General Medical Council

LED focus groups findings

Introduction

- The workforce is changing, and locally employed doctors (LEDs) have become a critical part of that workforce. LEDs are now the fastest-growing part of the profession. From 2019, the number of LE doctors grew by 75% to 36,831 doctors in England and Wales in 2023. While they provide critical services across the UK's healthcare system, their experiences, aspirations, and challenges remain largely unexplored.

- This paper seeks to share the views and lived experiences of LEDs gained through focus group discussions and uncovers the variable experiences across healthcare trusts and boards.

Methodology

- **We ran six virtual focus group discussions with a total of twenty-five locally employed doctors**. We used semi-structured interview questions to guide discussions. We had representation across England, Scotland, Wales and Northern Ireland, with a rich mix of doctors with varying levels of experience, from early career to more experienced doctors. LEDs were recruited through convenience sampling and the demographics of attendees reflected the data we have seen in *The state of medical education and practice in the UK* reports, where almost two-thirds of LEDs in England and Wales are non-UK graduates.

- Focus group transcripts were analysed and coded, and a thematic framework was developed. Key quotations were then identified within each theme and a narrative was developed.

- One of the limitations of this study is the small sample size. Additionally, all the LEDs that participated in this study did so on a self-nomination basis which may represent a sampling bias. We advise readers to not draw overgeneralisations based on this work.

- However, we feel these findings bring forth important discussion points and could form the foundation of further.

Summary of key findings

- **Broadly the LEDs we spoke to could be subdivided into three archetypes, with unique motivations and challenges**:
    - Early career UK graduates
    - Early career non-UK graduates
    - Experienced LEDs (tend to be non-UK graduates).

- **There are highly variable experiences across healthcare trusts and boards**. Some LEDs find themselves well-supported, with access to structured education, career mentorship, and clear routes into speciality training or more senior roles. While others describe barriers to professional development and service-driven contracts. This appears to be largely dependent on local culture and departmental priorities.

> *"After an intense couple of years doing foundation training…I wanted to work in a role where I wouldn't necessarily have the demands of a portfolio or at least an involuntary portfolio."*
>
> **UK graduate**

- **Service pressure is a key barrier to accessing education for LEDs.** Many described being stuck in a working pattern that prioritises clinical work over their professional development. Their education was often viewed as an optional extra, and something that can be provided if time allowed.

- **High quality supervision is a key protective factor for LEDs.** Some doctors reported having supervisors who engaged in career conversations and offered personalised guidance and enabled them to network and participate in activities to strengthen future training applications.

> *"I did apply for training in my F3 but the application wasn't successful, so I guess I took... more of a slightly involuntary F4 role. …. and then I applied for training again that year and was successful, hence why I've now started training."*
>
> **UK graduate**

- **In a self-directed environment, cultural barriers can hinder career progression.** As an LED, being proactive in seeking educational opportunities is crucial for career advancement. This can be a difficult adjustment for non-UK graduates who are new to the UK. Without clear signposting, opportunities that exist remain inaccessible to some.

Motivations

- When exploring the motivations that lead doctors into locally employed roles, three main archetypes were identified: early career UK graduates, early career non-UK graduates, and experienced doctors who have remained in locally employed posts for an extended period.

Early career UK graduates

- In this study, early career UK graduates represent those with less than 5 years of clinical experience post-qualification. This group is often referred to as 'F3s and F4s' to denote an extension of experience post-foundation.

- For early career UK graduates, the **LE role often serves as a purposeful pause from training** after foundation. Many report taking a deliberate step back to reflect on their long-term career goals. An LE role can offer a space to explore a specialty in greater depth and build a competitive portfolio for future training applications.

> *"If you come to a new country and you have to start establishing a new life…[getting] a house…a driving licence... [It] takes time…the person who comes to the UK…will face a lot of things along with his work and his career."*
>
> **Non-UK graduate**

- Furthermore, **wellbeing and work-life balance also play a significant role**. After the intensity and pressure of foundation and core training, some reported looking for greater stability and a predictable rota to manage their work-life balance better. For many, this was an active and positive choice, which they found deeply valuable.

