



Supporting careers, recognising contribution

Specialty, associate specialist, specialist
and locally employed doctors survey

Initial findings report

General
Medical
Council

Supporting careers, recognising contribution:

Locally employed (LE) and specialty, associate specialist and specialist (SAS) doctors survey 2026

Foreword

Doctors in specialty, associate specialist and specialist (SAS) roles, together with locally employed (LE) doctors, now account for nearly a fifth of the UK medical workforce. Health services increasingly depend on their contribution, both to patient care and to the development of other doctors.

More than 10,500 doctors responded to this survey, our first dedicated survey of SAS and LE doctors since 2019. In developing it, we worked with organisations across the four countries to make sure the questions reflected the current realities of these roles. The findings reveal a gap between the contribution expected of these doctors and the support and opportunities available to them.

Across both groups, one message comes through clearly. These doctors want opportunities to continue learning, progress in their careers and make fuller use of their experience. Yet too many face barriers that limit their development and progression.

Nearly half of LE doctors, and over a third of SAS doctors told us they had struggled to access continuing professional development in the past year, and 16% said they aren't even given opportunities to maintain their skills. Talented doctors, capable of contributing more, are being left to stand still or allowed to fall behind.

Contractual barriers add to the problem. 42% of specialty doctors said they were already eligible for a specialist contract but had been unable to secure one. A contract intended to provide progression for experienced doctors will not properly fulfil that purpose while so many eligible doctors are unable to access it. In addition, successive fixed-term contracts have created ongoing uncertainty for LE doctors, with particular implications for internationally qualified doctors whose visa status is tied to their employment. Since the survey closed, a new agreement in England means employers are expected to move LE doctors onto substantive contracts by default, a welcome step though similar commitments are not yet in place elsewhere in the UK.

One of the most troubling survey findings concerns workplace culture. Almost one in four LE doctors and nearly one in three SAS doctors said they had experienced or witnessed bullying or harassment in their role. Among those who chose not to report incidents locally, two thirds believed that doing so would make no difference and more than half feared repercussions.

This sits within a broader picture of barriers to reporting discrimination, from doctors'

understanding of the process to their confidence in what will happen next. Employers must consider the whole reporting process, from what may deter doctors from coming forward to what they experience when they do.

Inequalities in doctors' experiences run through the findings. Internationally qualified doctors were more likely than their UK-qualified colleagues to describe experiences of discriminatory behaviour or unequal access to opportunities.

Addressing individual incidents of discrimination is only one part of creating an inclusive workplace. SAS and LE doctors also need a meaningful voice in the conversations that shape the services they help deliver. The weight given to their perspectives should be commensurate with the extent to which health services rely on them. Drawing on their experience can help employers and system leaders develop roles and career pathways that better reflect the range of doctors' needs and ambitions.

Not every doctor's path looks the same. Some enjoy a stable, long-term career in these roles; others use them to gain experience or keep practising when established training routes are unavailable or don't fit their circumstances.

As thinking about medical education, training and careers evolves, we should learn from the adaptability these careers demonstrate. Recognising a broader range of career routes may help retain skilled, experienced doctors who might otherwise leave the profession.

The survey will inform our wider review of medical education and training, and our work to support SAS and LE doctors' career development. As part of that, we're working with organisations across the four countries to explore how doctors' learning can be better recognised and recorded, so it can travel with them as they move between roles.

Much of this report looks at differences by primary medical qualification. We will build on this with further analysis of how experiences vary by career stage, specialty, demographic characteristics and working pattern.

Despite their contribution to UK health services, many SAS and LE doctors feel their work is neither fully recognised nor valued. This report shows employers and system leaders where they need to act, so these doctors can realise their ambitions and patients can benefit from all they have to offer.

Charlie Massey

Chief Executive and Registrar

SAS and LE survey highlights and implications

Together, SAS and LE doctors have been the fastest growing group of doctors on the UK medical register and now account for nearly a fifth of all doctors. Given their vital contribution to patient care, it is important to understand and respond to their experiences.

- **SAS and LE doctors are essential to patient care and education:** 83% of SAS and 67% of LE doctors train others, either formally or informally, mostly medical students and doctors in training.
- **Uneven access to learning:** 48% of LE and 38% of SAS doctors had difficulty accessing CPD in the past year. The proportion of LE doctors who agreed they'd been offered training to advance their careers has decreased from 59% in 2019 to 52%.
- **Career progression barriers persist:** 42% of specialty doctors say they are eligible for a specialist contract but cannot secure one. 60% of UK-qualified LE doctors cite competition for training places as a reason for taking an LE role.
- **Insecure employment:** 46% of LE doctors are on one-year contracts, and 47% of those on fixed-term contracts have had more than one with their current employer.
- **Workplace culture remains a concern:** 31% of SAS and 23% of LE doctors have experienced or witnessed bullying or harassment, much the same as in 2019. Of those who did not report it, two thirds thought it would make no difference.
- **Unequal experiences:** around seven in ten respondents qualified outside the UK. They were less positive on almost every measure. For example, 68% of EEA/IMG SAS doctors feel valued in their team, compared with around 80% of UK graduates.
- **Limited recognition:** only 31% of SAS and 29% of LE doctors think their role is seen as a positive career choice, although for SAS doctors this has improved markedly since 2019 (20%).

These findings sit within a broader context of ongoing discussions about how postgraduate training and career development are organised across the UK, including NHS England's Medical Education and Training Review and the Future Medical Workforce Project in Scotland. There is growing recognition that doctors reach and sustain expertise through different routes, and that opportunities to do so are often more limited outside formal GMC-approved training programmes.

Against this backdrop, employers can help address the issues raised by:

- Ensuring eligible SAS doctors have access to a specialist contract and provide a clear rationale where one is not offered.
- Giving SAS and LE doctors fair access to study leave, CPD time and funding.
- Funding access to an appropriate e-portfolio, rather than requiring doctors to meet the cost themselves.
- Strengthening awareness, support and access to supervision, education and leadership opportunities for SAS and locally employed doctors.
- Reducing employment uncertainty wherever possible and offering permanent contracts where a post meets a long-standing service need.

- Assessing whether staff feel safe to raise concerns, not just whether reporting procedures exist, and to monitor experiences by place of qualification and ethnicity.
- Considering how educator capacity can support the development needs of all doctors as the SAS and LE workforce continues to grow.

Royal colleges and faculties should ensure their SAS and LE doctor members have the same access to e-portfolios and CPD as other doctor members and provide clear specialty guidance for those pursuing the portfolio pathway.

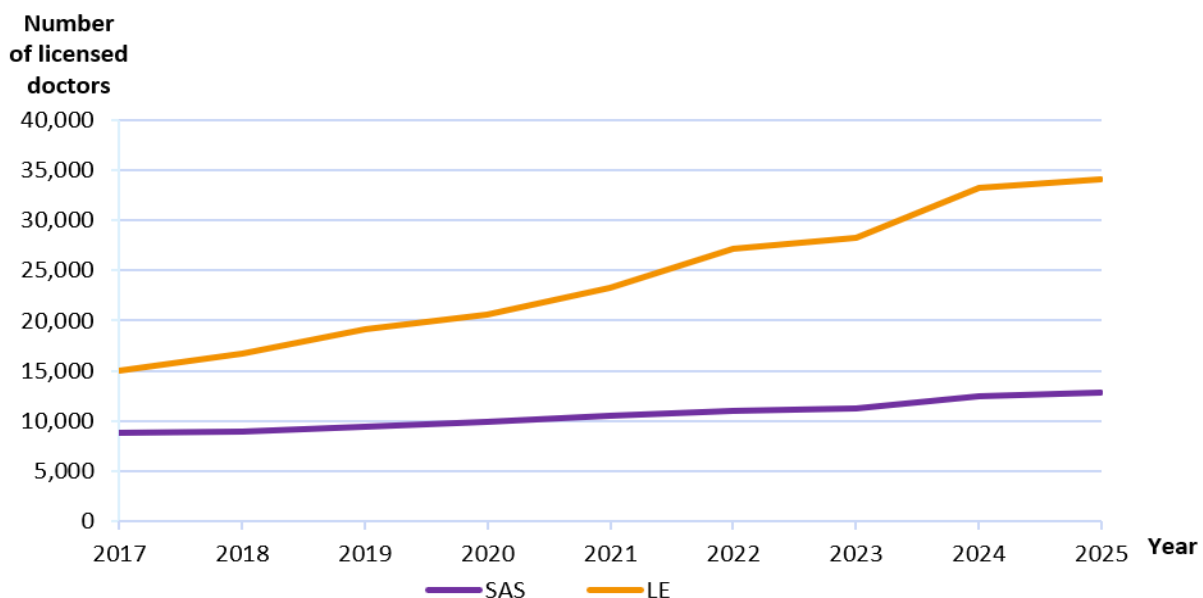
We're working with organisations across the four countries to explore how learning and expertise gained in these roles can be better recognised, so doctors do not have to repeatedly demonstrate their capabilities when moving between roles, training programmes or the portfolio pathway.

Understanding SAS and LE doctors

Specialty, associate specialist and specialist (SAS) doctors and locally employed (LE) doctors are distinct groups that play an essential role in delivering care to patients. Working alongside other doctors and multi-professional teams, they also contribute to leadership, education, research, and clinical governance across a broad range of specialties and organisations.

Since our first dedicated survey of these groups in 2019, the number of doctors working in SAS and LE roles has increased (Figure 1), highlighting their growing importance to the medical workforce and patient care.

Figure 1: Licensed doctors on neither register, not in training and holding a revalidation connection, working in England and Wales in a SAS or LE role, 2017 – 2025*



*This analysis is limited to England and Wales due to the data currently available to us. We are seeking equivalent data to better understand the unique workforces of Northern Ireland and Scotland.

SAS doctors work on national, permanent contracts with defined entry requirements and are experienced clinicians who view the role as a long-term and stable career. LE doctors, however, hold a variety of contract types and job titles, which are generally fixed-term.

Given these differences, the experiences and challenges faced by SAS and LE doctors can vary considerably so we have reported the headline findings separately for each group.

The 2026 survey

It has been seven years since the last survey, during which time the medical landscape has changed considerably. Alongside growth in the number of doctors working in SAS and LE roles, there have been broader changes in how doctors work, learn and develop throughout their careers.

This survey forms part of our ongoing work to update the standards, outcomes and guidance for education and training. It will also help us deepen our understanding of the experiences, aspirations and development needs of SAS and LE doctors within the wider medical workforce across the UK.

To ensure the survey reflected the current realities of these roles, we undertook a comprehensive review of the 2019 questionnaire. The review drew on extensive input and feedback from key stakeholder organisations across the UK, ensuring the question set accurately represented the experiences and challenges facing these doctors.

The survey was open for six weeks between April and June 2026. We invited 81,796 doctors with a licence to practise who were neither in training nor on the specialist or GP register to take part via email. To maximise participation, an open web link was also made available for doctors who did not receive an email invitation.

Respondents were asked to identify their role or post at the start of the survey. This allowed us to direct participants to the appropriate survey questions and analyse responses by doctor group.

Results for all survey questions [can be explored in our online data tool](#). Findings can be viewed by country, region, trust/board, specialty, PMQ and demographic characteristics.

Insights: locally employed doctors

5,221

locally employed doctors completed the survey.

Motivations



Competition for training places and the desire for gaining experience of UK practice were key factors for choosing an LE role.

Perception of role

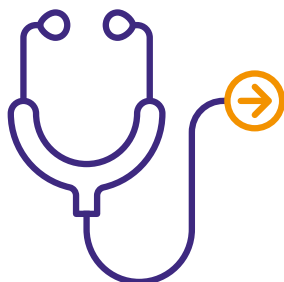
39%

don't think the role of an LE doctor is viewed as a positive career choice in the medical workforce.

