

# ‘I brought that up in my appraisal ... and my consultant said no.’ Structure and agency in specialty and associate specialist (SAS) doctors’ experiences of appraisal

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## ABSTRACT

### Background

Specialty and associate specialist (SAS) doctors comprise a significant proportion of the UK medical workforce.

Appraisal has the potential to support professional development, as well as being vital for revalidating a doctor’s licence to practise.

Early research indicated that SAS doctors experienced difficulties engaging with appraisal. It is not clear if the situation has improved over recent years, and SAS doctors’ voices are largely absent from the literature.

### Research question

What are SAS doctors’ understanding and experiences of appraisal and how do they make sense of them?

### Findings

Our qualitative, phenomenological case study identified four interrelated themes: development, compliance, recognition and wellbeing. The lived experiences of SAS doctors included compliance with organisational processes (including redundant processes) and structures that diminish agency (including unhelpful hierarchies). Positive experiences included support for development and recognition of unacknowledged work.

### Implication for practice

Our research reveals the importance of enhancing the professional status and agency of SAS doctors. There should be structured support and career guidance for new SAS doctors or those changing specialty and an expectation of support for professional exams. SAS doctors may benefit from explicit discussions around wellbeing. Some of these needs may be better addressed by having SAS doctors as appraisers, but this is likely to be insufficient in itself.

**KEYWORDS:** SAS doctors, appraisal, thematic analysis, phenomenology, qualitative

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### Introduction

Specialty and associate specialist (SAS) doctors are employed on specific contracts.<sup>1</sup> They do not follow traditional training pathways to be general practitioners (GPs) or consultants for a variety of reasons including flexibility and work–life balance. There are two contractual groups of SAS doctors working in the UK NHS; the specialty doctors and the associate specialists, the latter is often described as the more senior role.

A very recent overview of the role of appraisal in revalidation of doctors suggests that more research is needed on the intended and unintended consequences of appraisal.<sup>2</sup> In 2013, a review of appraisal for SAS doctors identified serious difficulties with the process.<sup>3</sup> These included the existence of a hierarchical appraisal culture, a lack of awareness of the requirements for revalidation, a lack of parity with their consultant colleagues and problems with engaging with these important members of the NHS workforce. While subsequent policy documents have continued to assert the importance of maximising SAS doctors’ potential (including through appraisal), it is not clear that the situation has significantly changed.<sup>4</sup> This is important, as while there have been high profile critics of doctors’ appraisal, it nonetheless has the potential to give shape and substance to professional conversations about doctors’ development.<sup>5,6</sup>

To date, research on SAS doctors’ appraisal has largely focused on whether or not it is occurring. Low appraisal rates for SAS doctors were first reported in 2004, and subsequent surveys have revealed a highly heterogeneous picture with rates ranging from 17% to 90% depending on geographical region and specialty.<sup>7–12</sup> The arrival of revalidation in 2012 had significant influence on SAS doctors’ appraisal rates; a survey by a joint working group of the British Medical Association, Health Education England and NHS Employers reported a rate of 93%, placing SAS doctors on a par with GPs and consultants.<sup>13</sup>

Despite this recent improvement in appraisal rates, there remains a notable lack of evidence regarding SAS doctors’ experiences of appraisal. Consequently, we undertook an in-depth, phenomenological enquiry to understand the authentic, lived experiences of appraisal among this, often-marginalised, group of doctors.

### Methods

#### Study design

The research followed a qualitative case study design, drawing on the principles of interpretive phenomenological analysis in

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which in-depth interviews were used to explore SAS doctors' lived experiences of appraisal.<sup>14</sup> Given the previously reported hierarchical culture within SAS appraisal, analysis was sensitised by critical theory in which the researchers were attuned to issues of power and hierarchy within the participants' stories.<sup>3,15</sup>

### Sampling and recruitment

Criterion sampling was used to recruit participants, who were contacted via an email request sent by a postgraduate education administrator of a large NHS trust.<sup>16</sup> Ethical approval was gained from the Health Research Authority (project reference 275973).

