Editorial

Developing future surgical workforce structures: A review of post-training non-Consultant grade specialist roles and the results of a national trainee survey from the Association of Surgeons in Training

A B S T R A C T

The optimal workforce model for surgery has been much debated historically; in particular, whether there should be a recognised role for those successfully completing training employed as non-Consultant grade specialists. This role has been termed the ‘sub-consultant’ grade. This paper discusses historical and future career structures in surgery, draws international comparisons, and presents the results of a national trainee survey examining the post-Certificate of Completion of Training (CCT) non-consultant specialist grade. Junior doctors in surgical training (i.e. pre-CCT) were invited to participate in an electronic, 38-item, self-administered national training survey. Of 1710 questionnaires submitted, 1365 were appropriately completed and included in the analysis. Regarding the question ‘Do you feel that there is a role in the surgical workforce for a post-CCT non-consultant specialist (“sub-consultant”) grade in surgery?’, 56.0% felt there was no role, 31.1% felt there was a role and 12.8% were uncertain. Only 12.6% of respondents would consider applying for such a post, while 72.4% would not and 15.0% were uncertain. Paediatric (23.3%), general (15.7%) and neurosurgery (11.6%) were the specialties with the highest proportions of trainees prepared to consider applying for such a role. For both questions, there was a significant gender difference in responses ($p < 0.0001$, Chi-square test) with female trainees more likely to consider applying. Overall 50.8% of respondents felt that the introduction of a post-CCT non-consultant specialist grade would impact positively upon service provision, however, only 21.6% felt it would have a positive impact on patient care, 13.9% a positive impact on surgical training, 11.1% a positive impact on the surgical profession and just 7.9% a positive impact on their surgical career. This survey indicates that the introduction of a ‘sub-consultant’ grade for surgeons who have completed training would be unpopular, with the majority believing it would be to the detriment of both patient care and surgical training. Changes to surgical career structures must be made in the interests of patient safety and quality, and on this basis ASiT supports the continued provision of primarily Consultant-delivered care.

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1. Introduction to ASiT

The Association of Surgeons in Training (ASiT) is a professional body and registered charity working to promote excellence in surgical training for the benefit of junior doctors and patients alike. With a membership of over 2200 surgical trainees from all 10 surgical specialties, ASiT provides support at both regional and national levels throughout the United Kingdom and Republic of Ireland. Originally founded in 1976, ASiT is independent of the National Health Service (NHS), Surgical Royal Colleges, and specialty associations.

2. Background to non-Consultant grade specialists in the surgical workforce

In the United Kingdom the conclusion of formal post-graduate medical training is recognised by the award of the Certificate of Completion of Training (CCT), granted under the auspices of the Royal Colleges and General Medical Council (GMC). The various pathways and the current detail of surgical training has previously been described elsewhere.\(^1\) Possession of a CCT allows entry onto the Specialist Register held by the General Medical Council, and the certificate holder may apply directly for Consultant posts. It was previously also possible for a CCT holder to apply for Staff Grade and Associate Specialist Doctor posts for service provision outside of the Consultant career structure. These grades are now closed to new entrants, being replaced by ‘Specialty Doctors’ in 2008. The current workforce structure and trainee progression through this is illustrated in Fig. 1.

Consultant surgeons nominally work as independent practitioners following appointment, although in practice work with colleagues on a departmental basis. This contrasts with continental Europe, where a ‘chef de service’ model is more commonly seen. This hospital-appointed head of service, typically an experienced senior clinician, is responsible for both business and professional aspects of a department, line-managing colleagues.\(^2\)

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The structure of the surgical workforce in the United Kingdom has been much debated historically; in particular, whether there should be a recognised role for CCT holders employed as non-Consultant grade specialists. This role has been termed the ‘sub-consultant’ grade. This was revisited by NHS Employers in their 2008 briefing document stating that “the future NHS will not require all doctors to progress to the current role of consultant”. The paper proposed a rationale for non-consultant specialists, referring to workforce planning, changes in training necessitated by Modernising Medical Careers (MMC) and the European Working Time Regulation (EWTR), and a perceived lack of experience of CCT holders for what was described as a “traditional consultant post”. This latter topic has been the subject of a previous position statement by ASiT and responses by other groups reflecting trainees’ views on the future surgical workforce.