Intentions

33%

plan to be in postgraduate medical education in 5 years.



Accessing CPD



48%

experienced difficulties accessing CPD training opportunities in the last year.

Training others



67%

are responsible for training others, either formally or informally.

Burnout



32%

feel burnt out because of their work to a high/very high degree.

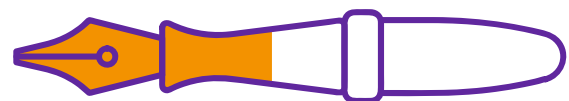
Discriminatory behaviours



43%

experienced micro-aggressions, negative comments, or oppressive body language from colleagues.

Contracts



47%

have had more than one fixed term contract with their employer.

Locally employed doctors survey 2026

Initial findings

LE survey background and context

Since the last survey the number of doctors working in locally employed roles increased significantly (Figure 1). Combined with wider changes in healthcare delivery, career pathways and workforce patterns, this has reinforced the need to better understand the experiences, aspirations and development needs of locally employed doctors.

This survey forms part of our ongoing work to explore how education and training can continue to meet the needs of patients, healthcare professionals and the wider health system.

Building on previous [engagement with LE doctors, including focus groups](#), the survey was undertaken to improve understanding of their experiences and inform future work in this area.

The survey attracted responses from 5,221 LE doctors. We estimate this represents approximately 8% of the UK LE population. The findings portray a diverse workforce with varying medical educational backgrounds, career motivations and professional aspirations. They also evidence shared challenges related to employment security, training access, career progression, workplace culture and wellbeing.

Respondent profile

Locally employed doctors are a diverse group. Among survey respondents, 28% held a UK primary medical qualification (UK PMQ), and 72% held a qualification from another European Economic Area country (EEA PMQ) or were international medical graduates (IMG PMQ).

The majority of respondents (88%) worked in England. 5% worked in Scotland, 4% worked in Wales and 2% worked in Northern Ireland. This pattern broadly reflects the distribution of locally employed doctors across the UK.

Education, training and professional background

UK PMQ

- 66%** Completed foundation training (“F3” doctors)
- 2%** Completed a Certificate of Completion of Training (CCT)
- 30%** Have undertaken some specialty training

EEA/IMG PMQ

- 40%** Trained to UK foundation equivalent
- 21%** Trained to post-CCT/consultant level abroad
- 31%** Had at least 8 years clinical experience outside the UK
- 24%** Have undertaken some specialty training in the UK

The educational and clinical backgrounds of locally employed doctors prior to entering their current roles varied considerably. Most UK PMQ doctors were at an early stage of their careers, with around two thirds having completed Foundation Training but not entered specialty training (often referred to informally as "F3" doctors). In contrast, EEA/IMG doctors typically entered these roles with more extensive clinical experience.

Factors influencing the decision to be a locally employed doctor

For UK PMQ respondents, the most selected reason for becoming a locally employed doctor was competition for specialty training places. Three fifths (60%) identified this as an influential factor. Work-life balance, geographical stability and opportunities to gain experience in different specialties were also commonly selected (Figure 2).

Among internationally qualified doctors, the dominant factor was gaining experience of working in UK clinical practice. Nearly 70% identified this as a reason for choosing a locally employed role. Portfolio careers, competition for training places and the chance to gain broader clinical experience were also frequently selected (Figure 3).

Figure 2: UK PMQ – Top four factors influencing the decision to work as a LE doctor

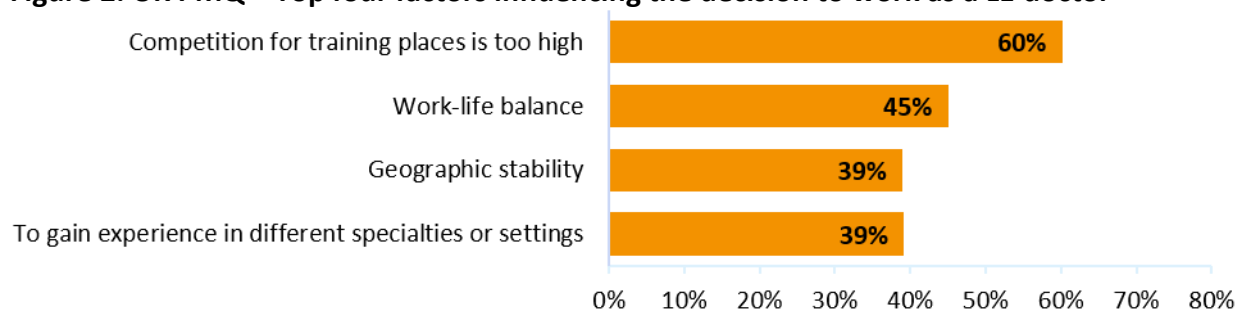
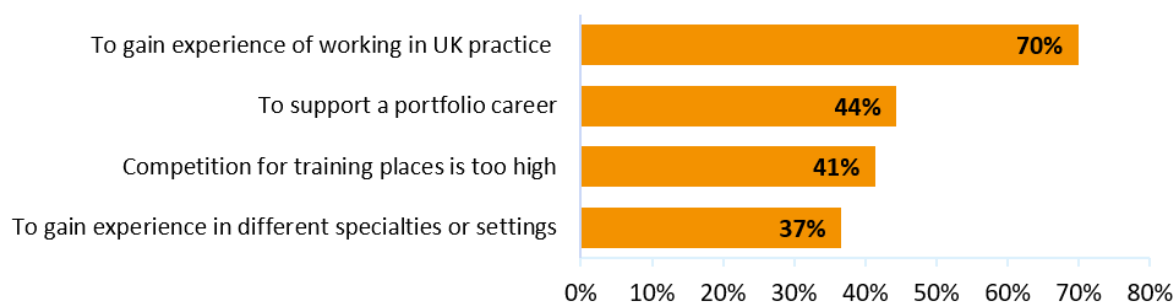


Figure 3: EEA/IMG PMQ – Top four factors influencing the decision to work as a LE doctor



The results suggest that locally employed roles serve different functions for different groups. For UK graduates, they often represent an alternative to immediate progression into specialty training, while for international medical graduates they frequently act as a gateway into UK healthcare systems and future career advancement.

Leaving postgraduate medical training

The survey explored the reasons why doctors who had previously undertaken UK postgraduate medical training did not continue in a UK postgraduate training programme (Figure 4 and 5).

Figure 4: UK PMQ – Four most reported reasons for leaving postgraduate medical training

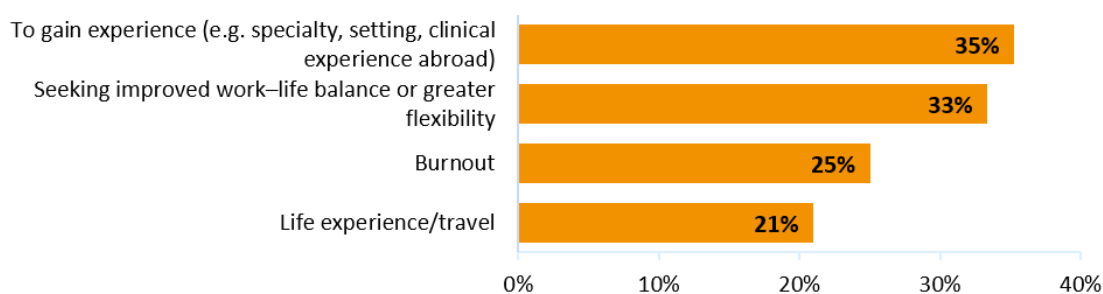
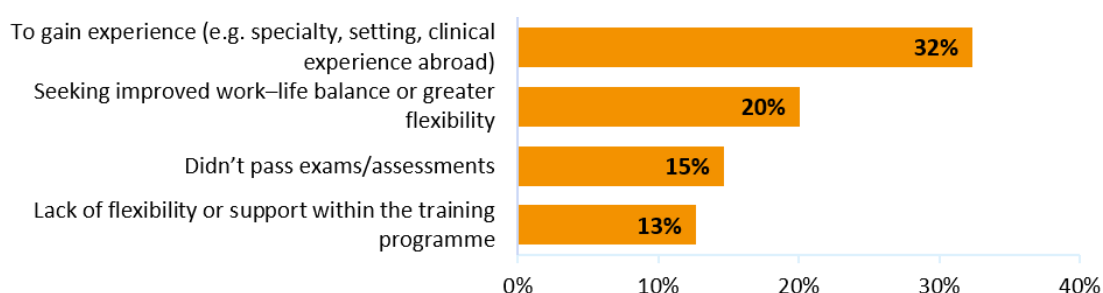


Figure 5: EEA/IMG PMQ – Four most reported reasons for leaving postgraduate medical training



Note: "other reason" was included in the top four reasons but has been excluded from these charts.

The findings illustrate how some doctors who were unable to continue postgraduate training use locally employed roles to gain experience in a particular specialty or setting. Worklife-balance and burnout also emerged as important factors, particularly among UK graduates. EEA and IMG doctors also cited unsuccessful examination outcomes, limited programme flexibility, and insufficient support within training pathways.

Clinical specialty

Emergency medicine was the most commonly selected specialty among locally employed respondents, accounting for 11% of all survey participants. This aligns with data in [The state of medical education and practice in the UK: Workforce report 2025](#). Acute internal medicine and general internal medicine each represented 9% of respondents. General surgery accounted for 6%, while anaesthetics represented a further 6%.

The prominence of acute and emergency specialties highlights the importance of locally employed doctors in maintaining service provision across frontline clinical settings. Many of the specialties most represented in the survey are those currently facing substantial workforce pressures.

Employment contracts and job security

Almost half (46%) of locally employed doctors reported working on a fixed-term contract lasting one year. Among those employed on fixed-term arrangements, 47% stated that they had already worked through more than one consecutive fixed-term contract with their current employer.

While 40% of UK PMQ locally employed doctors reported actively seeking a permanent contract, this increased to 72% among EEA and IMG respondents.

Although short-term contracts may provide flexibility for some, the findings suggest that many locally employed doctors, particularly international graduates, experience uncertainty about their long-term employment. This may not only impact personal, financial, and social stability, but also affect access to learning and development opportunities, continuity of supervision, and career progression.

Less than full-time working

Only 13% of locally employed doctors reported working less than full time. However, important differences emerged by qualification background. Among those with a UK PMQ, 21% worked less than full time compared with only 10% of internationally qualified doctors.

These findings may reflect differences in caring responsibilities, life stage, financial circumstances, visa requirements, or career goals. UK graduates may also use locally employed roles to gain greater flexibility than structured training programmes offer.

