

Recruitment of doctors to non-standard grades in the NHS: analysis of job advertisements and survey of advertisers

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Abstract

Objectives To estimate the proportion of advertised non-consultant hospital posts that do not conform to nationally recognised terms and conditions of service and to investigate why these posts exist, who fills them, and what the doctors in such jobs do.

Design Analysis of job advertisements and a cross sectional survey of advertisers.

Setting Job advertisements in one of the leading UK publications listing hospital doctor vacancies (*BMJ Careers*).

Results Nearly a quarter of non-consultant posts advertised in the two study periods (23% and 21%) were for non-standard grade posts. A questionnaire was sent to the medical staffing officer for each post. Of 430 questionnaires sent out 192 (45%) were returned. 98 trusts said they advertised non-standard grades because there was no more funding from the deanery for approved posts and 75 because service needs could not be met by doctors in training grades. In 132 posts (69%) the post holder would be required to do on-call work, and 50 advertisers (26%) required on-call duty for 1 in 5 or more frequently, which would conflict with the European Working Time Directive. 131 advertisers (68%) expected the posts to be filled by doctors from outside the European Economic Area.

Conclusions Non-standard grade posts are mostly being created to meet service requirements when there is no more funding for standard training posts and are expected to be filled by doctors from overseas. Doctors in such posts can be more easily exploited and their careers hindered. The Department of Health's annual census should include non-standard grade doctors.

Introduction

The number of doctors in the United Kingdom who are appointed to hospital posts that don't conform to the standard NHS grades is rising, as trusts try to comply with restrictions on working hours in the NHS's "new deal" for doctors in training and the European Working Time Directive.¹⁻³ We define non-standard grade posts as non-consultant jobs that do not conform to the recognised hospital grades (box 1). Doctors appointed to non-standard grades—which tend to be described as though they are training grades—are usually called trust doctors, because they are employed on terms and conditions set by individual trusts. However, a variety of other job titles are used, such as hospital specialist, assistant surgeon, and clinical fellow registrar grade. Terms of employment and education are not standardised.

The actual number of doctors holding non-standard grade posts is not known, as the Department

of Health does not include them in its annual census.¹ However, an unsubstantiated statement in a recent health department report said that "separate analysis shows that there are around 5000 doctors on local contracts, for whom the national grade is unclear."⁵

The problem with non-standard grade posts is that they can be confusing and may exploit doctors unfamiliar with the UK system. For example, time spent in non-standard posts cannot be counted towards basic specialist training.⁶ Some doctors may not realise that posts are not recognised training grade posts. Many of the job titles do not clearly convey the type of job the doctors will be doing. Also, applicants need to know where they will fit into the medical hierarchy; doctors holding such posts are seen as "lacking in status and recognition," and there is a "feeling that they are overlooked in terms of professional development, study leave and discretionary points."⁵

We investigated the proportion of advertisements for non-standard grade posts in *BMJ Careers*, the *BMJ* supplement that advertises almost all hospital posts in the United Kingdom. We also looked at the reasons why these posts exist, who fills them, and what the appointed doctors do.

Methods

To investigate the proportion of non-standard grade posts placed in *BMJ Careers* and the range of job titles advertised we took a random sample of eight issues published in the 12 months to 9 September 2002. We took two issues from each quarter, as the type of posts advertised may vary across the year. We compared all non-consultant job advertisements with the standard

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Box 1: Standard NHS hospital grades for non-consultant doctors

Training grades

House officer
Senior house officer
Specialist registrar
Senior registrar (entry to this grade is now closed)

Career grades

Staff grade doctor
Associate specialist
Clinical assistant
Hospital practitioner

The health department's *Guide to Specialist Registrar Training* requests that advertisements for approved standard posts contain the words "The postgraduate dean has confirmed that this programme has the required educational and staffing approval."⁴ The BMA also advises every week in *BMJ Careers* that junior doctor hospital posts should contain this statement prominently.