Alternative workforce structures are by no means new and have been discussed since the inception of the NHS in 1948, when the Spens Committee report suggested that service would be mainly consultant provided. Over a decade later the Senior Hospital Medical Officer (SHMO) grade was discussed, initially included in the staffing plans for the NHS as a way of dealing with a perceived excess of doctors in training. The plan at the outset for that grade was seemingly a familiar one — that it would be a period of independent practice, but of lesser complexity and responsibility than that of a consultant. The expectation was that an SHMO post would lead to appointment as a hospital consultant. It soon became clear that there was very little chance of progression. In 1961, the Platt Committee concluded that the work of an SHMO and that of a consultant were essentially identical, and recommended that the SHMO grade be abandoned, a recommendation which was implemented shortly thereafter in 1964. The Report of the Royal Commission on Medical Education, led by Lord Todd and published in 1968, also proposed generating the grade of ‘junior specialist’.

The idea of seamless progress through ‘higher specialist grade’ was outlined by a report in 1986, and the ‘senior registrar’ grade was abolished in the nineties with the introduction of ‘Calman’ training. One of the drivers of ‘Calmanisation’ was to ensure that training was no longer “protracted by unnecessarily prolonged spells in repetitive posts of limited educational value or by an inappropriate and time-consuming process of competition each time a new post or entry to a new grade is required”. The current MMC program, introduced from 2005 onwards with the first specialty appointments in 2007, unified the old Senior House Officer (SHO) and Specialist Registrar (SpR) grades into a combined Specialty Registrar (StR) grade. In an attempt to streamline this many specialties offer run-through training following successful appointment into this grade. Many surgical specialties, however, have kept time-limited ‘uncoupled’ Core Surgical Training (CST) appointments as the first two-years, which are similar in nature to the old SHO grade. Following successful completion of CST, there is competitive entry into the StR grade in order to complete Higher Surgical Training (HST). Successful completion of this program, culminating in the award of the CCT, qualifies a surgeon to apply for Consultant posts. Numerous problems were encountered with the framework and implementation of the MMC changes, resulting in an independent enquiry lead by Sir John Tooke in 2008. As a result of these failings, a generation of doctors has a deep mistrust of changes relating to workforce career planning and their implementation.

This historical background is important to appreciate and these numerous reviews are summarised in Table 1. These also serve to highlight that it has never previously been deemed acceptable or workable to have a grade whereby the overlap in duties and responsibilities makes roles difficult to distinguish, or whereby despite undertaking similar duties (e.g. operations) one is deemed...
to be of lower responsibility or requiring less skill.\textsuperscript{15} This remains as valid for today’s surgical workforce as it has done in the past.

Further changes may still lie ahead, with the ‘Shape of Training’ review led by Professor David Greenaway re-examining postgraduate medical training and career structures.\textsuperscript{16} In addition, recent Government moves to pursue modifications to both junior doctor and Consultant national employment contracts could see wide-ranging changes.\textsuperscript{17}

This paper from the Association of Surgeons in Training reports the results of a national trainee survey regarding such ‘sub-consultant’ posts and discusses the arguments surrounding these.

3. National surgical trainee survey results

In order to assess surgical trainees’ opinions regarding ‘sub-consultant’ posts in the workforce, specific questions were included in an electronic, 38-item, self-administered national training survey. All junior doctors in surgical training (i.e. pre-CCT) in the UK were invited to participate in this anonymous, non-mandatory survey through surgical mailing lists and websites by ASiT and specialty associations. Responses were collected through the SurveyMonkey web-survey portal (SurveyMonkey.com, LLC, Palo Alto, California, USA). Data was analysed with Prism (version 5.0, GraphPad Software, California).

Of 1710 questionnaires submitted, 1581 were appropriately completed sufficient for further analysis. From these, only current surgical training grade junior doctors (SHO/Core Trainee (CT) and SpR/StR) responses were included, leaving 1365 individuals in the following analysis. Responses were received from all 19 postgraduate medical training Deaneries covering the geographical training regions in England, Northern Ireland, Scotland and Wales, plus military trainees in the Defence Deanery. Responses were received from all surgical specialties. Overall, 906 of the 1365 respondents were male (66.4%) and the mean age was 32.5-years old.

Regarding the question ‘Do you feel that there is a role in the surgical workforce for a post-CCT non-consultant specialist (“sub-consultant”) grade in surgery?’, 56.0% felt there was no role, 31.1% felt there was a role and 12.8% were uncertain. A breakdown of the responses to ‘Would you consider applying for a post-CCT non-consultant specialist (“sub-consultant”) post’ can be seen in Table 2. Only 12.6% of respondents would consider applying for such a post, while 72.4% would not and 15.0% were uncertain. The proportion of trainees who would consider applying for such a post fell from 18.9% of the most junior grades (CT year 1) to only 9.3% of the most senior (StR year 7/8). Of note, for both these questions, there was a significant difference in the responses by gender ($p < 0.0001$, Chi-square test) with female trainees more likely to consider applying for such a post.