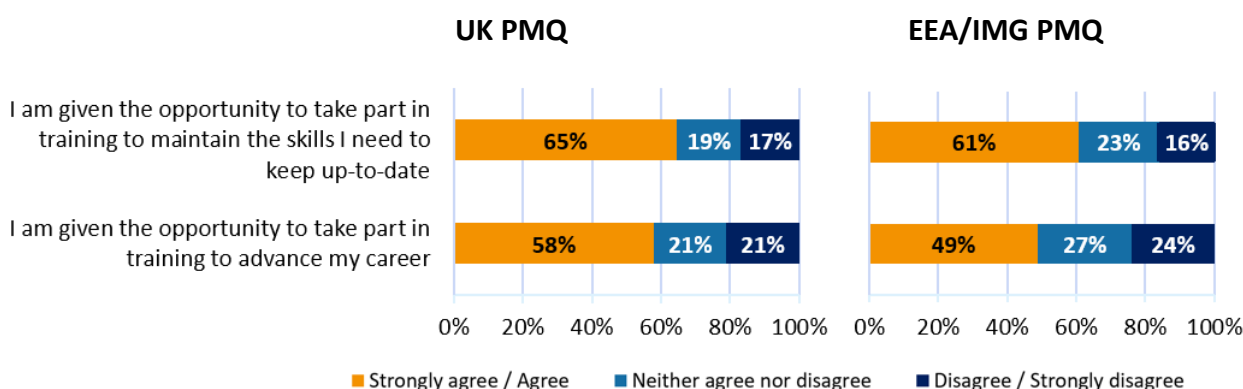
Training, continuing professional development (CPD) and career development

Training opportunities emerged as one of the main concerns for those doctors in a locally employed role. Nearly half (48%) of locally employed doctors reported difficulties accessing continuing professional development opportunities within the previous year. 17% felt they were denied opportunities because they were not in a training programme. 16% (as in 2019) stated that they were not provided with opportunities to undertake training necessary to maintain the skills required to remain professionally up to date, both of which are important for supporting good, safe patient care.

Only around half of respondents (52%) agreed that they were offered training opportunities that would help advance their careers, representing a decline from 59% in 2019.

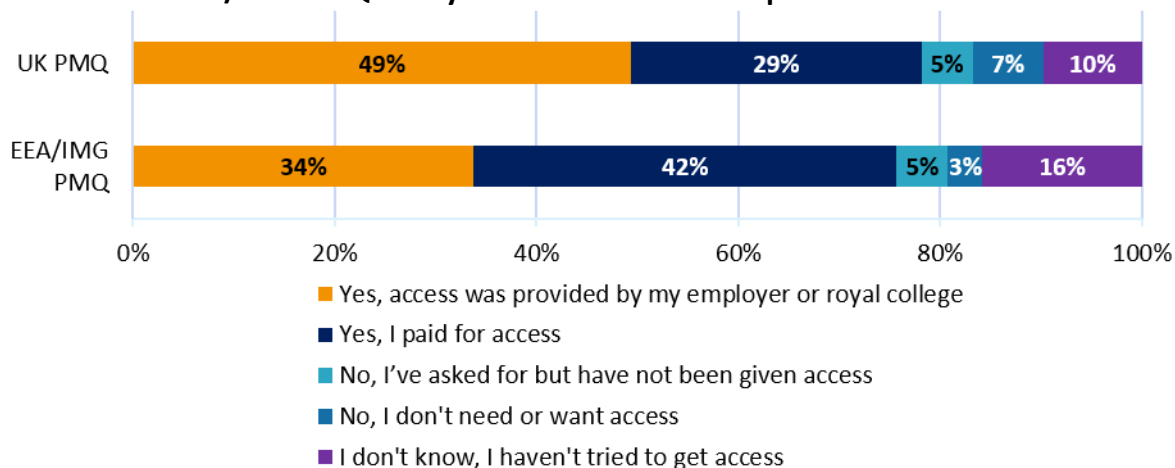
Experiences varied by PMQ. Internationally qualified doctors were less likely than UK-qualified doctors to agree that they had access to career-advancing training opportunities (49% compared with 58%) (Figure 6).

Figure 6: UK and EEA/IMG PMQ – Training and CPD



Differences were also evident in access to e-portfolios (Figure 7). A higher proportion of doctors with an EEA or IMG PMQ reported paying for access themselves (42%, compared with 29% of those with a UK PMQ), while UK-qualified doctors were more likely to have access provided by their employer or royal college (49% versus 34%).

Figure 7: UK and EEA/IMG PMQ – Do you have access to an e-portfolio or similar?



These findings indicate variations in access to development opportunities and support arrangements among locally employed doctors. Overall, they suggest that many continue to perceive significant barriers to professional development and career progression.

Roles and responsibilities

Although locally employed doctors are not always formally recognised as educators, many contribute to training activities.

Two thirds (67%) reported that they train others either formally or informally. 22% stated that locally employed doctors are given opportunities to act as supervisors within their organisations. Among these respondents, 19% reported working as educational supervisors, clinical supervisors or both.

Among those contributing to training, 87% reported teaching medical students and 64% reported training doctors in postgraduate training programmes. Many also supported other locally employed doctors (37%) and wider healthcare professionals (36%).

Additionally, some respondents reported undertaking duties outside their usual role. 26% stated that they were asked daily or weekly to undertake work normally performed by more senior doctors, while 43% reported carrying out tasks usually completed by a doctor in a more junior role.

While these findings suggest considerable role flexibility among locally employed doctors, further work is needed to understand the context of these arrangements and their implications.

The portfolio pathway

Among doctors holding international medical qualifications, 29% reported being in the process of applying for the portfolio pathway. By comparison, only 8% of UK PMQ doctors reported doing

so. Across all locally employed respondents, 23% were currently applying and 3% reported having successfully completed the process.

Of those respondents who were undecided or did not intend to apply, 41% stated that they instead planned to obtain a CCT through specialty programme training. Over a third had negative perceptions about the portfolio pathway. 39% believed it was too complicated and 35% felt it was excessively lengthy.

Notably, only 8% reported that they preferred remaining in a locally employed role, suggesting that many view the position either as a stepping stone towards broader career ambitions or as an interim role taken to meet immediate employment needs.

Feeling valued and supported

Most locally employed doctors reported that they felt valued within their immediate teams. Overall, 72% agreed that they were valued members of their team, slightly lower than the 75% reported in the 2019 survey. However, there was a variation between different qualification backgrounds. 81% of those with a UK PMQ agreed with the statement compared with 68% of EEA and IMG respondents.

Perceptions of fairness improved compared with the 2019 survey. 59% agreed that staff, including locally employed doctors, are always treated fairly, compared with 52% in 2019. Nevertheless, only 55% of internationally qualified respondents agreed, compared with 71% of colleagues with a UK PMQ, suggesting that while progress has been made in improving the workplace experiences of some locally employed doctors, inequalities remain.

Support systems

A quarter (25%) of locally employed doctors said they have access to an LE doctor tutor or the equivalent, for guidance and pastoral support. A fifth (20%) said they're part of a formal mentoring scheme through their employer. Although [mentoring is recognised as beneficial throughout a doctor's career](#) and is promoted in [Good medical practice as part of CPD](#), 38% reported no support from a mentor. 46% said they benefited from an informal mentoring arrangement.

Bullying and harassment

Almost a quarter of locally employed doctors (23%, unchanged since 2019) reported experiencing or witnessing bullying or harassment in their role. However, 70% of those doctors did not report the incident locally.

Among those who chose not to do so, 67% believed it would not make a difference and 60% feared adverse consequences. In secondary care, consultants were most commonly identified as the source of bullying or undermining behaviour.

Internationally qualified doctors were more likely than UK-qualified colleagues to report experiencing or witnessing bullying or harassment (26% versus 15%), as were doctors from ethnic minority backgrounds compared with white doctors (25% versus 17%).

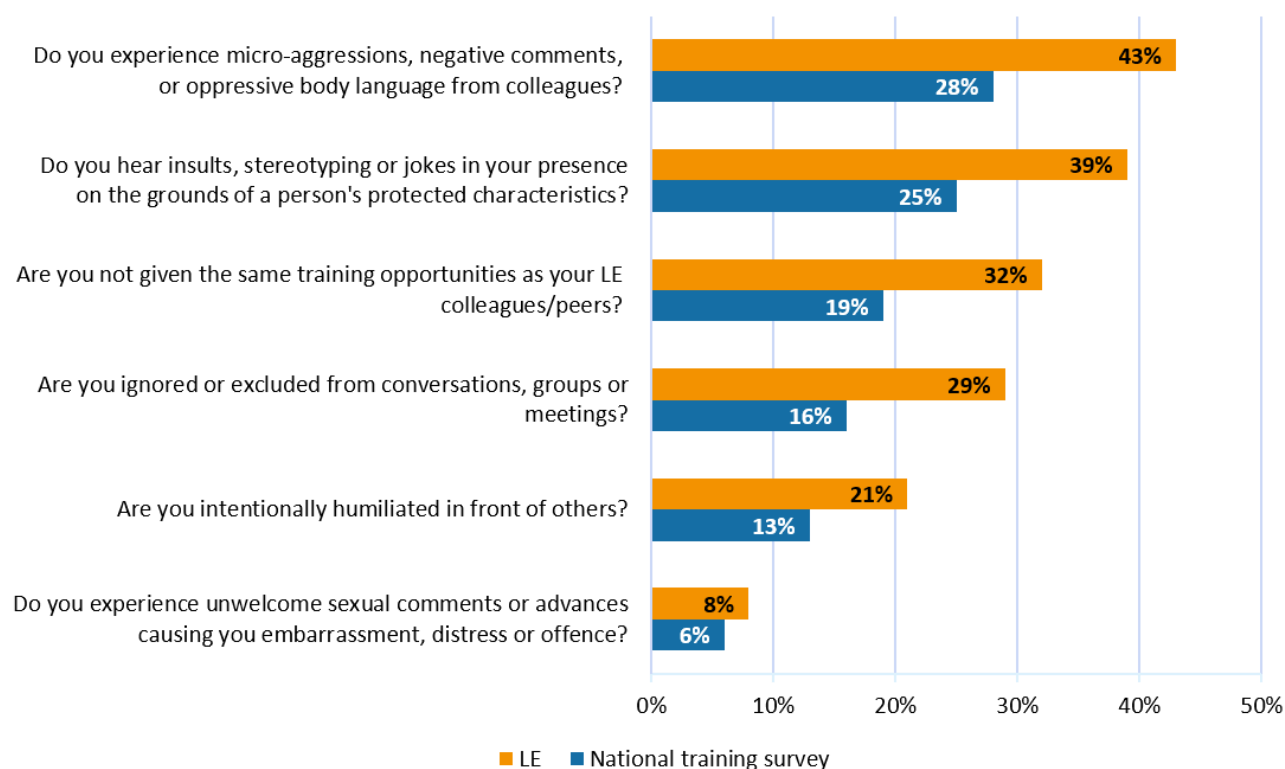
Experiences of discriminatory behaviours

Several optional questions from the national training survey were included to explore experiences of discriminatory behaviours from colleagues and healthcare professionals. This allows direct comparison between survey respondents and doctors in training. A total of 69% of respondents completed these questions (Figure 8). When interpreting comparisons, it is important to note that the national training survey asks respondents about their posts, whereas locally employed doctors were asked about their roles.

Figure 8: Discriminatory behaviours – locally employed doctors vs doctors in training 2026

In your current workplace how often:

(all negative results combined: daily, weekly, monthly, less than once a month)



Differences by PMQ were notable. Almost half (45%) of internationally qualified respondents reported experiencing micro-aggressions, including 14% who experienced them on a daily or weekly basis, compared with 37% of their UK-qualified colleagues. A larger proportion of EEA/IMG doctors (34%, compared to 27%) reported unequal access to training opportunities.

Similar patterns were evident across demographic groups. For example, 32% of locally employed (LE) doctors from ethnic minority backgrounds reported being ignored or excluded from conversations, groups, or meetings, compared with 22% of their white counterparts.

Overall, the findings highlight differences in workplace experiences between groups. They suggest that internationally qualified doctors and those from ethnic minority backgrounds continue to experience less inclusive working environments, indicating a need for further exploration of the factors driving these differences.