The questionnaire that was sent to advertisers appears on bmj.com

Box 2: Job titles advertised in *BMJ Careers* that are not recognised by the BMA

- Admissions ward officer
- Anaesthetic fellow
- Assistant surgeon
- ASTO fellowship
- Bone marrow transplant coordinator
- Breast screening physician
- Clinical fellow registrar grade
- Clinical fellow SHO level
- Clinical fellow
- Clinical lecturer
- Clinical liaison assistant
- Clinical research fellow
- Clinical research associate
- Clinical specialist
- Clinical trust fellow
- Clinical tutor
- Combined clinical and research fellow
- Coronary care officer
- Dialysis fellowship
- Doctor for service
- ECMO clinical fellows
- ECMO fellow post SpR training equivalent
- Emergency medical officer
- Examination preparation trust fellow
- Fellow
- Foundation fellow
- Foundation officer
- Hand fellow
- Hepatobiliary fellow
- Hospice doctor
- Hospice physician
- Hospital fellow
- Hospital specialist
- Intermediate SHO
- Joint trust grade
- Junior clinical fellow
- Junior clinical fellow SHO equivalent
- Junior clinical medical officer
- Junior clinical surgery fellow
- Junior doctor
- Junior medical officer
- Junior physician
- Junior research fellow
- Junior surgeon
- Junior trust doctor
- Locum trust house officer
- Locum trust SHO
- Medical casualty officer
- Medical clinical fellow
- Medical officer
- Medical practitioner
- Middle grade SHO
- Night trust doctor
- Non heart beating kidney donor transplantation fellow
- Orthopaedic fellow
- Paediatric fellow
- PICU fellowship
- Post fellowship post
- Resident medical officer
- Resident paediatric officer
- Senior clinical fellow

grades (box 1) and recorded the job titles for all the posts whose details did not meet the standard definitions (box 2).

We then surveyed advertisers to investigate why they were advertising non-standard posts, who they expected to fill these posts, and what they expected the post holders to do. For each new advertisement for a non-standard grade post published in the four issues of *BMJ Careers* from 11 January to 1 February 2003 we sent a questionnaire (see bmj.com) to the medical staffing officer responsible for the post. Most advertisers were contacted by post. We telephoned non-responders up to three times, and if they still didn't respond we sent the questionnaire again. Finally, the *BMJ's* editor and the director of *BMJ Careers* sent a letter to the chief executives of non-responding trusts requesting their help in ensuring that questionnaires were completed.

Results

Of the 4949 non-consultant jobs advertised in the random sample of eight issues of *BMJ Careers* published in 2001-2, 1150 (23%) did not conform to the standard NHS grades. In the four issues between 11 January and 1 February 2003, 430 (21%) of the 2073 non-consultant jobs advertised were for non-standard grades. We received 192 completed questionnaires (45%) from these advertisers.

Factors preventing recruitment to standard training grades—The most frequently reported reasons that respondents gave for their not being able to recruit to a standard grade were that there was no more funding from the deanery for approved posts (98 respondents (51%)) and that service needs could not be met by doctors in standard training grades (75 (39%)). Nineteen respondents (10%) said that the posts could be filled only by doctors with limited GMC registration.

Type of post—Of the 192 advertisements 161 (84%) were for substantive (non-locum) posts. Eighty five posts (44%) had been newly created. Twenty nine posts (15%) were advertised because the previous post holder had moved to a senior job, 16 (8%) because the previous post holder had moved to a junior job, and 57 (30%) because the previous post holder had left for other reasons. Fifty four (64%) of these new posts were created to fill gaps in service when doctors in training were unavailable.

On-call commitments—Of the respondents 132 (69%) said the post holder would be expected to take part in regular on-call duty, and 50 of these respondents said the on-call duty would be at least 1 in 5 (being on call for 24 hours every five days and one in five weekends).

Working level—Respondents expected that the non-standard grade doctors would work at the level of various standard grades: 41 (21%) said the post holder would share an on-call rota with consultants, 73 (38%) with specialist registrars, 80 (42%) with senior house

officers, 30 (16%) with staff grade doctors, and eight (4%) with associate specialists.

Teaching commitments—Sixty three respondents (33%) expected their post holders to teach medical students, 38 (20%) to teach house officers, 26 (14%) to teach senior house officers, and three (2%) to teach specialist registrars. No teaching commitment was expected by 106 respondents (55%).