50.8% of respondents felt that the introduction of a post-CCT non-consultant specialist (“sub-consultant”) grade would impact positively upon service provision, however, only 21.6% felt it would

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes (%)</th>
<th>Yes (n)</th>
<th>No (%)</th>
<th>No (n)</th>
<th>Uncertain (%)</th>
<th>Uncertain (n)</th>
<th>Grand total (n)</th>
</tr>
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<td>Gender</td>
<td></td>
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<tr>
<td>Female</td>
<td>19.0%</td>
<td>87</td>
<td>61.2%</td>
<td>281</td>
<td>19.8%</td>
<td>91</td>
<td>459</td>
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<tr>
<td>Male</td>
<td>9.4%</td>
<td>85</td>
<td>78.0%</td>
<td>707</td>
<td>12.6%</td>
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<td>100.0%</td>
<td>12</td>
<td>0.0%</td>
<td>0</td>
<td>12</td>
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<td>Unspecified</td>
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<td>0</td>
<td>66.7%</td>
<td>4</td>
<td>33.3%</td>
<td>2</td>
<td>6</td>
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<td>Plastic surgery</td>
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<td>64</td>
<td>17.9%</td>
<td>15</td>
<td>84</td>
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<td>6</td>
<td>79.0%</td>
<td>64</td>
<td>13.6%</td>
<td>11</td>
<td>81</td>
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<tr>
<td>ENt</td>
<td>7.9%</td>
<td>9</td>
<td>75.4%</td>
<td>86</td>
<td>16.7%</td>
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<td>114</td>
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<td>8.6%</td>
<td>3</td>
<td>77.1%</td>
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<td>14.3%</td>
<td>5</td>
<td>35</td>
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<td>Trauma &amp; orthopaedics</td>
<td>10.1%</td>
<td>24</td>
<td>75.5%</td>
<td>179</td>
<td>14.3%</td>
<td>34</td>
<td>237</td>
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<td>Neurosurgery</td>
<td>11.6%</td>
<td>10</td>
<td>75.6%</td>
<td>65</td>
<td>12.8%</td>
<td>11</td>
<td>86</td>
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<td>General surgery</td>
<td>15.7%</td>
<td>105</td>
<td>68.5%</td>
<td>457</td>
<td>15.7%</td>
<td>105</td>
<td>667</td>
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<td>Paediatric surgery</td>
<td>23.3%</td>
<td>10</td>
<td>69.8%</td>
<td>30</td>
<td>7.0%</td>
<td>3</td>
<td>43</td>
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<tr>
<td>Grade of trainee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>CT year 1</td>
<td>18.9%</td>
<td>25</td>
<td>59.8%</td>
<td>79</td>
<td>21.2%</td>
<td>28</td>
<td>132</td>
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<tr>
<td>CT year 2</td>
<td>15.4%</td>
<td>27</td>
<td>61.1%</td>
<td>107</td>
<td>23.4%</td>
<td>41</td>
<td>175</td>
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<tr>
<td>Research fellow</td>
<td>13.5%</td>
<td>18</td>
<td>68.4%</td>
<td>91</td>
<td>18.0%</td>
<td>24</td>
<td>133</td>
</tr>
<tr>
<td>StR 3-4/SpR 1-2</td>
<td>9.1%</td>
<td>30</td>
<td>78.0%</td>
<td>256</td>
<td>12.8%</td>
<td>42</td>
<td>328</td>
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<tr>
<td>StR 5-6/SpR 3-4</td>
<td>14.2%</td>
<td>48</td>
<td>72.6%</td>
<td>246</td>
<td>13.3%</td>
<td>45</td>
<td>339</td>
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<tr>
<td>StR 7-8/SpR 5-6</td>
<td>9.3%</td>
<td>24</td>
<td>81.0%</td>
<td>209</td>
<td>9.7%</td>
<td>25</td>
<td>258</td>
</tr>
<tr>
<td>Country of qualification</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>12.4%</td>
<td>138</td>
<td>72.7%</td>
<td>811</td>
<td>15.0%</td>
<td>167</td>
<td>1116</td>
</tr>
<tr>
<td>European union</td>
<td>9.4%</td>
<td>6</td>
<td>78.1%</td>
<td>50</td>
<td>12.5%</td>
<td>8</td>
<td>64</td>
</tr>
<tr>
<td>excluding UK</td>
<td>15.1%</td>
<td>28</td>
<td>68.6%</td>
<td>127</td>
<td>16.2%</td>
<td>30</td>
<td>185</td>
</tr>
<tr>
<td>Overall</td>
<td>12.6%</td>
<td>172</td>
<td>72.4%</td>
<td>988</td>
<td>15.0%</td>
<td>205</td>
<td>1365</td>
</tr>
</tbody>
</table>