Confidence in reporting discrimination

Confidence in challenging and reporting discrimination was low. Under two thirds of locally employed doctors (63%) said they were confident they knew how, or could find out how, to report discrimination. Half (49%) felt confident reporting discrimination without fear of adverse consequences. And a similar proportion (48%) agreed that they felt confident challenging discrimination or unprofessional behaviours among colleagues.

Internationally qualified doctors were less confident across all measures. For example, only 45% of EEA/IMG respondents reported confidence in challenging discrimination, compared with 58% of those with a UK PMQ.

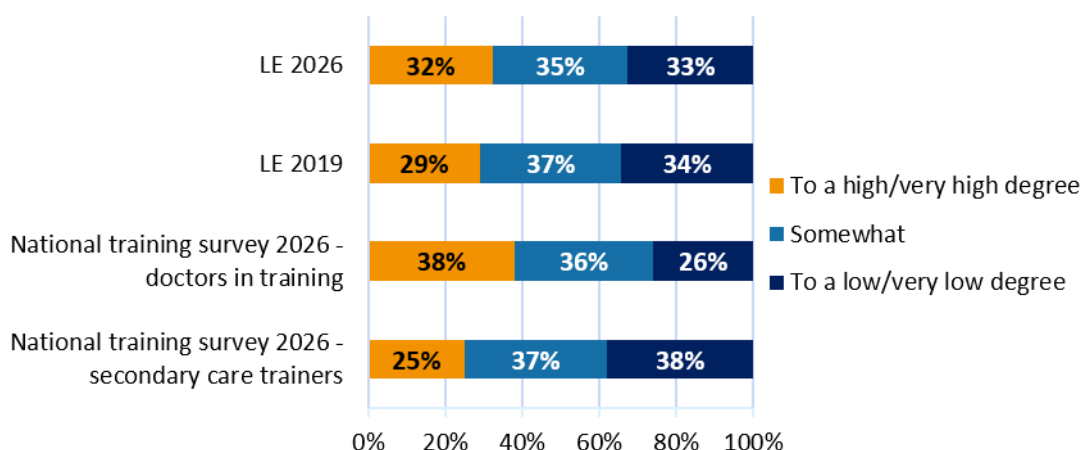
These findings suggest that awareness of reporting procedures alone may not be sufficient to foster confidence if doctors remain concerned about the consequences of speaking up.

Burnout

Workforce pressures continue to have significant implications for the wellbeing of locally employed doctors. In response to the question, “do you feel burnt out because of your work?” 32% of locally employed doctors reported feeling burnt out to a high or very high degree, compared with 29% in 2019 (Figure 9).

Internationally qualified doctors again reported poorer outcomes. 35% reported high levels of burnout compared with 25% of locally employed doctors with a UK PMQ.

Figure 9: Do you feel burnt out because of your work? 2026 vs 2019, including 2026 national training survey data



Disability, neurodivergence and access needs

Two new questions relating to disability, neurodivergence, impairments and access needs were developed through our engagement with stakeholders.

9% of locally employed doctors identified themselves as disabled, neurodivergent, living with an impairment or having an access need. 51% of these doctors said that these factors were important in influencing their decision to work in a locally employed role, including a fifth (20%) who said to a great extent.

Most respondents who identified as disabled, neurodivergent, living with an impairment or having an access need felt they had equal access to learning and development opportunities. However, one out of five (21%) disagreed. This suggests that disability-related barriers to career development and professional participation continue to affect a significant minority of doctors.

The findings highlight areas that may benefit from further exploration, to help better understand the experiences of doctors who identify as disabled, neurodivergent, living with an impairment or having an access need.

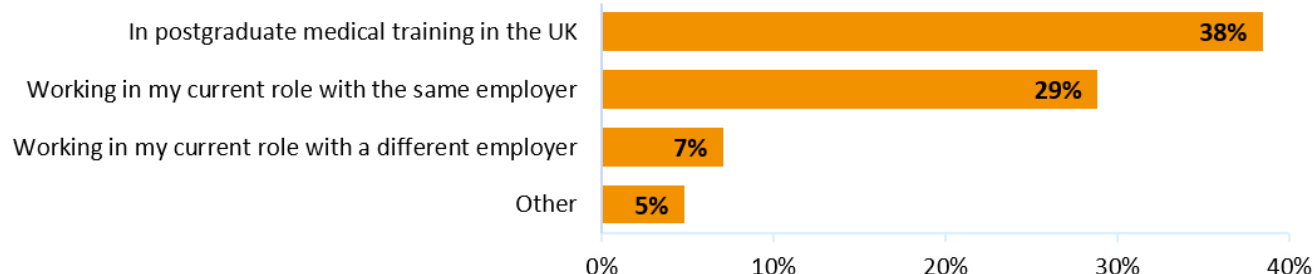
Future career intentions

Among locally employed doctors with a UK PMQ, the most common expectation for the following year was to be in postgraduate medical training (Figure 10). 38% selected this option. A further 29% expected to remain in their current role with the same employer. Five-year aspirations were strongly focused on career progression (Figure 11). 49% expected to be in postgraduate medical training and a fifth (20%) working as consultants or GPs within five years. Some respondents (5%) anticipated moving into a specialty doctor role.

Among internationally qualified doctors, 34% expect to be in their current role in a year's time, 20% in postgraduate training and 13% collecting evidence for the portfolio pathway. Three out of ten (31%) anticipate being consultants or GPs within five years, while 27% expect to be in postgraduate medical training. 7% hope to be working as a specialty doctor.

Figure 10: What best describes what you see yourself doing one year from now? (top 4 options selected) by PMQ

UK PMQ



EEA/IMG PMQ

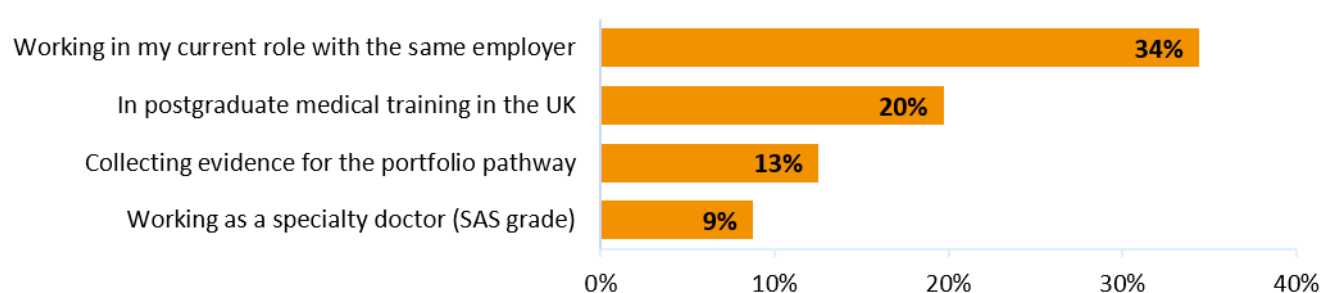
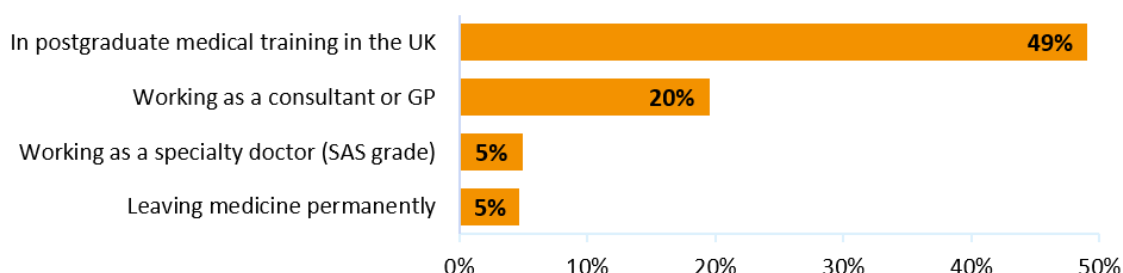
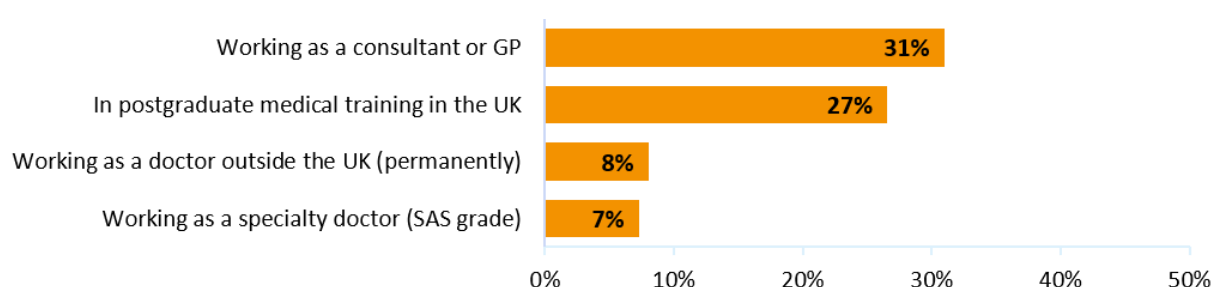


Figure 11: What best describes what you see yourself doing five years from now? (top 4 options selected) by PMQ

UK PMQ



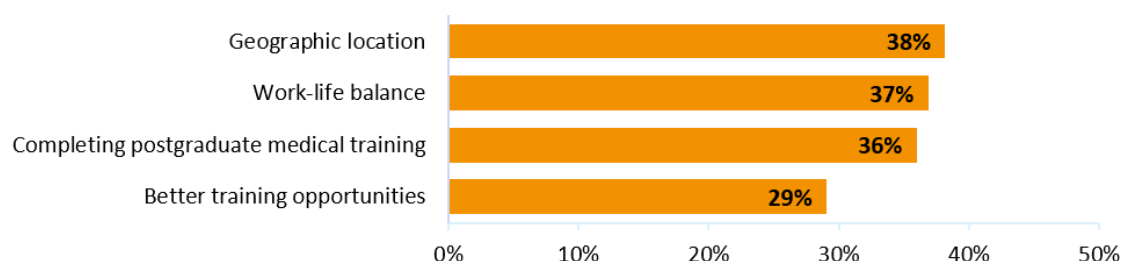
EEA/IMG PMQ



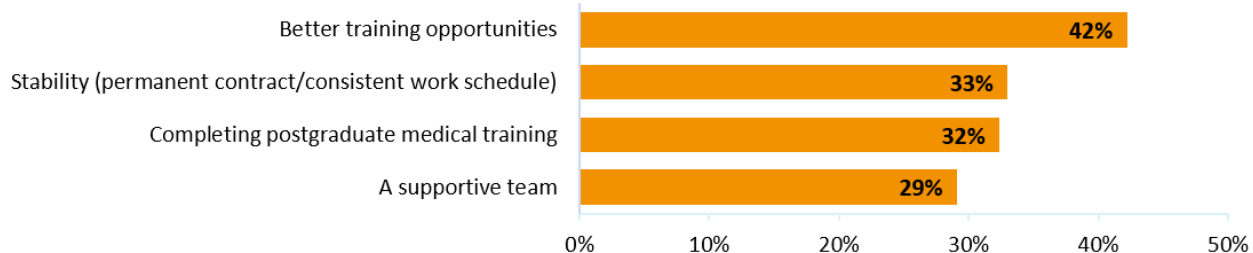
When considering factors that were important in making plans for the future, respondents prioritised better training opportunities, completion of postgraduate training and employment stability. UK PMQ doctors particularly prioritised completing postgraduate training, geographical location and work-life balance. Internationally qualified doctors placed greater emphasis on training opportunities, stable employment arrangements and supportive workplace teams (Figure 12).

