Continuing medical education and training for associate specialists: results of a survey in Yorkshire

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The associate specialist grade was introduced in 1981 to replace the former medical assistant grade. Each appointment is made on a personal basis and is governed by strict procedures.¹ In the light of educational initiatives for trainee doctors and reductions in their hours of work,² we assessed the provision of continuing medical education for associate specialists in Yorkshire.

Subjects, methods, and results

All 112 associate specialists working in the former Yorkshire region were sent a confidential structured questionnaire. Seventy two (64.3%) were returned, but as 10 of the specialists were new appointees only 62 (55%) were analysed. Of the 62 doctors 46 were men, 40 had a fellowship or membership, and 27 had been appointed since 1991.

The results are summarised in the box. The 38 doctors who did on call work were on rotas more onerous than allowed for junior doctors, and 11 were first on call; 10 were required to be resident when on call. Twenty associate specialists were paid for two additional notional half days to reflect their workload, 10 for one, and 16 for none. Nineteen had experienced difficulty in acquiring extra payment to reflect their duties.

Fifty attended "educational activities." Of the 12 who did not two were providing middle grade cover in acute obstetric units and one sometimes provided consultant cover in accident and emergency. Thirty six received no feedback on their performance, and 22 felt unable to discuss their requirements for study leave. Unsolicited comments on the questionnaire showed that many associate specialists were responsible for supervising and training junior doctors but were given neither training nor recognition for this function.

Comment

These results, along with confidential comments, reveal a career grade outside mainstream postgraduate education. No educational body takes responsibility for the welfare or continuing medical education and professional development of this group of doctors, who shoulder an onerous service load.

The number of associate specialists appointed in Yorkshire since 1991 reflects trusts' response to the new deal² and parallels the increase in England and Wales as a whole—from 908 in 1992 to over 1100 now. Furthermore, the regrading of many clinical medical officers as associate specialists³ may increase the number fourfold. It is unsatisfactory that some associate specialists are on rotas more onerous than trainees, that some need to be resident on call, that many have difficulty obtaining payment for this extra work,⁴ and that many get no study leave and educational advice. Many associate specialists do not have the training to enable them to achieve a certificate of completion of specialist training, and expansion of the consultant grade may lead to

Details of 62 associate specialists working in Yorkshire

<i>Country of birth</i>	
India	29
UK	12
Middle East	15
Africa	4
America (North or South)	2
<i>Country of primary medical qualification</i>	
UK	15
India	28
Middle East	15
Other	4
<i>On call duties</i>	
1:3 rota	18
1:4 rota	20
First on call	10
Second on call	28
<i>Resident on call</i>	
Obstetrics and gynaecology	6
Anaesthetics	2
ENT	1
Surgery	1
<i>Acting as consultant on call</i>	
Psychiatry	4
Anaesthesia	2
Accident and emergency	3
General surgery	2
Orthopaedics	2
Dermatology	1
Elderly medicine	1
Gastroenterology	1
Maxillofacial surgery	1
Obstetrics and gynaecology	1
Ophthalmology	1

further dislocation of the associate specialist's place in hospital services. If goodwill and service commitment are not to be lost, the following recommendations should be met.

(1) All associate specialists should meet their clinical director and a representative of the chief executive to review their current job plan, and the plan should be re-reviewed every three to five years. (2) Onerous rotas not complying with the new deal should be amended. (3) Residential on call should be phased out. (4) Training requirements should be discussed. Secondment to another hospital for further training could be arranged, and associate specialists with higher qualifications may wish to be assessed by the postgraduate dean and college adviser to ascertain whether further training would enable them to apply for specialist certification. (5) Associate specialists who supervise trainees should be made aware of their responsibilities. (6) Appropriate study leave should be available annually. Associate specialists require their contribution to the service to be recognised so they feel valued members of the hospital staff.

1 NHS Management Executive. *Delegation of procedures for appointment to the associate specialist grade in the medical specialties*. London: Department of Health, 1990 (EL(91)150).

2 NHS Management Executive. *Junior doctors: the new deal*. London: Department of Health, 1991.

3 NHS Management Executive. *Assimilation of senior clinical medical officers and clinical medical officers, into a combined child service*. London: Department of Health, 1994 (HSG(94)10).

4 British Medical Association. *Model workload document for associate specialists in all specialties*. London: BMA, 1994:306.

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