Abbreviations: CT, Core Trainee (formerly Senior House Officer (SHO)); ENt, Ear, Nose and Throat (otolaryngology); OMFS, Oral and Maxillofacial Surgery; SpR, Specialist Registrar; StR, Specialty Registrar. NB: Specialty Registrar (StR) grade numbering continues on from Core Training (CT) and is replacing the old Specialist Registrar (SpR) grade.
have a positive impact on patient care, 13.9% a positive impact on surgical training, 11.1% a positive impact on the surgical profession and only 7.9% a positive impact on their surgical career (Table 3).

4. Discussion

This comprehensive survey has shown a clear weight of opinion among trainees across all 10 surgical specialties and all levels of training against the introduction of a ‘sub-consultant’ grade. This opinion is particularly strong in terms of the proposal’s potential negative impact on surgical professionalism, surgical training and, most worryingly, on patient care. The distinction between ‘service’ and ‘care’ is not clearly defined and an overlap exists between these terms in the context of healthcare. ‘Service’ is not necessarily directly related to patient ‘care’, for example administrative tasks. Similarly, in this survey, trainees may have interpreted ‘service’ as productivity without consideration of the quality or holistic nature of patient care.

In relation to the question: ‘Would you consider applying for a post-CCT non-consultant specialist (“sub-consultant”) post?’, a significant gender difference was observed. The reasons for this difference were not explored in the survey and, as such, any interpretation is speculative. It is possible that this gender difference may have arisen because of a perception of inadequate arrangements for less than full-time working and family-friendly practices in surgery.

The findings of this survey corroborate those of a previous survey of medical registrars by the Royal College of Physicians of London, which indicated only 15% would consider a sub-consultant role.10

Table 4 summarises the arguments against the introduction of a post-CCT non-consultant specialist (“sub-consultant”) grade. ASiT supports the principle that all patients are entitled to consultant-delivered care and this view is mirrored by other trainee groups. The rationale for this premise is supported by a recent report from the Academy of Medical Royal Colleges (AoMRC) entitled ‘The Benefits of Consultant-Delivered Care’.16 The report examined the evidence base for the consultant-delivered care model focusing on quality, outcomes and productivity rather than pay or working conditions. Part of the evidence was taken from an externally commissioned independent review of the literature, and the findings are summarised in Table 5. In an era of ‘Teaching Assistants’ and ‘Community Support Officers’ this independent review of the literature demonstrated that in medicine, when you invest in a high quality workforce there will be the expected benefits of innovation and efficiency.

Accepting the benefits of consultant-delivered care, it is no surprise that patients and their relatives desire high-quality care and relate this to the concept of a ‘consultant’ being the senior clinician in the team. The Consultant role has an accepted meaning within the UK and it is becoming increasingly expected by patients to request and receive Consultant-delivered care. A move towards introducing a new grade would also risk compounding existing patient confusion surrounding the different roles and responsibilities of the many different medical staff they will see during a typical healthcare episode.10,21

Workforce planning is notoriously difficult, especially in surgery given that the duration of craft specialty training is, at its fastest, more than a decade. Politically driven changes to post-graduate medical education, first with the Calman reforms14 and latterly with MMC, aimed to speed production of the workforce. In combination with the “Hutton bulge” (which relaxed the restriction on creating National Training Numbers [NTNs] between 2003 and 2005 with implementation of the first stage of EWTR) increasing recruitment into training, this has led to a surplus of fully-trained surgeons. It is therefore to be expected that there is the potential for a 60% increase in trained post-CCT doctors by 2020, as stated by the Centre for Workforce Intelligence (CfWI),22 although the validity of the data used as the basis for this report is disputed.23 If viewed solely through a financial lens this represents a significant challenge to the NHS, employers and the public purse. There would, however, be clear opportunities for the public to benefit from the number of trained surgeons currently in the UK. As recommended in the Temple Report “Time for Training”, commissioned by the Secretary of State for Health, a reconfiguration of the services would yield significant benefits with a consultant-delivered service.24

Consistent access to senior doctors was also identified as a challenge to the NHS, employers and the public purse. There would, however, be clear opportunities for the public to benefit from the number of trained surgeons currently in the UK. As recommended in the Temple Report “Time for Training”, commissioned by the Secretary of State for Health, a reconfiguration of the services would yield significant benefits with a consultant-delivered service.24

The benefits of Consultant delivered care.