Figure 12: Select up to three options that are important to you in making plans for the future (top 4 options selected) by PMQ

UK PMQ



EEA/IMG PMQ



These priorities reinforce recurring themes throughout the survey regarding career progression, training access and long-term professional development.

Career development priorities

The survey asked respondents what single factor would add the greatest value to their career.

The most common response, selected by almost half (45%) of locally employed doctors, was greater opportunities for career progression. Employment stability and longer contracts ranked second, selected by more than a quarter (26%) of respondents. More specialty-specific training and improved CPD opportunities were also mentioned.

These responses reinforce the broader finding that locally employed doctors are seeking clearer career progression pathways and more secure employment arrangements.

How locally employed roles are perceived

The survey concluded by assessing how locally employed doctors believe their role is viewed by the wider medical workforce.

Only 29% agreed that locally employed roles are viewed as a positive career choice. 39% disagreed with the statement, while 31% remained neutral.

UK qualified doctors were particularly negative, with almost half (48%) disagreeing that locally employed practice is regarded positively within medicine. Although EEA/IMG PMQ doctors were somewhat more positive, many still perceived a lack of recognition and status associated with their role with 36% disagreeing with the statement.

The findings suggest that concerns about professional identity and recognition remain an important issue for the locally employed workforce.

Locally employed doctors – key findings

The 2026 survey provides a detailed picture of a large, diverse and increasingly important locally employed medical workforce. These doctors make a substantial contribution to clinical service delivery, education and patient care across the NHS, but their experiences and career pathways are far from uniform.

The findings reveal important differences between UK-qualified and internationally qualified doctors. For many UK PMQ doctors, locally employed roles are seen as a temporary stage in their career, while doctors with an EEA or IMG PMQ are more likely to view them as a route into UK practice and as part of their longer-term career progression. For some, these roles appear to be valued principally for the opportunities they may provide for future progression, such as entry into specialty training, rather than as a preferred career destination in their own right. Across both groups, locally employed roles are often seen as one stage within a broader career journey rather than an end point in themselves.

Alongside these differing career perspectives, respondents reported a range of challenges, including employment insecurity, limited access to development opportunities, discrimination, burnout and uncertainty about future progression. Despite these barriers, aspirations for learning, development and career advancement remained consistently high.

Taken together, the findings underline the importance of ensuring that locally employed doctors have access to the support, development opportunities and recognition needed to realise their potential and progress in their careers. They also emphasise the need for education and training systems that are flexible, inclusive and responsive to the varied experiences and aspirations within this workforce.

These themes align with wider work exploring how education and training can better support doctors at different stages of their careers. This includes strengthening organisational support for learning and development, alongside examining how learning gained in these roles could be better recognised, with evidence of that learning carried between organisations.

Addressing the issues highlighted by the survey will be crucial to retaining, developing and maximising the long-term contribution of locally employed doctors, ensuring that this vital workforce is supported to thrive and continue delivering high-quality care.

Insights: specialty, associate specialist and specialist doctors

5,359

SAS doctors completed the survey.

Motivations



Work-life balance and job stability were key factors for choosing a SAS role.

Perception of role

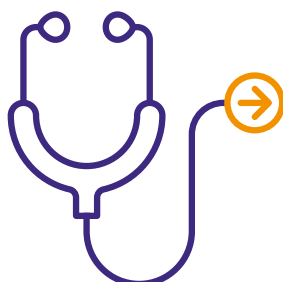
39%

don't think the role of a SAS doctor is viewed as a positive career choice in the medical workforce.

Intentions

28%

plan to be working as a consultant or GP in 5 years.



Accessing CPD



38%

experienced difficulties accessing CPD training opportunities in the last year.

Training others



83%

are responsible for training others, either formally or informally.

Burnout



28%

feel burnt out because of their work to a high/very high degree.

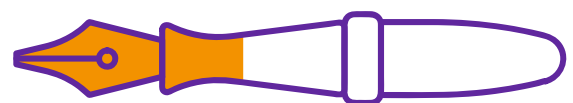
Discriminatory behaviours



44%

experienced micro-aggressions, negative comments, or oppressive body language from colleagues.

Contracts



42%

of specialty doctors eligible to move onto a specialist contract have been unable to do so.

SAS doctors survey 2026

Initial findings

SAS survey background and context

We last surveyed this group of doctors in 2019. Since then, the specialist grade contract has been introduced, and the number of SAS doctors in the medical workforce has steadily increased (Figure 1). Wider discussions about medical career structures and evolving workforce pressures have changed the context in which SAS doctors work, highlighting the need for up-to-date evidence on their experiences, aspirations, and the challenges they face.

The survey attracted responses from 5,359 doctors working in SAS roles. We estimate this represents approximately 30% of SAS doctors. The findings provide important insights into training backgrounds, motivations, employment conditions, educational opportunities, workplace culture, wellbeing, discrimination, career aspirations and perceptions of SAS careers.

Respondent profile

Table 1: % responses by SAS doctor role

Role	% responses
Specialty doctor	75%
Associate specialist doctor	11%
Specialist doctor	14%

Table 2: Approx response rate by country

Country	Response rate
England	28%
Northern Ireland	41%
Scotland	50%
Wales	34%

The SAS respondent group was highly diverse. 31% held a UK primary medical qualification (PMQ), 69% held a qualification from the European Economic Area (EEA) or were international medical graduates (IMGs). Three-quarters (76%) of respondents worked in England, while 11% worked in Scotland, 6% in Wales and 6% in Northern Ireland.

The high proportion of internationally qualified doctors means that understanding differences between UK and non-UK graduates is essential when exploring the results. Throughout the survey, notable variations emerged between these groups in relation to career aspirations, workplace experiences and professional development opportunities.

Education, training and professional background

UK PMQ

- 13%** Completed a Certificate of Completion of Training (CCT)
- 72%** Have undertaken some specialty training

EEA/IMG PMQ

- 37%** Trained to post-CCT/consultant level abroad
- 51%** Had at least 8 years clinical experience outside the UK
- 31%** Have undertaken some specialty training in the UK
- 5%** Completed a CCT in the UK

The respondent profile highlights the substantial clinical expertise, seniority and experience that SAS doctors bring to their roles, encompassing both doctors who have completed formal specialty training and those who have followed alternative career pathways.

Factors influencing the decision to be a SAS doctor

The survey explored the factors that influenced doctors' decisions to pursue SAS careers (Figure 13 and 14).

Figure 13: UK PMQ – Top four factors influencing the decision to work as a SAS doctor

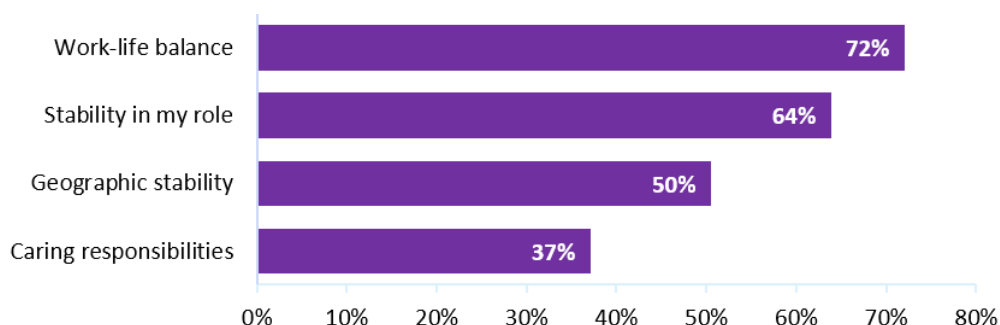
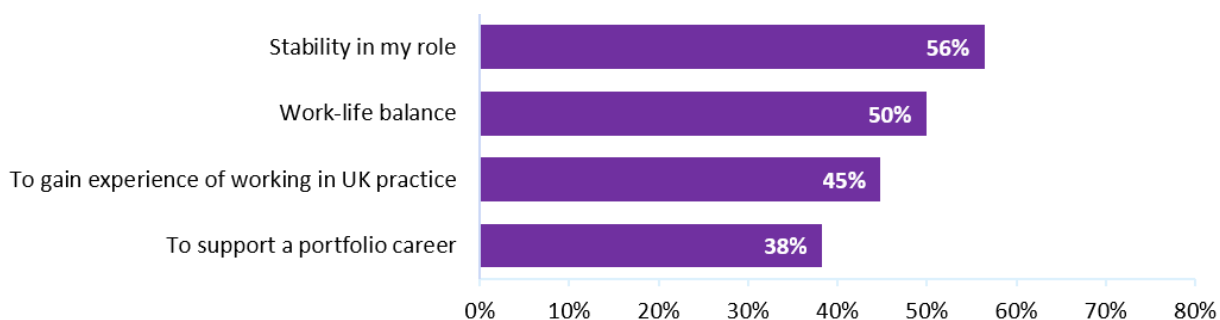


Figure 14: EEA/IMG PMQ – Top four factors influencing the decision to work as a SAS doctor



Among UK PMQ SAS doctors, work-life balance was the most commonly selected motivation, chosen by almost three quarters (72%) of respondents. Stability within their role was selected by 64%, while geographical stability and caring responsibilities were also significant considerations.

Among EEA and IMG SAS doctors, role stability and work-life balance were also important.

However, gaining experience of UK practice and supporting a portfolio career also emerged as motivations.

The survey findings indicate that, for some doctors, SAS careers represent a deliberate career choice that aligns with their needs, preferences, and aspirations. For others, however, entry into SAS roles appears to have been influenced more by experiences within the training system, as reflected in responses to questions about postgraduate medical training.

Leaving postgraduate medical training

The survey explored the reasons why doctors who had previously undertaken UK postgraduate medical training did not continue in a UK postgraduate training programme (Figure 15 and 16).

Figure 15: UK PMQ – Four most reported reasons for leaving postgraduate medical training

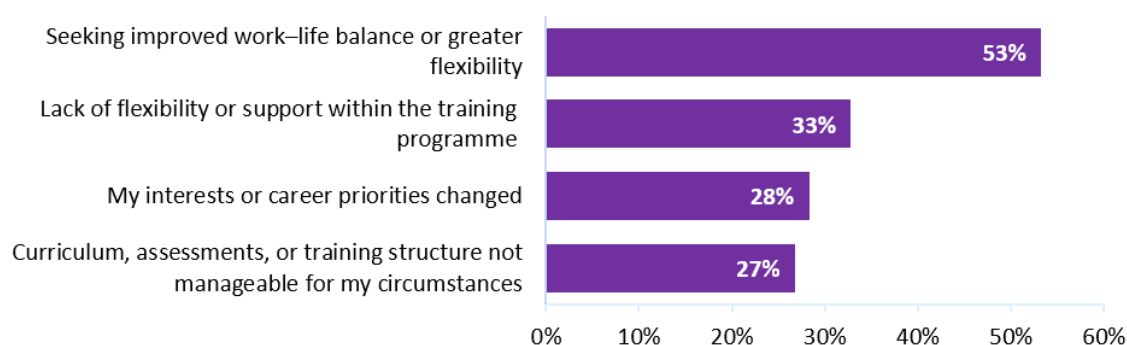
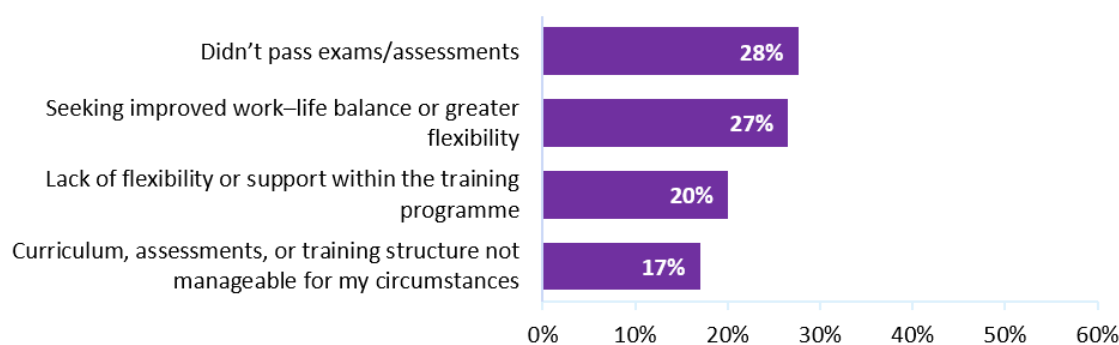


Figure 16: EEA/IMG PMQ – Four most reported reasons for leaving postgraduate medical training



Among SAS doctors with international primary medical qualifications, not passing examinations and concerns about flexibility, support, work-life balance, curriculum design and assessment structures were prominent reasons for leaving training.