### Data collection

An interview guide (Box 1) was used to explore SAS doctors' experiences of appraisal. Participants were encouraged to discuss their experiences with as little prompting as possible. Data collection was interrupted by the coronavirus pandemic, the first two interviews were held face-to-face as planned,

however, telephone interviews were used for the two subsequent participants. Additional field notes were made immediately after each interview. Interviews were audio recorded and transcribed verbatim by the interviewer. A six-step procedure described by Azvedo *et al* was used for transcription.<sup>17</sup>

### Thematic analysis

Transcripts were coded immediately after transcription by the interviewer using NVivo v12 (QSR International, Melbourne, Australia). Thematic analysis of the transcripts of the interviews was undertaken using Braun and Clarke's six-phase approach.<sup>18</sup> Cross checking of themes was undertaken by both authors.

### Data presentation

In keeping with the idiographic focus of phenomenological enquiry, in which individual experiences are valued over generalisable principles, quotations are attributed to individual participants using pseudonyms. Moreover, quotations are presented in context to facilitate an understanding of participants' experiences and the sense that they had made of them.

The data presentation follows a narrative style, in order to give a voice to participants whose views often go unheard in the research literature.

## Box 1. Semi-structured interview guide

### Introduction

Thank you for giving up your time to talk to me for this study. The purpose of this study is to understand the experiences of doctors undergoing appraisal. The study will involve a confidential interview which will be recorded and transcribed. This research is voluntary and confidential, you can withdraw at any time during the interview. The results of the study can be shared with you at the end of the study if you wish.

### Warm up

I am interested in doctors' experiences of appraisal. Please can you tell me about your experiences of appraisal?

### Main body

Can I ask how would you describe appraisal to newly qualified doctors?  
 What are your expectations of appraisal conversations?  
 Tell me about how you would conduct an appraisal conversation with a colleague.  
 Tell me about any aspects of appraisal conversations that you have found helpful and why.  
 Tell me about any aspects of appraisal conversations that you have found unhelpful and why.  
 I am interested in doctors' experiences of feedback given in appraisal meetings, can you tell me about your experiences of receiving feedback in appraisal meetings?  
 Can you tell me about whether or not you think appraisal is useful? (Probes: useful to whom and why.)  
 Do you think appraisal could be improved and, if so, how?  
 (Other probes: What do you mean by 'x'? Can you tell me a bit more about that? Why is that important?)

### Cool off

So, we have to complete this interview shortly. I need to ask which year did you qualify from medical school and do you work full time?  
 Are there any questions you have for me?

### Closure

Thank you for participating today.

## Results

Four interrelated themes were identified: development, compliance, recognition and wellbeing.

### Development, including support, agency and status

The theme of development was recurrent across all interviews. Participants recounted how appraisal could support continuing professional development (CPD). 'Asif' described the planning process for his CPD:

*Well, we talk about the CPD things ... what I am doing and why is it relevant with my practice ... erm ... and also the last year's personal development plan, whether I achieved it or what stopped it achieving ... and ... next year's plan. So that's the three main things.*

'Mary' also identified a role for appraisal in supporting her development. However, in doing so, she highlighted a comparative lack of support within her day-to-day work as a doctor:

*I think the main things that I have found helpful is just having the space to ... erm ... speak about areas, mainly, kind of, about cases that I might have found challenging ... erm ... because we don't have much time in the year ... I don't have ... I don't have a set person I can necessarily go to, to reflect on cases ... that's not to say I don't ... I have, I have many colleagues who I feel comfortable to just ... to go to, but there's not a designated person to say, 'I've had quite a difficult case, let's talk about this in the set time,' whereas I think the trainees do have that.*

'Mary' had recently left a specialty training programme. These programmes are described by detailed curricula and doctors are supported by a well-developed educational architecture, including formative workplace-based assessments and clinical and educational supervision. For SAS doctors such as 'Mary', the

clearly valuable annual appraisal is nevertheless very different to the support for doctors in training.