- However, it is important to acknowledge that **not all doctors choose LE roles**. A number find themselves in these roles after unsuccessful specialty training applications. Some reported using the LE role as a bridge while preparing to re-apply for a training post. Yet, even in these cases, doctors frequently reported finding value in the role, gaining clinical experience and increasing their confidence.

Early career non-UK graduates

- In this study, early career non-UK graduates represent a cohort of doctors who gained their primary medical qualification (PMQ) abroad and have transitioned into the UK before entering speciality training abroad.

- For early-career non-UK graduates, **the LE role is a crucial stepping stone** into a new healthcare system, offering a unique opportunity to acclimatise to a new way of working. Having time to adjust to a new healthcare system and understanding the 'hidden curriculum' were key benefits of the role. The hidden curriculum represents the informal, often unspoken rules and norms, such as communication styles and team dynamics, that shape clinical practice.

> *"So the way I see it, it's a very good stepping stone for a first job…[it] gets you into the system, let's you learn the way of the system without putting too much pressure on you in terms of portfolio requirements…You can take the time to adjust. You can take the time to slow down."*
>
> **Non-UK graduate**

- **This phase of adjustment is vital**. Learning in clinical environments is culturally sensitive and relies on shared expectations and navigating hierarchies. The LE role provides the space to absorb these nuances at a manageable pace without the immediate pressure of meeting portfolio requirements or progressing against a fixed timeline.

- **Stability is another important factor** that makes these roles particularly valuable to international doctors. For many, the geographical mobility demanded by rotational training adds a layer of uncertainty that can be especially challenging when doctors are already adapting to a new country. The consistency of staying in one location and working with the same team provides a grounding that is essential during this period of transition.

- Ultimately, many of the early career non-UK graduates **aimed to apply for a training post and progress in their careers**. The data suggests this often occurs after a period of acclimatisation, which aligns with the conversations that emerged through our discussions. Recognising the significance of this acclimatisation period is essential to support international doctors effectively.

Experienced locally employed doctors

- In this study, experienced LEDs represent a cohort of doctors who have more than 5 years of clinical experience post qualification. This group was largely made up of non-UK graduates.

> *"I feel like I'm very appreciated in this department, but I'm working with them for five years…they love me. They appreciate me, they recognise my work."*
>
> **Non-UK graduate**

- The motivations of experienced LEDs were **highly individual and contextual**. They reflected the complexities of life, where personal circumstances and career aspirations did not always align with the training structures available. For many of these doctors, especially those with significant personal responsibilities, the appeal of the LE role lies in its stability and predictability. In these cases, the structure of the role supports life beyond medicine, which in turn can make a sustainable medical career more feasible.

> *"It was probably the best decision that I've made actually, but it was mostly family life that I made the decision to ... take this role."*
>
> **UK graduate**

- **Career goals and prior experience play a significant role** in shaping how experienced LEDs engage with their work. This is especially true for non-UK graduates later in their careers, often bringing a wealth of prior experience. There will be doctors for whom entering a training post would not be appropriate. Instead, they may decide to pursue alternative routes, such as the portfolio pathway, to gain entry into the specialist register.

> *"I was a consultant [in home country]…Because I [didn't] know the system, I [didn't] want to start as a consultant... So actually it is a nice place as a starter…but I've been stuck there…I'm going to be approaching six years in March."*
>
> **Non-UK graduate LED**

Experiences of education and training

- **Education is essential for an effective medical workforce.** However, there is significant variability in the experiences of education and training for LEDs. Some thrive in supportive environments where their goals are recognised and nurtured. However, others can find themselves in service-driven posts where education is deprioritised or actively discouraged.

- This inconsistency often comes down to local culture and employer priorities. In the absence of national standards or expectations, doctors' experiences often hinge on where they happen to work.

