top of this ladder, while those doctors who no longer aspired to become consultants — notably general practitioners — were deemed to have 'fallen off' (Hansard, 1950).

In 1988, a new post, the staff grade, was created (Department of Health and Social Security, 1986, 1987; Department of Health, 1988). It was intended to provide a secure career in hospital medicine for doctors who did not wish, or were unable, to become consultants.

Staff grade doctors are fast emerging as a significant component of the secondary care medical workforce. In 1991 there were 490 doctors employed as staff grades in England, by 1996 this figure had risen to 2120 (Department of Health, 1996). In Trent the ratio of staff grades to consultants is now around 1:10. The experiences and views of staff grade doctors in Scotland has been researched (Rippin and Buckley, 1996), however, little is known about the reasons why doctors take up staff grade posts in England and Wales (Standing Committee on Postgraduate Medical Education (SCOPME), 1992, 1994). Did they fall off the consultant ladder, did they step off or were they pushed?

We set out to identify staff grade doctors in Trent region, and sought to investigate their experiences, their attitudes to their status, their working conditions and their access to career development opportunities.

Dr Maureen Baker is Associate Adviser in General Practice, Centre for Postgraduate and Continuing Medical Education, **Dr Jacky Williams** is Research Associate and **Dr Roland Petchey** is Lecturer in General Practice in the Division of General Practice, and **Dr Andy Flett** is Research Associate, Centre for Postgraduate and Continuing Medical Education, University of Nottingham, Nottingham NG7 2UH

Correspondence to: Dr M Baker

METHOD

A list was compiled of all doctors employed in staff grade posts from information supplied by trusts in Trent in January 1997. Semi-structured interviews were carried out with a variety of key informants — including clinical tutors, college regional advisers and trust chief executives. Their responses informed the development of a 1-page questionnaire, which was sent in March 1997 to all the staff grade doctors identified.

They were asked to specify their age, gender and place of graduation, and they were requested to indicate their level of satisfaction with their current employment status using a five-point Likert scale. It was recognized that level of satisfaction is determined by the perceived characteristics of the job within a set frame of reference, which in turn is a function of career expectations, experience and availability of viable alternatives (Smith et al, 1969).

Six factors held to represent the primary reasons for practising at the staff grade level — as suggested by the key informants — were described and the respondents were asked to supplement their subjective perceptions of 'satisfaction' by specifying which factors (if any) were relevant to their current situation. On completion, the respondents were invited to participate in a focus group. Non-responders were sent a postal reminder after 4 weeks. Responses were coded and analysed using the SPSS statistical package.

Five focus groups were conducted in June 1997. Each was made up of four or five doctors (a voluntary sample), a facilitator and an assistant to make notes. The groups — each lasting approximately an hour — were audiotaped, transcribed verbatim and content analysed by means of iterated reading using a grounded theory approach (Glaser and Strauss, 1967). Initial analysis was carried out independently by three of the researchers and a consensus was reached on which were the most pertinent themes.

RESULTS

Survey

Of the 256 staff grade doctors in the Trent region, 183 (71.5%) responded to the questionnaire. Of these, 27 were returned uncompleted, because of addressees moving to other posts (11 cases), leaving the Trent region (13 cases), being on maternity leave (one case), retiring (one case) or death (one case). Nine questionnaires were returned with insufficient data to process, leaving 147 useable questionnaires which were coded and analysed.

Table 1 illustrates the gender and place of graduation makeup of the sample. The majority of respondents

TABLE 1.
Characteristics of respondents

		Graduated from		
		UK	Overseas	Total
Gender	Male	16 (10.9%)	91 (61.9%)	107 (72.8%)
	Female	29 (19.7%)	11 (7.5%)	40 (27.2%)
	Total	45 (30.6%)	102 (69.4%)	147 (100%)

were males who had graduated from medical schools overseas. This breakdown of the sample by gender and source of primary qualification, while statistically similar to the sample of the SCOPME study (SCOPME, 1994) (χ^2=2.114; degrees of freedom (df) =1; P>0.10), is significantly different from the Scottish study (Rippin and Buckley, 1996) (χ^2=42.217; df=1; P<0.001).