'Peter' also identified a developmental role for appraisal, and demonstrated a high degree of perceived agency in emphasising the ability of doctors to identify their own developmental needs:

*Appraisal is an annual event ... erm ... that is both for the clinician themselves to identify areas for development ... and to put a plan in place ... to ... for the following year.*

'Peter' had been a doctor for 30 years and an associate specialist in a surgical specialty for 12 years. As an associate specialist, he is likely to have enjoyed an elevated status among colleagues compared with specialty doctors. Indeed, he appeared well embedded in his department and referred to his consultant colleagues as 'peers'.

By contrast, while 'Rina' had 29 years of experience as a doctor and had worked as a specialty doctor for 12 years, she had received very poor support for her development in a previous job. Furthermore, although she described her recent appraisal as 'helpful', she had found her request for development as a medical educator blocked by her previous appraiser:

*I brought that up in my appraisal, this [teaching course] is probably what I would like to do. It's 14 days of study days in a whole year ... erm ... you know, they give you the dates at the onset, so I could, you know, let them know that these are the dates. I was going to self-fund it ... erm ... and my consultant said, 'No, we don't have ... erm ... we don't need a person with those skills in the unit.'*

The consultant's response could be described as managerial and 'Rina's' lack of agency is apparent in the hierarchical relationship between herself and her appraiser.

It seems, therefore, that the cultural capital enjoyed by 'Peter' as an associate specialist allowed him to exhibit an agency in appraisal that was not available to 'Rina'. However, the social capital that he had accrued as an established, relatively high-status individual in his department appeared to work against the use of appraisal for meaningful developmental purposes:

*Erm ... [extended pause] ... maybe having, I don't know, as I say it at the moment, it does seem very comfortable, it being in, you know, all within one department and a little bit, I might say 'chums together' [laugh].*

*I think that you ... well ... you want to try and maximise sort of people's strengths etc, make people think a little bit more about what they are doing. If there is somebody else looking at it from the outside, whether they would have a slightly different view on it, perhaps a different perspective. I think that's what it is really.*

Consequently, it seems that while there are limits to specialty doctors' agency, possibly attributable to their relatively low status within the medical hierarchy, higher status associate specialists may also miss out on valuable development if close working relationships with colleagues allow them to avoid challenge.

That said, associate specialist status is no guarantee of support if genuine development is sought. 'Asif', also an associate specialist, had 33 years' experience as a doctor, 16 of which were in his current surgical specialty. He described how a capricious appraiser blocked his career progression, despite his intended course of action having originally been suggested by the same appraiser:

*Well I was told by my appraiser to take the part 3 exam of the fellowship, because I had the old FRCS ... and when the time came, when I applied for the ... exam it needed the structured reference from the referee and my appraiser / clinical lead reference stopped [the] college [from letting] me take the exam.*

Thus, even 'Asif', an experienced doctor and associate specialist, was denied professional development and possible career progression as a result of being dependent on an appraiser who was able to obstruct his development. Indeed, his account of how he came to apply for the assessment – 'I was told by my appraiser to take the part 3 exam' (our emphasis) – also indicates a significant lack of agency.

## Compliance

Building on the concept of lack of agency, the doctors in our study typically understood appraisal as compliance with organisational policy and regulatory requirements.

'Peter' provided an account of appraisal that situated it within organisational processes and related it to revalidation of a doctor's licence to practise.

*Well the appraisal is the way in which ... is the route to getting yourself revalidated to show that you have engaged in the appraisal process and that somebody has sort of reviewed your practice ... and ... erm ... deemed you suitable [laugh] ... erm ... that they have no concerns over your practice essentially, that's what it is ... that you are keeping up with ... erm ... keeping yourself up to date, that you don't have any other health concerns or probity concerns etc.*

'Peter' was clear that the process involved a judgement of him as a doctor. However, he articulated a performative element to that judgement; for Peter, demonstrating that one is *participating* in appraisal is an end in itself, rather than being a means by which other ends (such as objective setting and reflection) may be achieved.