Educational needs—One hundred and sixty five respondents (86%) said a session would be allocated to the educational needs of the post holder, though 19 of these said they expected that the post holder would miss teaching time because of clinical commitments.

Recruitment from overseas—One hundred and thirty one respondents (68%) said they were expecting to recruit someone from a country outside the European Economic Area. Most respondents said they expected it was likely or very likely that the posts would be filled by doctors trained outside the United Kingdom (166 (86%)), by doctors coming to the United Kingdom for training (129 (67%)), or by doctors who had failed to find training posts (152 (79%)).

Discussion

Just under a quarter of non-consultant posts advertised in two different study periods were for non-standard grade posts. Half of such posts are created to meet service requirements when there is no more deanery funding for recognised training posts. More than two thirds of the doctors filling these posts are required to do on-call work, and a quarter are on call for 24 hours every five days and one in five weekends, or more frequently, breaching the European Working Time Directive. Most advertisers expect the posts to be filled by doctors from outside the European Economic Area.

Strengths and limitations of the study

The response rate to the survey was low, even though we used recognised techniques to improve completion rates, such as reply envelopes, follow up reminders, and personal letters to trusts' chief executives.^{7 8} The low response rate may be due to the sensitive nature of the questions. Furthermore, because we sent one questionnaire for each non-standard post advertised, some medical staffing officers received several questionnaires.

Medical staffing officers may not have known all the information asked for in the survey. Ideally, we should have sent questionnaires to the person responsible for creating the post, but the limited information given in the advertisements made it difficult to identify who this person was.

BMJ Careers advertises most but not all hospital posts in the United Kingdom. Also, our survey was conducted at the start of the year, and it is possible that jobs advertised at this time differ from those advertised at other times of the year. However, the proportion of non-standard grade jobs in our four week survey in January 2003 (21%) was similar to the proportion of these posts advertised in the random sample of eight issues published in the 12 months to September 2002 (23%).

Implications for policy makers

The NHS's new deal for doctors in training recommends that "trusts should not use job titles that may mislead applicants because of their apparent similarity

What is already known on this topic

Hospital doctors in the United Kingdom are being recruited to posts that do not conform to NHS standard grades, but the number of these posts is not known

Little is known about why non-standard posts exist, who fills them, what the post holders do, and whether the post holders are being exploited

What this study adds

Nearly a quarter of advertisements for non-consultant jobs in the United Kingdom are for non-standard grade posts

These posts are created to keep the service going when there is no more funding for recognised training posts

Trusts advertising the posts expect them to be filled by doctors from outside the European Economic Area

Working conditions for a quarter of non-standard grade posts conflict with the European Working Time Directive

to recognised NHS training posts."² Our study shows that misleading job titles are widely used by trusts. Most respondents to our survey expected that these posts would be filled by graduates from non-European Economic Area countries looking for training posts. Overseas graduates may not appreciate the difference between standard and non-standard training grade posts, especially when titles such as "junior clinical fellow SHO equivalent" are used. Thus they may be unaware that, unlike their training grade colleagues, they are not entitled to educational supervision.

It may be that non-standard grade doctors are being exploited. A quarter of post holders were expected to participate in on-call duty for 1 in 5 or more. These doctors are protected under the European Working Time Directive and should not be working more than an average of 48 hours each week. Posts that entail an on-call rota of 1 in 5 or more cannot fulfil the directive's requirements.

Conclusions

Doctors in non-standard grade posts should be included in the Department of Health's annual census to show employment trends. Cohort studies following the career paths of trust grade doctors would show whether these doctors are being sidelined.

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Ethical approval: The *BMJ*'s ethics committee.

- Cooper N, Burr B. Are trust doctors the new lost tribe? *BMJ* 2002;325:491.
- Department of Health. *Junior doctors: the new deal*. London: HMSO, 1991.
- Council Directive 93/104/EC. *Official Journal of the European Community* 1993;L307:18-24. (http://europa.eu.int/eur-lex/en/consleg/pdf/1993/en_1993L0104.do_001.pdf).
- Department of Health. *A guide to specialist registrar training*. London: DoH, 1996.
- Department of Health. *Choice and opportunity: modernising medical careers for non-consultant career grade doctors*. London: DoH, 2003.
- Norcliffe G, Finlan C. Non-standard grade posts. *BMJ* 2001; 323(suppl):S2.
- Dillman DA. *Mail and telephone surveys: the total design method*. New York: Wiley, 1978.
- Edwards P, Roberts I, Clarke M, DiGiuseppi C, Prartrap S, Wentz R, et al. Increasing response rates to postal questionnaires: systematic review. *BMJ* 2002;324:1183.