Logistic regression (Ryan, 1997) was used to predict the respondents' identification of each of the factors relevant to their current situation, based on gender and place of graduation. *Table 2* illustrates that female respondents (graduating both from the UK and overseas) were significantly more likely than males to cite the factors 'lack of desire to become a consultant' (B=-2.157; df=1; P=0.0024) and 'conflict between home and career' (B=-1.802; df=1; P=0.0086).

Overseas graduates (male and female) were significantly more likely to cite 'inability to find a suitable post' than UK graduates (B=-2.043; df=1; P=0.034). Male overseas graduates were significantly less likely to cite 'no desire to become a consultant' than any other subgroup (B=2.201; df=1; P=0.02). Level of satisfaction was processed as a dichotomous 'satisfied/not satisfied' response for the logistic regression procedure. UK graduate respondents were significantly more likely to express satisfaction with their current employment status than overseas graduate respondents (B=-1.390; df=1; P=0.017).

Focus groups

Participants emphasized the enormous variability of staff grade posts and the difficulty of generalizing even within a single specialty. Nevertheless, a number of inter-linked themes emerged.

Staff grade careers: Staff grade doctors appear to fall into three broad groupings. Most UK graduates had opted for a staff grade post for reasons connected with family commitments or geographical immobility. They viewed the staff grade post as a temporarily acceptable second-best and were expecting to resume specialist training at some future date when their circumstances altered. There was little acknowledgement of the difficulties that this might entail.

Satisfaction derived mainly from the compatibility of their pattern of working with their non-work commitments. A minority of UK graduates perceived the staff grade post as a career destination. These doctors recognized that they were atypical. Often they had made a late or radical change of career direction (e.g. from GP principal to genitourinary medicine or anaesthesia). They viewed the staff grade post positively as a means of practising in their new specialty without undergoing lengthy retraining.

The third group consisted of overseas graduates. These were the majority of focus group participants, and most had emigrated from the Indian sub-continent. Reflecting the quantitative findings, these doctors were most likely to express dissatisfaction with their posts.

The issue of racial discrimination was spontaneously raised in all of the groups. Participants distinguished between direct and institutional racism. None had experienced overt racism in appointment procedures, but most were convinced that being overseas qualified had prevented their acceptance onto registrar or senior registrar rotations.

They rejected the appellation 'stuck doctors', and its implication that they were inadequate. They saw themselves as blocked by a system that was loaded against them. Particular resentment was directed against the Home Office and the Royal Colleges, which were viewed as remote and bureaucratic at best and downright obstructive at

TABLE 2.
Frequencies and percentages of respondents positively identifying factors

		Males			Females			
	No of valid cases	UK graduates	Overseas graduates	Total (M)	UK graduates	Overseas graduates	Total (F)	Total
Satisfaction with current employment status	147	14 (87.5%)	54 (60.0%)	68 (63.6%)	26 (89.7%)	8 (72.7%)	34 (85.0%)	102 (69.4%)
Lack of appropriate qualifications	147	9 (56.3%)	28 (30.8%)	37 (34.6%)	7 (24.1%)	2 (18.2%)	9 (22.0%)	46 (31.3%)
No desire to be a consultant	147	9 (56.3%)	8 (8.8%)	17 (15.9%)	16 (55.2%)	5 (45.5%)	21 (51.2%)	38 (25.9%)
Conflict between family and career	147	1 (6.3%)	11 (12.1%)	12 (10.9%)	17 (58.6%)	5 (45.5%)	22 (55.0%)	34 (23.1%)
Personal illness/disability	147	0 (0%)	3 (3.3%)	3 (2.7%)	0 (0%)	0 (0%)	0 (0%)	3 (2.0%)
Unable to find a suitable post	146	1 (6.3%)	48 (53.3%)	49 (45%)	2 (6.9%)	4 (36.0%)	6 (14.6%)	55 (37.7%)
Lack of geographical mobility	147	2 (12.5%)	6 (6.6%)	8 (7.3%)	10 (34.5%)	0 (0%)	10 (25%)	18 (12.2%)

worst. Several retained a desire to re-enter training grades and some thought that these aspirations were being thwarted by the colleges' attitudes towards staff grade doctors.

None of the participants felt they had received adequate career counselling from informed sources such as college regional advisers or postgraduate deans. Few had received formal induction into their posts.

Status conflict: For most participants a major source of dissatisfaction was the incongruities and inconsistencies in their status (*Figure 1*). One described staff grades as the 'mongrels' of the medical hierarchy. The variability of staff grade posts was evidence of the arbitrariness of the regulations that distinguished them from consultants and specialist registrars.