The 2012 Academy of Medical Royal Colleges report entitled ‘The Benefits of Consultant-Delivered Care’16 concluded that the benefits of consultant delivered care are:

- Rapid and appropriate decision making
- Improved outcomes (in both normal and exceptional circumstances), with particular reference to acute surgery12
- More efficient use of resources
- General practitioners’ access to the opinion of a fully trained doctor
- Patient expectation of access to appropriate and skilled clinicians and information
- Benefits for the training of junior doctors

Table 3
How do you feel the introduction of a post-CCT non-consultant specialist (“sub-consultant”) grade would impact upon the following:

<table>
<thead>
<tr>
<th>Answer options</th>
<th>Positive (%)</th>
<th>Positive (n)</th>
<th>Neutral (%)</th>
<th>Neutral (n)</th>
<th>Negative (%)</th>
<th>Negative (n)</th>
<th>Total (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service provision?</td>
<td>50.8%</td>
<td>691</td>
<td>25.1%</td>
<td>342</td>
<td>24.1%</td>
<td>328</td>
<td>1361</td>
</tr>
<tr>
<td>Patient care?</td>
<td>21.6%</td>
<td>294</td>
<td>37.7%</td>
<td>514</td>
<td>40.8%</td>
<td>556</td>
<td>1364</td>
</tr>
<tr>
<td>Surgical training?</td>
<td>13.9%</td>
<td>189</td>
<td>20.1%</td>
<td>274</td>
<td>66.0%</td>
<td>900</td>
<td>1363</td>
</tr>
<tr>
<td>The surgical profession?</td>
<td>11.1%</td>
<td>151</td>
<td>18.7%</td>
<td>255</td>
<td>70.2%</td>
<td>957</td>
<td>1363</td>
</tr>
<tr>
<td>Your career?</td>
<td>7.9%</td>
<td>108</td>
<td>18.9%</td>
<td>258</td>
<td>71.1%</td>
<td>977</td>
<td>1363</td>
</tr>
</tbody>
</table>

Note that ‘Total’ counts varied with question item as not all questions were answered by all respondents.

Table 4
Summary of arguments against the introduction of a post-CCT non-consultant specialist (“sub-consultant”) grade.

- Potential reduction in autonomy for non-consultant specialists
- Additional need for established lines of clinical authority
- Decreased career incentive for trainees
- Need for additional new pathways for career progression
- Potentially conflicting interests of those who are existing ‘Consultants’
- Effectively re-creating the previously disbanded ‘Senior Registrar’ grade
- Retrograde step moving emphasis from excellence onto basic competence
- Sub-consultants would not be trainers under current regulations
- Lack of clarity for patients regarding additional new job titles

The Bene...
Where surplus CCT holders exist, the number of trainees in that speciality should be reduced through appropriate awarding of NTNs. NHS service requirements will still remain, so any reduction in NTNs should be balanced with the creation of non-training posts to address this. This ASIT survey indicates that while the idea is unpopular, 50% of those questioned feel that a sub-consultant grade would improve service provision. ASIT does not believe a CCT-holder should be required to take up such non-consultant posts, as these are different roles requiring different skills to a Consultant position, for which a CCT-holder has been trained over many years.

An economic argument for the introduction of a sub-consultant grade is also difficult to support. A sub-consultant would need to be overseen by a named Consultant, both electively and when providing out-of-hours care, thereby creating an extra level of cover and cost. Without close supervision this may increase the likelihood of inappropriate investigations, admissions and potential litigation costs. Equally, consultants may require additional remuneration for providing overall responsibility for the care of patients admitted under a sub-consultant. Their introduction is therefore likely to increase, rather than decrease, the costs to NHS trusts whilst not providing equivalent patient safety or patient satisfaction. It is also counter intuitive to train doctors to the standard of a higher grade in independent practice only to recruit them to lower levels.