- It is essential to recognise that in healthcare, **meaningful relationships are at the heart of education**.

Relationships in the workplace

- What is particularly striking is that although educational opportunities may vary, the general workplace environment is often a source of satisfaction and connection. LEDs often spoke of having positive and meaningful relationships, where they described feeling respected, valued, and seen as integral members of their clinical teams.

- **One of the key advantages of being in an LE role is the continuity it can offer**. Unlike rotational training posts, these roles allow doctors to remain with the same team over time and develop longitudinal relationships. This continuity matters, because learning in a clinical environment often depends on trust and familiarity between learners and trainers. LEDs described receiving more meaningful learning opportunities when they felt understood by their team.

> *"If you've been in in the same post for a long time and you're working with the same people, you do build relationships and they do understand that you need to develop as well."*
>
> **Non-UK graduate**

Access to training

- Access to training means having protected time within your work schedule to focus on learning and development. This includes having access to study leave, protected teaching time and the opportunity to rotate through areas that support targeted skill development.

- **Access to training opportunities for LEDs is highly variable.** Some describe overwhelmingly positive experiences, where their departments treat them equitably alongside trainees. In these environments, rotas are designed with learning in mind, and doctors are encouraged to pursue areas of interest and build toward their next steps.

> *"They put a real emphasis on trying to treat you the same and give you the same benefits as a trainee…You get given opportunities, so if you want to spend time in anaesthetics or shadowing the major trauma consultant…or shadowing the outreach service they'll make provisions to allow you to observe that and take you off the rota for that period of time."*
>
> **UK graduate**

- However, this is far from a universal experience. **Many LEDs describe the tension that exists between service provision and education.** Some describe being stuck in a working pattern, prioritising clinical work over professional development. When the ward is busy, their training time disappears first. Teaching sessions and study leave are sacrificed to keep rotas running smoothly. Their education is often viewed as an optional extra and something that can be provided if time allows.

> *"A lot of times clinical fellows or locally employed doctors are used as rota fodder for service provision, so clinical needs outweigh [education]…. Attendance to teaching… they're…actively discouraged."*
>
> **Non-UK graduate**

Supervision

- Doctors in training programmes have access to structured and consistent clinical and educational supervision. However, in locally employed roles, the picture is much more variable

- **Supervision in these roles is not mandated, and its quality depends heavily on local culture and individual supervisors.** Some LEDs reported having named consultants or informal mentors actively interested in their progress. When this kind of high-quality, career-focused supervision is present, it can be transformative. Without the constraints of a rigid curriculum, doctors described being able to engage in more personal conversations about their individual goals and ambitions. These mentor-like relationships allowed supervisors to get to know the doctor as a person, not just as a trainee and often led to meaningful guidance and targeted opportunities that may not have developed within a training programme.

> *"[The conversations were] more about what I wanted to try and get out of the role… It made things a bit more specific and personal…as opposed to being like, oh, have you done this number of case based discussions? Have you done this number of MiniCexs?... I guess it has been very beneficial as well."*
>
> **UK graduate**

- However, this lack of structure carries risks. **For some LEDs, the experience of supervision was poor,** with educational supervisors, if assigned, being minimally engaged or entirely absent. Some reported never meeting their supervisor, while others described a single token meeting that offered no structured guidance. This is particularly concerning for non-UK graduates, who often face additional challenges navigating the system. Some reported feeling misunderstood or unsupported by supervisors who lacked awareness of their specific needs or circumstances.

> *"There might be this initial period where your educational supervisor might not be able to understand you…They might…You know, judge your competence."*
>
> **Non-UK graduate**

> *"So as it stands, we have no educational supervisor, clinical supervisor or any kind of pastoral support, no one…to go to if we need…support with anything."*
>
> **Non-UK graduate**

Cultural differences

- When understanding why experiences vary widely among LEDs, we often focus on the employer's role. However, it is important to view things from the learner's perspective.