At a personal level, working relationships were generally thought to be good. Many felt valued by their consultants and several had been given opportunities to develop a specialist service niche. However, a change of consultant could leave them vulnerable to drastic changes in their duties.

Relationships with patients were usually not problematic, although some reported that patients were uncertain about the status of staff grade doctors. In an attempt to avoid this, various alternative titles were used in dealings with patients. Titles that identified them with a specialty (such as 'Staff Anaesthetist') were strongly preferred.

Status incongruities were felt most keenly in their relationships with junior doctors. They saw little essential difference between their own responsibilities and those of colleagues in the training grades, yet their experience did not count for accreditation purposes. They perceived it as anomalous that they were often involved in training junior doctors (even up to specialist registrar level), yet were not as eligible for training posts themselves. The 'master–apprentice' model of postgraduate medical education was incongruent with the possibility that their apprentices might shortly become their masters.

Personal and professional development: Very few doctors reported difficulties in this area. All attended departmental meetings and were expected to participate in these meetings. Problems with study leave were more likely to be site- specific rather than post-specific. Although staff grade doctors had opportunities to attend local and regional educational meetings, they often could not attend national meetings, which tended to be monopolized by consultants and specialist registrars. However, many commented on the reduced value and relevance of personal and professional development while they were denied career progression.

'It is well known that once a staff grade always a staff grade, a dead end or siding post, it doesn't go anywhere.' (Male, overseas graduate)

'Outside the department I have a little badge that says 'Staff Physician' just to cheer me up a little bit.' (Male, UK graduate)

'The respect, the money, the career, the progression, your standing is not commensurate with your experience.' (Male, overseas graduate)

'The key issue for people, for staff grades, are immigration status, immigration status, immigration status, and at a later date would be age, age, age.' (Male, overseas graduate)

'I don't think we're doing any different job on the ground. On paper, yes, one is a training job and one is a non-training job, but in reality there is very little difference.' (Male, UK graduate)

'I'm married and we haven't planned yet to have children, but I could feel happy about having children in that sort of post.'(Female, UK graduate)

Figure 1. Participants ' comments about staff grade posts.

The future: Participants referred frequently to their vulnerability to exploitation. Several reported unilateral changes in their contracts of employment and pressure to cover unpopular shifts and sessions. There was particular concern about their capacity to sustain current clinical workloads, antisocial hours and on-call commitments as they got older. They were sceptical that experience and seniority would count for anything with their employers in terms of remuneration and job security.

A major issue was whether there might be any possibility of advancement. Although some saw associate specialist posts as a possible solution, many doubted that they would be treated fairly in competition for them.

DISCUSSION

Most of the staff grade doctors targeted were, in general, satisfied with their posts. However, almost a third expressed some form of dissatisfaction. This dissatisfaction was most prevalent among male overseas graduates, who represent the majority of staff grade doctors.

Distinct differences were noted between the views of UK and overseas graduates. UK graduates were more likely to regard a staff grade post as a temporary solution to current personal circumstances and to expect to resume specialist training when their circumstances altered. Overseas graduates were more likely to be and to remain in these posts with reluctance.

Although professional relationships were considered to be positive on an interpersonal level for most, many staff grade doctors felt exploited and undervalued by the system. They perceived a discrepancy between their role and their status. They felt that their skills and experience were not sufficiently recognized or rewarded and that they were denied opportunities to fulfil their potential.

An important source of dissatisfaction was their involvement in teaching junior doctors. This appears to be widespread despite being contrary to medical Royal Colleges' policy. Staff grades receive no training in educa-

TABLE 3.
Standing Committee on Postgraduate Medical Education recommendations regarding the staff grade

Doctors in training should be educated on the role of the staff grade and its place in the medical staffing structure
Careers advice should be given before entry to the staff grade
Formal induction should be provided
The educational needs of staff grades should be included in systems for continuing medical education and professional development

From Standing Committee on Postgraduate Medical Education (1994)

tional methods and are not paid for teaching. The respondents did not report experience of direct racism in medical appointments; however, other studies suggest that this does exist (Esmail and Everington, 1993, 1997). In order to avert suspicions of institutional racism the guidelines regarding discrimination should be rigorously applied (Commission for Racial Equality, 1996).