Among UK-qualified SAS doctors, the leading reasons differed slightly. The most selected reason for leaving training was a desire for improved work-life balance (53%). Lack of flexibility or support within training programmes was cited by 33%, while around 28% said that their interests or career priorities had changed. More than a quarter (27%) stated that training structures, assessments or curricula were not manageable within their circumstances.

These findings suggest that movement away from training is shaped by a range of factors. While examination-related challenges play a role for some SAS doctors, many are attracted to working arrangements that offer greater flexibility, sustainability and work-life balance. As a considerable

number of respondents also selected "other reasons," this indicates decisions to leave formal training are often influenced by multiple interacting factors rather than a single cause.

Clinical specialty

Respondents represented a wide range of specialties. Anaesthetics was the largest specialty represented, accounting for 12% of all SAS respondents followed by emergency medicine (11%), demonstrating the substantial contribution SAS doctors make to front-line acute services. General psychiatry represented 8% of respondents, while general surgery and geriatric medicine accounted for 5% and 4% respectively.

Employment arrangements and working patterns

40% of SAS doctors had held their current contract for two years or less, while 18% had remained in the same contract for more than ten years. This suggests a mix of workforce renewal and long-term retention within SAS careers. The relatively high proportion in post for two years or less may partly reflect the introduction of the specialist grade in 2021, which prompted some established SAS doctors to move onto new contracts.

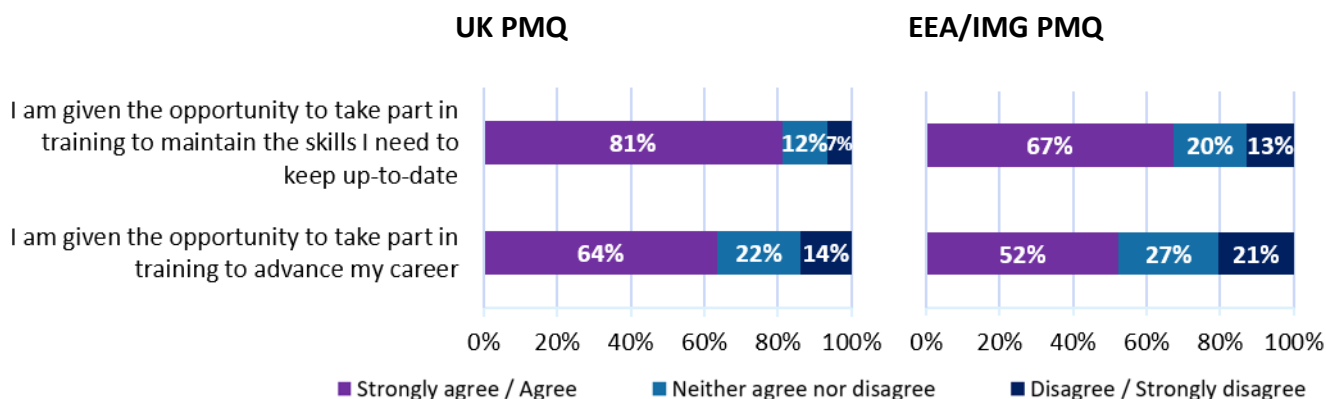
Working less than full time (LTFT) was common among SAS doctors, reflecting the importance placed on work-life balance. Overall, a quarter (25%) reported working LTFT. However, there were differences between doctors of differing PMQs. Half (50%) of UK PMQ SAS doctors worked LTFT compared with only 14% of internationally qualified SAS doctors.

Training, continuing professional development (CPD) and career development

Training and educational opportunities emerged as a key area of concern. 38% of SAS doctors reported experiencing difficulties accessing CPD opportunities during the previous year. Although most respondents (71% as in 2019) believed they were given opportunities to undertake training necessary to maintain clinical skills, many were less confident that they were offered training opportunities that would support longer-term career progression (56%) - a finding broadly consistent with 2019 (54%).

Among UK PMQ doctors, 64% agreed they had opportunities to undertake training to advance their careers, compared with 52% of EEA and IMG doctors. Non-UK PMQ respondents were consistently more negative when evaluating the support available for career development (Figure 17).

Figure 17: UK and EEA/IMG PMQ – Training and CPD



Similar disparities were evident in access to e-portfolios. Around a third (34%) of EEA/IMG doctors reported paying for access themselves, compared with 19% of UK PMQ doctors. In contrast, UK-qualified respondents were more likely to have access provided by their employer or royal college (43% versus 30%).

These findings suggest that organisations are generally supporting SAS doctors to maintain professional competence. However, there is scope to strengthen access to learning and development opportunities and to create more structured and equitable career development pathways, particularly for internationally qualified doctors.

Educational contribution

The survey illustrates how SAS doctors play a major role in educating the future workforce.

More than four fifths (83%) reported that they train others either formally, informally or both. Around half stated that SAS doctors are permitted to act as supervisors where they work. Of those, 42% reported acting as clinical supervisors, educational supervisors or both.

Among doctors with teaching responsibilities, 80% reported training doctors in postgraduate training and a similar proportion trained medical students. More than half (55%) also trained other healthcare professionals and over one third (36%) reported training locally employed doctors.

Roles and responsibilities

Many SAS doctors said they regularly work beyond the expectations of their formal grade. Almost half (46%) reported being asked daily or weekly to undertake tasks usually completed by more senior doctors. And 44% reported regularly undertaking work generally associated with more junior doctors.

While these findings indicate that SAS doctors undertake a range of responsibilities and contribute to service delivery in a variety of ways, further work is needed to understand how these arrangements shape doctors' experiences, and their implications.

The portfolio pathway

The portfolio pathway continues to be an important route for career progression for some SAS doctors, particularly those with an EEA/IMG PMQ.

31% of internationally qualified SAS doctors said they were in the process of applying for the portfolio pathway. This compares with only 8% of UK qualified SAS doctors. Overall, 24% of respondents reported being in the process of applying.

Among those who were not planning to apply nearly half (46%) felt the process was too lengthy and too complicated (46%). However, one third (32%) stated that they preferred remaining in a SAS role, demonstrating that SAS careers are valued in their own right and that not all doctors view consultant equivalence as their preferred career destination.

Feeling valued and supported

Most SAS doctors reported positive experiences of being valued within their teams, although there were notable differences between those with a UK and those with an EEA/IMG PMQ.

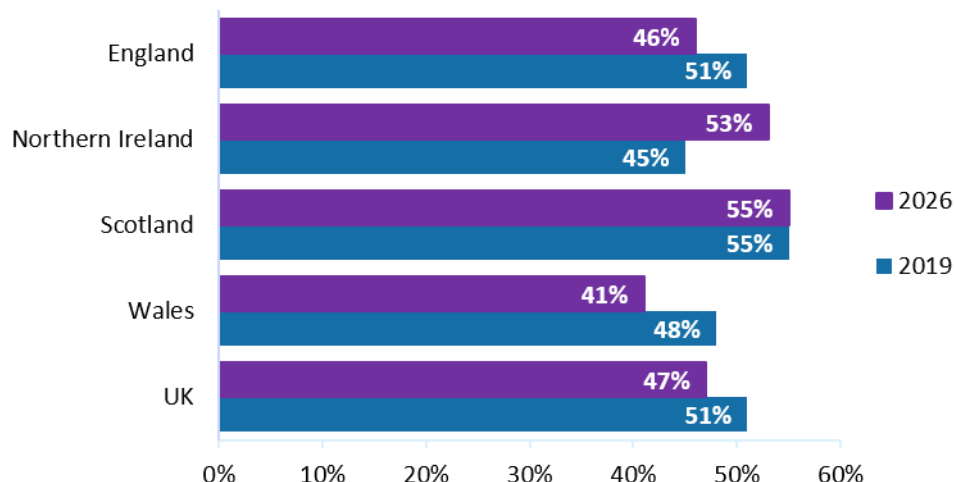
72% agreed that they felt valued within their teams, unchanged from the 2019 survey. However, UK qualified doctors reported more positive experiences than their internationally qualified colleagues, with 80% agreeing compared with 68% among EEA and IMG respondents.

Perceptions of fairness improved considerably since the last survey. Agreement with the statement that staff, including SAS doctors, are always treated fairly increased from 36% in 2019 to 50% in 2026. Nevertheless, perceptions remained less favourable than the national training survey trainee survey findings (70% agree) and were notably weaker among non-UK PMQ SAS doctors (47% agree).

Support systems

When SAS doctors were asked if they have the information needed to access the guidance, support and opportunities available to them 47% agreed, a slight decrease since the 2019 survey (51%). A fifth (21%) of IMG and EEA doctors disagreed with the statement compared to 15% of those with a UK PMQ. There was also a variation across the four countries (Figure 18).

Figure 18: I have the information I need to access the guidance, support and opportunities available to me as a SAS doctor – % agree/strongly agree by country (2026 vs 2019)



There's also a variation across the UK in the type of support that SAS doctors can access in their health board or trust (Table 3).

Table 3: Do you have access to any of these support staff in your health board or trust?

Country	SAS tutor	SAS education advisor	SAS lead	SAS advocate (or equivalent)	None of these
England	40%	11%	35%	31%	28%
Northern Ireland	3%	5%	69%	24%	22%
Scotland	3%	45%	35%	16%	22%
Wales	41%	14%	30%	39%	24%

Bullying and harassment

Bullying and harassment remains a serious concern.

31% of SAS doctors reported either experiencing or witnessing bullying or harassment in their role. This figure is virtually unchanged since 2019 (30%) and substantially higher than among doctors in training (8%), although the national training survey question refers to the trainee's current post.

Among SAS doctors who had experienced or witnessed bullying or harassment, 58% did not report the incident locally. Of those who chose not to do so, two thirds (67%) believed it would not make any difference, while more than half (54%) feared adverse consequences. Consultants were the most commonly identified source of bullying or undermining behaviour. A quarter of SAS doctors (26%) reported experiencing or witnessing bullying involving management.