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Russian mortality trends for 1991-2001: analysis by cause and region

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Abstract

Objectives To investigate trends in Russian mortality for 1991-2001 with particular reference to trends since the Russian economic crisis in 1998 and to geographical differences within Russia.

Design Analysis of data obtained from the Russian State statistics committee for 1991-2001. All cause mortality was compared between seven federal regions. Comparison of cause specific rates was conducted for young (15-34 years) and middle aged adults (35-69 years). The number of Russian adults who died before age 70 in the period 1992-2001 and whose deaths were attributable to increased mortality was calculated.

Main outcome measures Age, sex, and cause specific mortality standardised to the world population.

Results Mortality increased substantially after the economic crisis in 1998, with life expectancy falling to 58.9 years among men and 71.8 years among women by 2001. Most of these fluctuations were due to changes in mortality from vascular disease and violent deaths (mainly suicides, homicides, unintentional poisoning, and traffic incidents) among young and middle aged adults. Trends were similar in all parts of Russia. An extra 2.5-3 million Russian adults died in middle age in the period 1992-2001 than would have been expected based on 1991 mortality.

Conclusions Russian mortality was already high in 1991 and has increased further in the subsequent decade. Fluctuations in mortality seem to correlate strongly with underlying economic and societal factors. On an individual level, alcohol consumption is strongly implicated in being at least partially responsible for many of these trends.

Introduction

The huge fluctuations in Russian mortality during the 1990s have attracted much interest.¹⁻³ Although Russian adult mortality was relatively high in 1991 compared with levels in western Europe, it increased rapidly in the immediate period after the break up of the Soviet Union, with a more marked increase among men. Subsequent to this, a sharp improvement was observed in the period 1995-8. Analyses of these trends identified vascular diseases and external causes as being responsible for most of the changes and focused on the role of alcohol and socioeconomic stress related to rapid economic changes.¹⁻⁶ Individual level information on possible aetiological factors is, however, limited.

Russia experienced a further economic crisis in 1998, including rapid devaluation of its currency and increases in poverty. This economic crisis coincided with a further increase in adult mortality in the three years up to 2001, with life expectancy falling to 58.9 years among men and 71.8 among women, levels similar to the low points reached in 1994. The cause of this recent dramatic decrease in life expectancy is not known. We examined the disease specific trends during this period to clarify these unique patterns.

Methods

We obtained data from the Russian State statistics committee, including deaths by cause, sex, five year age group, and calendar year together with corresponding population denominators.

We analysed trends of total and cause specific mortality for 1991-2001 for Russia overall and for seven federal regions, five in European Russia (North Western, Central, Privolzhski, Southern, and Uralski) and two in Asian Russia (Siberian and Far Eastern). We excluded data on Chechenskaya and Ingushskaya republics from the Southern region because of war. All death rates were standardised to the world standard population.⁷

Results

Mortality by age, sex, and cause

Age standardised mortality from all causes increased between 1998 and 2001 by 189/100 000 among men and 49/100 000 among women. Similar to the increase in mortality in 1991-4 and the decrease up to 1998, over 80% of the 1998-2001 increase was due to changes in those aged 35-69 years (middle age). However, an increase in mortality was also observed among younger adults. We restricted analysis of these trends to young and middle aged adults.

All cause mortality in the 15-34 age group in 2001 was similar to that observed in 1994 among both men and women, with the modest improvements in the years up to 1998 having been completely reversed (table). Most of the increase in the mortality trends in the period 1998-2001 could be explained by trends in deaths from external causes. Mortality from cancer changed little over the 10 year period.

In middle aged adults (35-69 years) total mortality in 2001 was 21% higher for men and 15% higher for women than in 1998. The large increase between 1998