The medical Royal Colleges have an important role in accrediting doctors who hope to return to training grades. The focus group findings here suggest that relationships between staff grade doctors and the colleges are poor. Given that many staff grades are members of colleges and have important roles in direct patient care, the colleges — perhaps through the Academy of Medical Royal Colleges — should review their role in providing support and continuing professional development to them.

In 1994 specific recommendations were made regarding the staff grade (SCOPME, 1994) (*Table 3*). On some of these recommendations (for instance, access to continuing medical education) progress appears to have been made. On others, urgent action is needed, particularly to clarify the role and status of career grade doctors and to provide appropriate careers advice, induction and support during the early years of an appointment. Employers, not the postgraduate deans, are responsible for assessing and meeting the educational needs of staff grades, but the deans were advised by SCOPME to consider the educational provisions made for staff grade doctors by employers when assessing units as suitable training environments (Department of Health, 1994).

CONCLUSIONS

Almost a decade after the introduction of staff grade posts, it is clear that uncertainties about their role and status remain widespread, both in and outside the grade. Significant numbers of staff grade doctors are dissatisfied with their posts and concerned about their prospects. At the time of this study, the recommendations concerning methods of entry for staff grades onto the specialist register and improved potential for promotion to associate specialist were not widely known. It is vital therefore that employers ensure that important information is disseminated to staff grade doctors in an accurate and timely manner.

KEY POINTS

- The number of staff grade doctors in England has risen dramatically from 490 in 1991 to 2120 in 1996.
- Careers counselling is inadequate before entry to the staff grade.
- The majority of doctors in staff grade posts (over 70%) have qualified overseas.
- A substantial number of doctors in staff grade posts express dissatisfaction with these posts.

At a time when there are calls for recruiting and training greater numbers of doctors (Medical Workforce Standing Advisory Committee, 1997; Goldacre, 1998; Richards, 1997), we must establish that every medical position within the NHS is valued and that all doctors in this country have equal access to career development regardless of racial origin or country of graduation. **HM**

Commission for Racial Equality (1996) *Appointing NHS Consultants and Senior Registrars.* Commission for Racial Equality, London

Department of Health (1988) *The New Hospital Staff Grade.* Health Circular (88) 90. HMSO, London

Department of Health (1994) *Executive Letter* 95 (27). HMSO, London

Department of Health (1996) *Statistical Bulletin.* July. HMSO, London

Department of Health and Social Security (1986) *Hospital Medical Staffing: Achieving a Balance.* Department of Health and Social Security, London

Department of Health and Social Security (1987) *Hospital Medical Staffing: Achieving a Balance — Plan for Action.* Department of Health and Social Security, London

Esmail A, Everington S (1993) Racial discrimination against doctors from ethnic minorities. *Br Med J* **306:** 691–2

Esmail A, Everington S (1997) Asian doctors still being discriminated against. *Br Med J* **314:** 1619

Glaser BG, Strauss, AL (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research.* Aldine, Chicago

Goldacre M (1998) Planning the United Kingdom's medical workforce. *Br Med J* **316:** 1847–8

Hansard (1950) House of Lords. 18 October

Medical Workforce Standing Advisory Committee (1997) *Planning the Medical Workforce.* Third report. Department of Health, London

Richards R (1997) Disillusioned doctors. *Br Med J* **314:** 1705

Rippin H, Buckley EG (1996) The educational needs of staff grade doctors and dentists in Scotland. *Health Bull* **54(4):** 318–31

Ryan TP (1997) *Modern Regression Methods.* J Wiley, New York

Smith PC, Kendall LM, Hulin CL (1969) *The Measurement of Satisfaction: A Strategy for the Study of Attitudes.* Rand McNally, Chicago

Standing Committee on Postgraduate Medical Education (1992) *Working Paper on the Educational Needs of Staff Grades and Other Groups.* Standing Committee on Postgraduate Medical Education, London

Standing Committee on Postgraduate Medical Education (1994) *Meeting the Educational Needs of Staff Grade Doctors and Dentists.* Standing Committee on Postgraduate Medical Education, London

For comments on this article, please see p. 828 of this issue

CAN WOMEN HAVE CAREERS AS STAFF GRADE DOCTORS?