Experiences of discriminatory behaviours

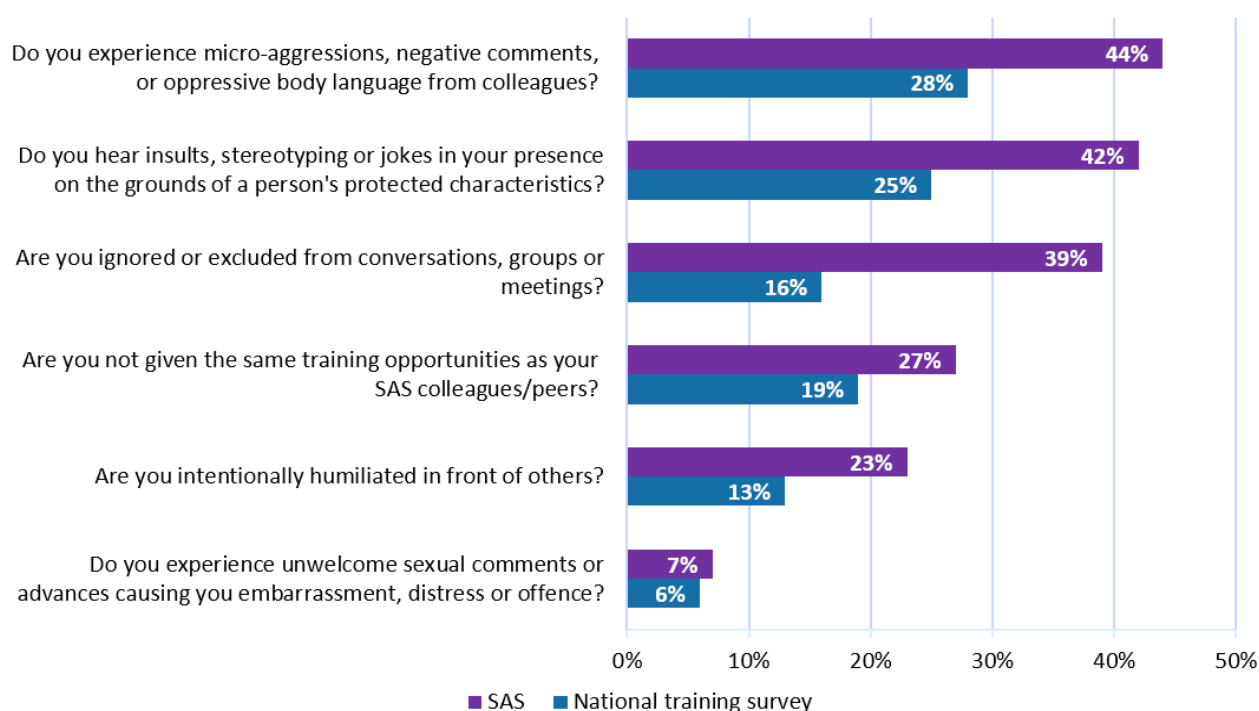
The survey included several optional questions from the national training survey about experiences of discriminatory behaviours from colleagues or healthcare professionals, enabling direct comparison with doctors in training. Three quarters (74%) of respondents chose to answer these questions.

Of these, 44% reported experiencing micro-aggressions, negative comments or oppressive body language. 42% reported hearing stereotypes, jokes or insults relating to protected characteristics, while almost four out of ten (39%) reported being ignored or excluded from conversations, meetings or groups (Figure 19).

Internationally qualified SAS doctors generally reported more negative experiences than UK PMQ SAS doctors. 31% of EEA/IMG SAS doctors said they're not given the same training opportunities as their SAS colleagues, compared to 18% of those with a UK PMQ. A quarter (25%) of EEA/IMG PMQ SAS doctors said they'd been intentionally humiliated in front of others compared to 18% of UK PMQ SAS doctors.

Figure 19: Discriminatory behaviours – SAS doctors vs doctors in training 2026

In your current workplace how often: (all negative results combined: daily, weekly, monthly, less than once a month)



Some differences were also evident across demographic groups. SAS doctors from ethnic minority backgrounds were generally more likely to report negative experiences. For example, 45% reported experiencing microaggressions, compared with 40% of white SAS doctors.

Nearly one in ten (9%) female SAS doctors reported experiencing unwelcome sexual comments or advances from colleagues, a proportion comparable to that reported by female doctors in training in the national training survey. All doctors should be able to work in an environment that is safe, respectful, and free from harassment. We continue to expect organisations to take decisive action to prevent and address such behaviour.

Confidence in reporting discrimination

Around half (49%) of SAS doctors felt confident challenging discrimination and unprofessional behaviours among colleagues. Although approximately two thirds (67%) believed they knew how to report concerns, less than half (48%) felt confident reporting discrimination without fear of adverse consequences.

Again, internationally qualified doctors and those from an ethnic minority background expressed less confidence across all measures. For example, 62% of EEA/IMG PMQ SAS doctors said they knew how, or could find out how, to report discrimination where they work, compared to 77% of those with a UK PMQ. Similarly, 46% of SAS doctors from ethnic minority backgrounds felt confident challenging discrimination and unprofessional behaviour, compared with 56% of their white colleagues.

These findings suggest that awareness of reporting routes alone is unlikely to be sufficient where concerns about potential adverse consequences persist. The differences between internationally qualified and UK PMQ doctors, and between ethnic minority and white SAS doctors, indicate that experiences and perceptions of workplace culture vary across groups.

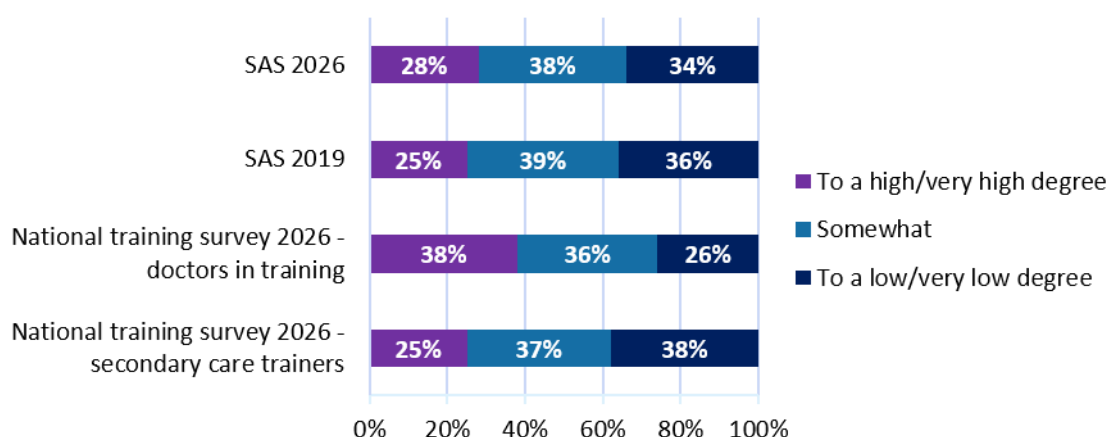
The reasons underlying these differences are likely to be complex. Further analysis would be valuable to explore the extent to which factors such as career stage, length of time practising in the UK and specialty influence confidence in reporting concerns.

Burnout

28% of SAS doctors reported feeling burnt out because of their work to a high or very high degree, compared to 25% in the 2019 survey (Figure 20).

International medical graduates reported higher levels of burnout than UK PMQ doctors. 30% of EEA/IMG respondents responded negatively to this question compared to 23% of UK PMQ respondents.

Figure 20: Do you feel burnt out because of your work? 2026 vs 2019, including national training survey 2026 data



Disability, neurodivergence and access needs

Two new questions on disability, neurodivergence, impairments and access needs, developed through stakeholder engagement, highlight areas for further exploration to better understand doctors' experiences and needs.

Overall, 13% of SAS doctors identified as disabled, neurodivergent, living with an impairment, or having an access need. Among this group, 35% said this was a factor in their decision to work in a SAS role. 31% said it was an important factor to a great extent.

Most (67%) felt they had equal access to learning and development opportunities compared with colleagues, although 13% disagreed.

Future career intentions

The findings indicate short-term workforce stability among SAS doctors, with most expecting to remain in their current role with the same employer over the next year. This was the most commonly selected career intention among both UK and EEA/IMG PMQ doctors. However, a notable minority of specialty doctors expected to pursue career progression through portfolio pathway applications or movement into specialist doctor roles, highlighting continued demand for development opportunities (Figure 21).

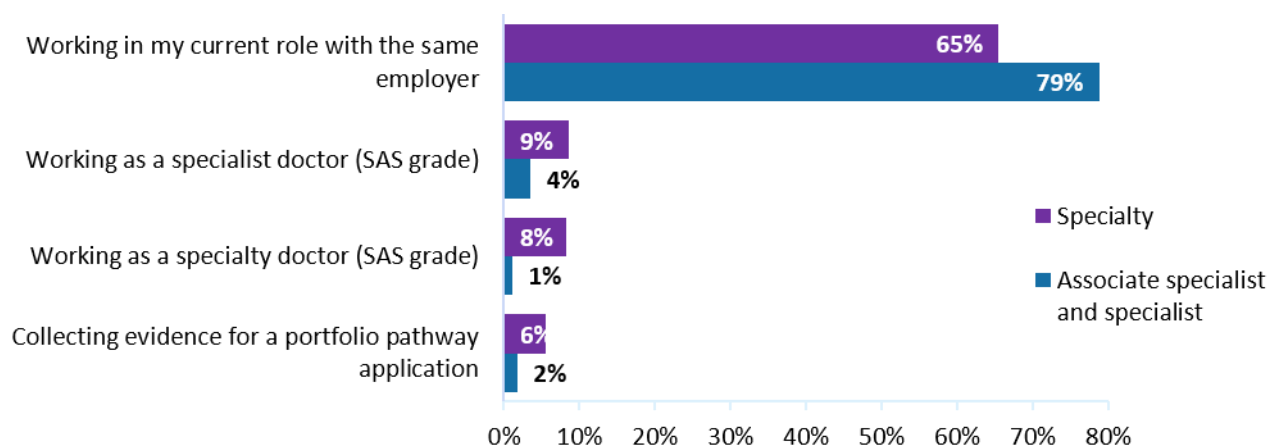
Looking five years ahead, career intentions are more varied (Figure 22). Among EEA/IMG PMQ specialty doctors, over a third (37%) expected to be working as a consultant or GP, while 13% anticipated progressing to specialist doctor roles, suggesting that many view their current post as a route to more senior clinical positions. 27% of UK PMQ specialty doctors expected to remain in their current role. Nearly a quarter (23%) intend to move to a specialist doctor role, while 14% anticipated working as a consultant or GP.

Among associate specialist and specialist doctors, longer-term intentions were more focused on retention and retirement. 42% of UK PMQ doctors and 28% of EEA/IMG PMQ doctors expected to remain in their current role with the same employer after five years, while retirement was anticipated by 33% of UK PMQ doctors and 19% of EEA/IMG PMQ doctors.

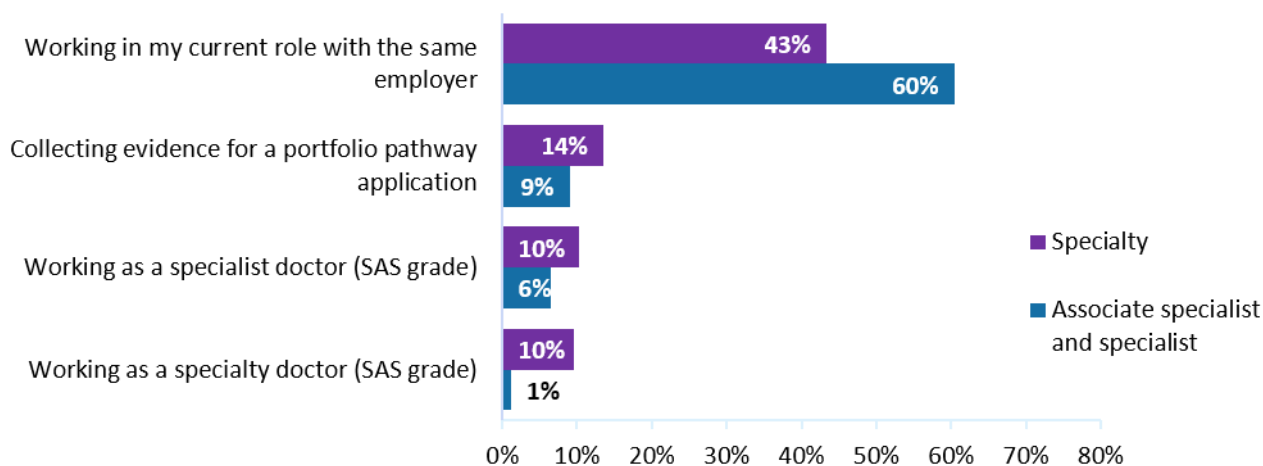
Overall, the results point to a stable SAS workforce in the short term, alongside a more varied range of career expectations over the longer term. While many doctors expect to remain in SAS roles, substantial proportions anticipate progression to other senior clinical roles or retirement within the next five years.