- One of the most powerful insights from conversations with non-UK graduates is how disorienting the experience of being an LED can be, especially given the high degree of self-direction required

to progress. In many LE roles, the responsibility for career development sits almost entirely with the learner. This can be manageable for UK graduates, who already know how the healthcare systems work. They understand the unwritten rules and know how to engage with supervisors to maximise learning opportunities. However, for non-UK graduates, it is a very different experience. Many described feeling lost, speaking of a process of 'cultural unlearning' when adapting to flatter hierarchies and expectations around communication. Feeling confident to speak directly to a consultant or negotiating access to training was unfamiliar and intimidating.

> *"Most of the IMGs…feel scared to disturb their [consultants]. You know, they are scared to speak because they are [more senior]."*
>
> **Non-UK graduate**

- Furthermore, this confusion often gets internalised. Several doctors spoke about experiencing self-doubt or feeling incompetent, not because they lacked clinical knowledge but because they were unsure of how to function within a new system. There is a difference between being able to care for patients and being able to manage the systems around that care. In a self-directed LED role, not understanding these rules could hinder progress and well-being.

> *"Looking at my colleagues who are already in training…they seem to sort of know these things intuitively…which sort of sets you back a little bit…I tend to get lost quite often."*
>
> **Non-UK graduate**

- **Without the proper support, non-UK graduates can feel isolated in a space that demands them to find their own way.** Recognising this gap and its emotional weight is essential if we want to build a more supportive and equitable environment for all doctors.

> *"The problem is in early career, you don't know the question[s] to ask. So…there are always people that can answer the question…the problem is you don't know what to ask for."*
>
> **Non-UK graduate**

Portfolio pathway

- The portfolio pathway was a topic that came up in discussion with LEDs**. This pathway represents an alternative to traditional training routes** and is especially relevant for LEDs who bring considerable experience but may not be seeking to enter into a formal training programme. On paper, the portfolio pathway is a viable and flexible option. However, it often exemplifies the structural and cultural challenges within the LE space.

- Success through the portfolio route demands an extraordinary level of personal motivation. Doctors have to be clear about their destination and understand the requirements needed to get there. They have to gather evidence, align their experiences with required competencies, and proactively manage their progression.

- **Crucially, their employer would also have to be actively engaged in their development.** This includes providing opportunities to meet requirements and guiding them through a long process. Unfortunately, many doctors we spoke to felt this support was missing. Some described employers who were disengaged or unaware of the pathway's requirements.

> *"CESR Pathway [Portfolio pathway] is so extensive…if you work in a hospital where they are not supportive…they can't sign for you."*
>
> **Non-UK graduate**

- **However, we also heard stories of success.** In these cases, the "golden combination" of a highly motivated individual paired with a supportive, informed employer made navigating the process smoother. The portfolio pathway does work, but only under the right conditions. It demands both the learner's intrinsic motivation and the employer's support and guidance. However, when it fails, it reinforces the isolation and under-recognition many LEDs face.

Conclusions

- **Locally employed doctors are not a peripheral part of the healthcare system;** they represent an increasingly significant group whose contributions are vital. Their experiences offer a lens through which we can understand the current gaps and potential improvements in postgraduate medical education.

- It is important to acknowledge that **not every doctor actively seeks progression at the same pace or intensity as a training programme might require.** Some doctors consciously slow down to focus on other areas of life, including their well-being and non-clinical interests. These decisions are not signs of disengagement but reflect the reality that careers do not always follow linear trajectories and that flexibility in pace is increasingly valued.

- The experiences of LEDs also teach us the value of taking an **individualised approach** when supporting learning. Embedding flexibility into the system could enhance job satisfaction and improve retention. Their views echo the direction of policy over the last decade, with initiatives which increasingly supports adaptable training pathways.

- Finally, another key learning point from our discussions was the **transformative role of mentorship** and supervision. High-quality, individualised supervision tailored to each doctor's specific needs and goals can make a profound difference. Personalised mentorship helps to develop confidence and clarity, giving doctors a clearer sense of direction.