'Asif' also identified a performative element to appraisal, in which accumulating the requisite number of CPD points was seen as a target rather than as a means to pursuing useful professional learning. Notably, he chooses to comply with this requirement, despite believing the points target to have been misunderstood by appraisers:

*Erm ... it's just that we attend ... we ... all specialties ... we have to have a certain number of CPDs ... though the [General Medical Council] says in their website that there is no fixed point ... but there is misconception that there have to be 50 or 30 or 40 [CPD credits] or what ... different people have different numbers ... and to achieve that we have to attend meetings or courses where half of the stuff is not relevant for my clinical practice.*

'Asif's' approach highlights the potential for high-stakes appraisal to exert a negative 'washback effect' on SAS doctors' continuing professional development. In other words, appraisal causes doctors to do things that they would not otherwise have done simply to fulfil the requirements of the summative, judgement elements of the process.

Some SAS doctors had managed to subvert the hierarchy inherent in the appraisal process by training as appraisers and appraising their colleagues, resulting in perceived benefits to their appraisees.

This was the approach taken by 'Asif':

*Because, I'm an overseas graduate as well ... [laugh] ... and I have gone through it ... I think that it helps me to give them ... not guidance ... I would say ... opinion so that they can reflect and think ... [extended pause] ... that what can be achievable because there was ... erm ... this [doctor] who has done [ear, nose and throat] in the past ... and ... erm ... I think she was from east Europe – some country – and she didn't have much clue, but I gave her the information that there are exams she can do without getting onto the training programme, like diplomas, and she has done that and then she went to get a training number. (Gaining a training number is synonymous with being accepted onto a recognised specialty training programme, which means that a doctor can work towards becoming a consultant in their chosen specialty.)*

The experiences reported thus far strongly suggest that SAS doctors are subject to professional hierarchies and hegemonic institutional power against which they appear to be able to offer little resistance. Accordingly, SAS doctors can still be considered a marginalised group. However, the next section demonstrates the potential for appraisal to deliver much needed recognition.

### Recognition, including visibility and (self-) affirmation

Some SAS doctors described finding preparation for appraisal (collecting information about the work that they had done over a year) helpful. For example, 'Rina' found it rewarding and encouraging, she valued the heightened visibility of the work she had done and the concomitant recognition of this by her appraiser:

*[Appraisal is] a formal way of saying, 'well look, this is how much I've done,' you know, and that's fantastic. I think it's useful for the person appraising me as well ... to see actually what I'm doing, how busy I am.*

When 'Rina' was asked how she would describe appraisal to a newly qualified doctor, she again made a reference to recognition of work done:

*So, I would say ... erm ... it's a process ... which ... erm ... mainly, where you are demonstrating over a year's duration ... erm ... you know, what you've done, ... erm ... how much you have done and how you can sort of prove it. How you can ... because if someone says to you, 'well what have you done in the last year,' you've got nothing to show.*

Using appraisal for recognition reflects how difficult SAS doctors find having their independent clinical work attributed to them.

### Wellbeing, including safe spaces, personal health and job satisfaction

Alongside the corollary positive effects of appraisal on wellbeing detailed earlier, some SAS doctors described how *explicit* discussions of their wellbeing during the appraisal process had been helpful. 'Rina' had agreed a coping strategy for a medical problem within appraisal, using a personal development plan approach:

*So ... when we chart out, like, a personal development plan, it helps me to focus on certain areas, so I might, you know, might want to ... erm ... for example ... erm ... in the last year I was*

*diagnosed with high blood pressure, and of course it meant I had to take medication ... erm ... it meant that I had periods of time where I was off sick. One of my personal development goals was to try to incorporate some yoga.*

'Peter' felt that job satisfaction was important to consider in appraisal conversations, despite him not being asked explicitly about wellbeing in his appraisals.

*If you're reviewing someone who is not immediately in your line of work ... erm [extended pause] ... and then I suppose, it would be a matter of the conversation would be looking at how people are feeling in terms of their role, whether they are satisfied in their role, whether they feel they are being supported in their departments etc, whether there's areas of concern to raise from it.*

All of the doctors interviewed thought that an individual's wellbeing ought to be an important part of any appraisal conversation, and all stated that, were they an appraiser, they would wish to discuss explicitly their appraisee's wellbeing.