The hospital medical career pattern has become even more of a 'ladder' since Lord Moran made this remark. However, it is not so much falling off the ladder as getting on it that is the problem. The reason for this is that following *Achieving a Balance* (Department of Health and Social Security, 1986) (clearly recognized at the time as racist and sexist in its implications), and with the tightening process of national training numbers, 'higher' training posts are supposed to lead automatically to consultant posts. However, consultant posts have not expanded sufficiently, and perhaps cannot efficiently, to cover the service deficiencies, hence the unsurprising expansion of the staff grade.

Baker et al's survey confirms and amplifies the Medical Women's Federation's awareness of this issue (Elmes, 1999). Most of the doctors are male overseas graduates, who would have preferred consultant posts; more women are content, but do not seem fully aware of the difficulties of moving from such a position. While there have been further improvements in terms and conditions, and the possibility of access to the hospital specialist grade, it is also now clear that achievement of specialist registration may not be sufficient for career progress — witness the 'superfluous' obstetricians and gynaecologists.

Non-consultant career grade posts are essential but need to be openly planned and valued. For women doctors, considerable reflection about their desired career pathways continues to be advisable, especially now that 'revalidation' is coming in.

Flexible training, although it may be long-drawn out, is now much more available, and may provide more satisfaction in the longer term.

Fiona Subotsky
President
Medical Women's Federation

Department of Health and Social Security (1986) *Hospital Medical Staffing: Achieving a Balance.* Department of Health and Social Security, London

Elmes M (1999) The staff grade doctor and career development. *Medical Woman* **60:** 22

ADDRESSING ISSUES: STATUS AND CAREER DEVELOPMENT

The hospital career structure is changing. Education no longer ends with consultant appointment. The Royal College of Obstetricians and Gynaecologists expects all UK career grade obstetricians and gynaecologists, including staff grade doctors, to participate in continuing medical education, now part of continuing professional development. Soon all doctors will need to undergo revalidation. Such changes begin to blur the difference between consultants and other grades.

The gender balance is also changing. Among entrants to UK medical schools the proportion of women is over 50% and among doctors achieving Membership of the Royal College of Obstetricians and Gynaecologists it is almost 75%. Soon most of the consultants in obstetrics and gynaecology may be women.

At present the specialty has more trainees than consultant vacancies. The Royal College of Obstetricians and Gynaecologists is pressing strongly for consultant expansion but as specialist registrar and senior house officer posts are being reduced, trusts may appoint more career grade doctors to keep the service going.

Consultants are being appointed at a younger age than previously. They will need career development. Lord Moran's idea of the consultant sitting complacently on top of a ladder for 30 years is sadly out of date.

Ideas of 'status' are deeply embedded in doctors' and patients' minds but are a block to rational thinking about hospital staffing. In the past trainees accepted low status posts, doing most of the NHS's work, because their eventual regard would be consultant status. In future all doctors will want flexibility and career progression, while patients will demand higher standards than ever. The Royal College of Obstetricians and Gynaecologists is actively discussing how these aspirations can be balanced.

James Drife
Junior Vice-president
Royal College of Obstetricians and Gynaecologists

REPRESENTING STAFF GRADE DOCTORS

Baker et al's article is consistent with previous surveys and adds to the mounting evidence of problems with the staff grade. The Royal College of Physicians has been concerned for some time about the plight of staff grade doctors, as detailed in the Royal College of Physicians publication *Staff Grade Doctors: Towards a Better Future* (Royal College of Physicians, 1993) and the subsequent review of this by the College.

The lack of response to recommendations in these publications prompted the Royal College of Physicians to form a working party looking into the problems of non-consultant career grade doctors. As a result a standing committee for non-consultant career grade doctors was formed with its inaugural meeting in June 1999. This committee, whose remit is to look after the concerns of medical non-consultant career grade doctors, has representation on other college boards and committees, including those concerned with education, training and professional affairs.

Since its formation the non-consultant career grade doctors committee has begun to develop a database of non-consultant career grade doctors in medical specialties (both members and non-members of the Royal College of Physicians) in order to identify the doctors its represents. The immediate and urgent goals of this committee are to ensure the continuing professional development of these doctors by improving both career structure and education and training for accreditation in the future.

Ghislaine Davies
Chairman
Standing Committee of Non-Consultant Career Grade Doctors
Royal College of Physicians

Royal College of Physicians (1993) *Staff Grade Doctors: Towards a Better Future.* Royal College of Physicians, London