Foundation Trains (FTs) have the ability to set new terms and conditions for staff and are thereby creating their own sub-consultant grade. University Hospitals Birmingham NHS Trust created 40 new roles for doctors in 2009 alongside the training grades. The most senior post had a new title of ‘specialist consultant’ and had terms and conditions based on the 2003 consultant contract. These posts allow post-CCT doctors positions of equivalent responsibility as a consultant, but without the protection of nationally agreed terms and conditions of service. As more Trusts aim for Foundation status, this is likely to become much more widespread, and the value of the name ‘consultant’ is at risk. ASIT is concerned that it may represent the start of a race to the bottom to find the lowest cost available “trained doctor” at the expense of quality. The short-term advantage for hospitals seeking to meet immediate workforce goals runs the risk of driving a short-termism that ultimately harms and destabilizes the medical workforce as a whole.

Another argument used to support the introduction of a sub-consultant grade is the reduced length of training, or the reduced working hours available since the introduction of the 48-h EWTR-compliant week. If there are concerns surrounding reduced competence or experience, then this must be addressed through the criteria for the award of a CCT. The suggestion that those completing specialist training are inexperienced, or unable to fulfil the roles of a consultant, should not lead to the notion that they should therefore have their own patients and deliver unsupervised service as a sub-consultant. If training needs based on service requirements are identified, then hospital employers should support, arrange or provide this to a consultant once they are appointed to a substantive post. As it currently stands, the majority of surgical trainees are themselves planning to undertake specialist fellowships to gain advanced skills and further experience.

When examining the role of non-consultant specialists, what such a group will add to the existing workforce structure requires consideration. Limited literature exits in relation to the substantive post. As it currently stands, the majority of surgical arrangements or provide this to a consultant once they are appointed to a service as a sub-consultant. If training needs based on service re-completing specialist training are inexperienced, or unable to fulfill their clinical and professional responsibilities and frequent antisocial working conditions. Changes to the career structure must be made in the interests of patient safety and quality, and not just cost. It is clear from this survey that the proposed sub-consultant grade is unpopular, and it is not felt that it would enhance patient care or safety. Neither the creation of a named “sub-consultant” grade nor the effective creation of such a grade by the alteration of contractual terms and conditions, working patterns and/or responsibilities is welcome. Such a sub-consultant grade has been considered and discarded in the past, and it

Table 6
Details of the proposed ‘Principal Consultant’ grade.

<table>
<thead>
<tr>
<th>The 2012 ‘Review Body on Doctors’ and Dentists’ Remuneration’ proposed and outlined the following details in relation to the ‘Principal Consultant’ grade:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Part of “an integrated package designed to recruit, retain and motivate consultants… to which experienced, high-performing consultants, who are undertaking larger roles in terms of service delivery, expertise or leadership could be promoted”</td>
</tr>
<tr>
<td>• “Some exceptional individuals could expect to be promoted to the principal consultant grade”</td>
</tr>
<tr>
<td>• “Recognise sustained, outstanding performance in roles that carry more responsibility, leadership, specialism, or that make particular demands on the job holder”</td>
</tr>
<tr>
<td>• “Around 10% of consultants would be in the principal consultant grade”</td>
</tr>
<tr>
<td>• Posts “filled from external or internal recruitment, while, in other cases, individuals undertaking highly specialist and demanding roles may be promoted to this grade”</td>
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<tr>
<td>• “Though all consultants, regardless of age, would be eligible to apply, we have assumed that the likelihood of promotion to the grade increases with experience”</td>
</tr>
</tbody>
</table>

5. Conclusions
Surgery is a rewarding career with traditionally high levels of job satisfaction and interesting and diverse opportunities to progress. It is a popular career despite the high stakes career structure, significant clinical and professional responsibilities and frequent antisocial working conditions. Changes to the career structure must be made in the interests of patient safety and quality, and not just cost. It is clear from this survey that the proposed sub-consultant grade is unpopular, and it is not felt that it would enhance patient care or safety. Neither the creation of a named “sub-consultant” grade nor the effective creation of such a grade by the alteration of contractual terms and conditions, working patterns and/or responsibilities is welcome. Such a sub-consultant grade has been considered and discarded in the past, and it
represents no better an idea now than it did 65 years ago. What is true now, and has always been true in the NHS, is that patients deserve the best—and the best is a Consultant.

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Conflict of interest
The authors are current surgical trainees and current or former elected members of the Council of the Association of Surgeons in Training. The authors have no other relevant financial or personal conflicts of interest to declare in relation to this paper.

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