## Discussion

The lived experiences of SAS doctors reported here show that, for these doctors, appraisal is something of a curate's egg: good in parts. Moreover, some of the SAS doctors' experiences of appraisal resonate with the experiences of other groups of doctors including consultants and GPs.<sup>19,20</sup>

SAS doctors in this study found the preparation for appraisal provided an opportunity to take stock of a body of work that often goes unnoticed, which has been reported previously.<sup>13</sup> The appraisal conversation facilitated recognition of this work by a senior colleague. This external recognition appeared to provide affirmation of the doctors' worth. The evidence-gathering process at the end of the year seemed to be self-affirming, which is known to be linked to well-being.<sup>21</sup>

Objective setting allowed SAS doctors to set meaningful goals for their ongoing professional development, which, at times, reflected important health and wellbeing needs. Appraisal conversations also provided a forum within which SAS doctors could seek support from colleagues.

However, the support that was evident in appraisal threw into sharp relief the relative lack of structured support throughout the rest of the year, particularly in comparison with doctors following recognised specialty training programmes.

It was also clear that, at times, SAS doctors felt required to comply with processes that they deemed irrelevant or unhelpful. The experiences reported here highlight the potential for high-stakes appraisal to exert a negative 'washback effect' on SAS doctors' continuing professional development.<sup>22</sup>

SAS doctors' compliance with the appraisal process (enacted as performativity and motivated by a desire to demonstrate appropriate engagement with a regulatory process) was a highly consequential act: participants had typically invested significant time and effort in their appraisal, even when they doubted the usefulness of their professional development activities, the evidence collection processes and their appraisal conversations, in order to ensure that they were not adjudged to be deficient. The data in this study support, to some degree, a previous publication on how revalidation has impacted upon doctors generally, suggesting that doctors' autonomy has reduced, and the extent of organisational oversight has increased resulting in a



change to what it means to be a doctor and how organisations are accountable.<sup>23</sup>

There was also evidence that there is a hierarchy within appraisal which is disadvantageous to SAS doctors. Evidence presented in this paper of development opportunities being blocked by colleagues strongly suggests that SAS doctors are still subject to hierarchical effects against which they appear to be able to offer little resistance.

The finding that SAS doctors can appropriate appraisal for their own purposes (for example by training as appraisers themselves and using appraisal as a vehicle to support SAS colleagues' career development) was interesting. However, we wonder whether this approach to appraisal is genuinely emancipatory or whether, instead, it is proof of a continuing hierarchical culture within medicine. Consequently, it seems that recommendations that SAS doctors be trained as appraisers can lead to positive outcomes for SAS doctors as appraisers and appraisees.<sup>3</sup> However, the questions that remain are: who appraises the SAS appraisers and are SAS appraisers able to access relevant advice and support for their own career development?

## Conclusion

While there is cause for optimism about the potential for appraisal to benefit SAS doctors' personal and professional development, there are ongoing difficulties with support and recognition.<sup>24</sup>

For doctors who have recently left specialty training programmes or changed specialty, we propose that a much more structured approach to professional learning be taken, and there may be a role for structured SAS mentorship programmes. There should also be an expectation that SAS doctors be supported to undertake professional exams, should they so desire. There is also an appetite for explicit support for wellbeing and for career guidance. Some of these needs may be more effectively addressed by having an SAS doctor as an appraiser. However, there is arguably also a need for ongoing support between appraisals.

Therefore, it appears that the enactment of unhelpful appraisal processes in the context of established systemic structural biases that disadvantage SAS doctors is likely to reinforce, or at least reflect, existing inequalities rather than reduce them. In our view, the status of SAS doctors must be enhanced so that they may engage with appraisal on more equal terms with their colleagues, rather than expecting that appraisal may somehow deliver the enhanced professional status that they deserve. ■

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