**Figure 21: What best describes what you see yourself doing one year from now?
(top 4 options selected, % by PMQ and SAS role)**

UK PMQ

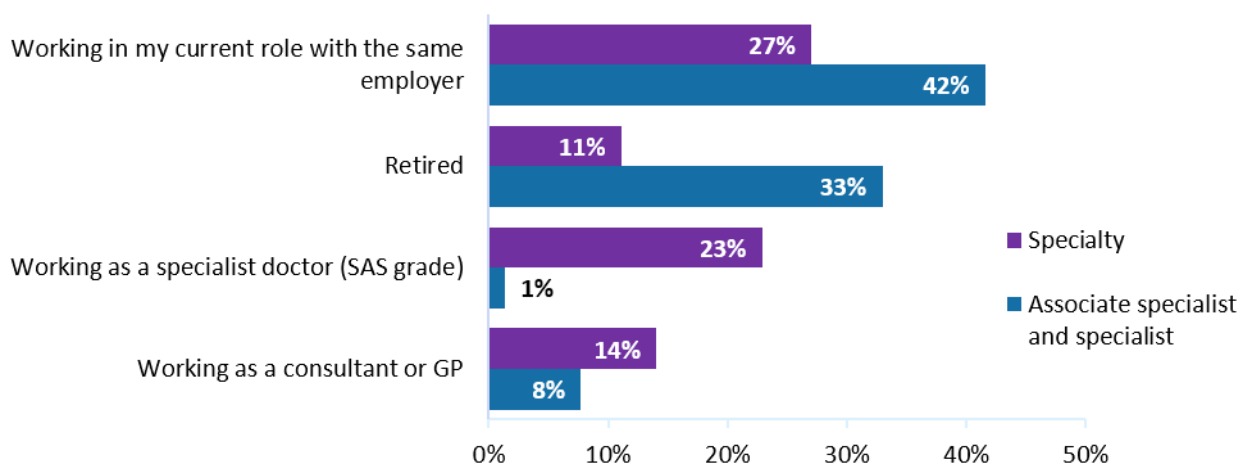


EEA/IMG PMQ

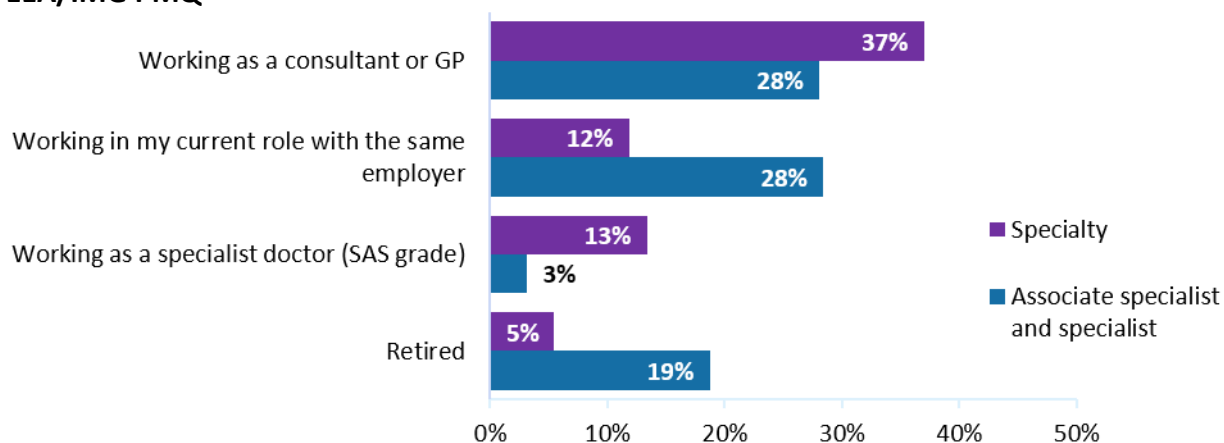


**Figure 22: What best describes what you see yourself doing five years from now?
(top 4 options selected, % by PMQ and SAS role)**

UK PMQ



EEA/IMG PMQ



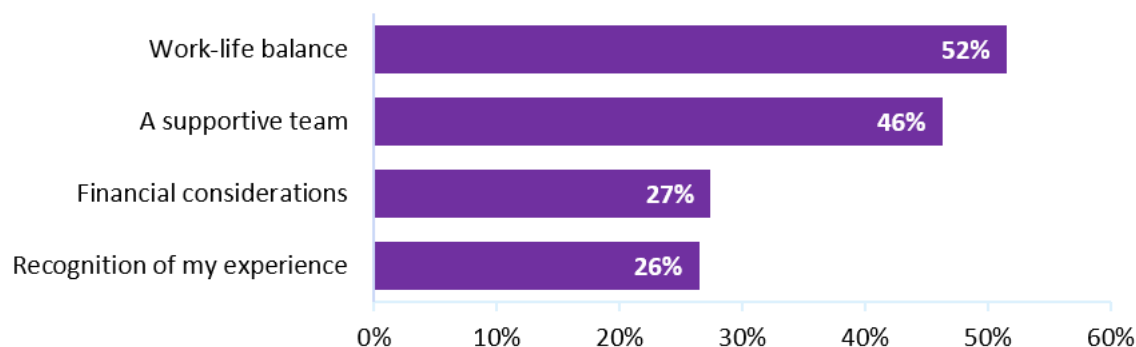
Considerations when making plans for the future

Work-life balance was the most important consideration shaping future plans. Respondents also highlighted supportive teams, recognition of experience and financial considerations (Figure 23).

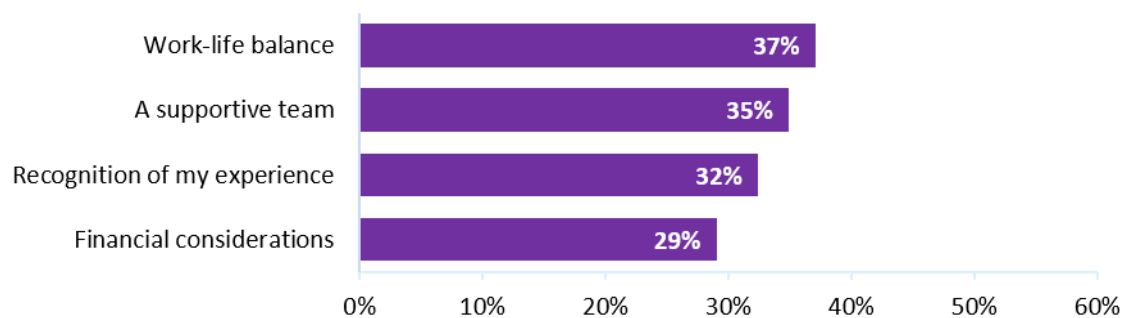
These priorities reflect a recurring theme throughout the survey: SAS doctors value careers that provide stability, support and flexibility, alongside recognition of their experience and contribution.

Figure 23: Select up to three options that are important to you in making plans for the future (top 4 options selected) by PMQ

UK PMQ



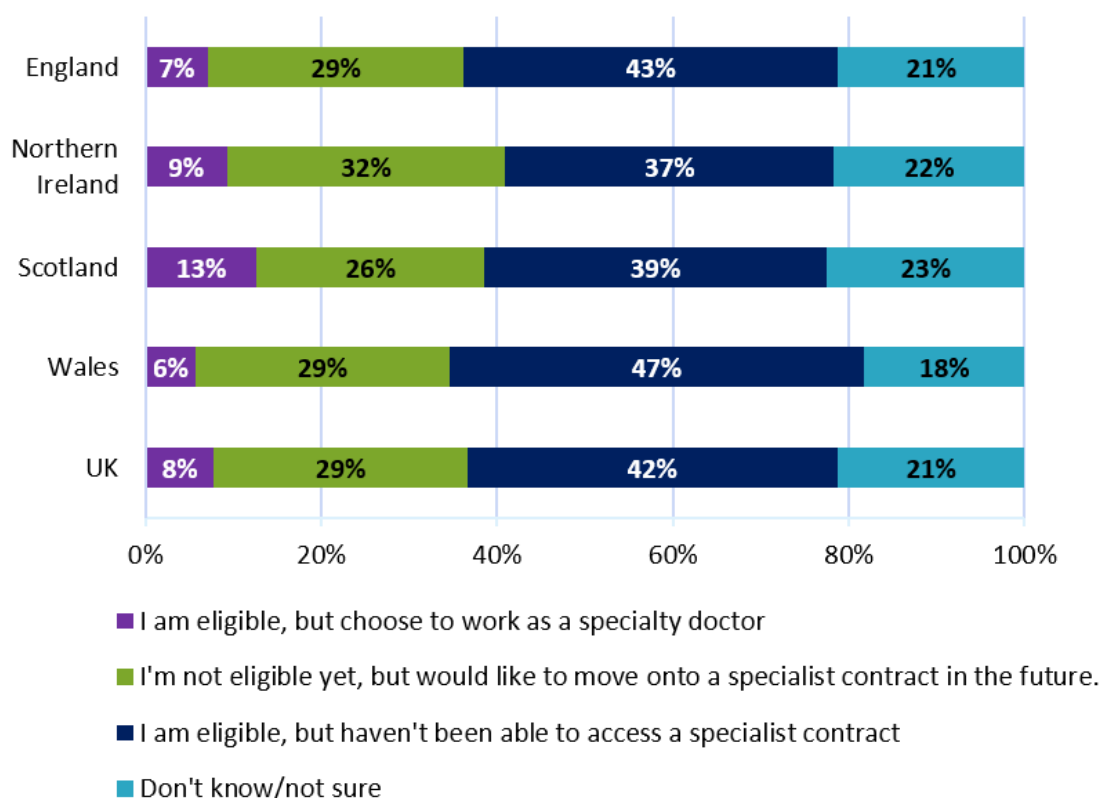
EEA/IMG PMQ



Specialist contracts

Respondents were asked about their intentions regarding the specialist doctor contract, which was introduced in 2021 to provide a career progression pathway for highly experienced clinicians practising at an advanced level of autonomy. While 29% of specialty doctors reported that they would like to move onto a specialist contract when they become eligible, 42% indicated that they were already eligible but had been unable to secure a specialist contract (Figure 24). Among these respondents, over a quarter (27%) cited resistance to transferring eligible doctors onto specialist contracts, while a further 21% reported that specialist contracts were not available within their organisation. By contrast, 8% of respondents said that, although they were eligible for a specialist contract, they had chosen to remain in a specialty doctor role.

Figure 24: Specialty doctors by country – What best describes your intention in relation to the specialist doct



Career development priorities

When asked what would add the most value to their career, the largest proportion of SAS doctors (44%) selected more opportunities for career progression. 13% chose “more training related to my specialty” and the same proportion selected “increased involvement in decision-making where I work.” 11% said they wanted to work with greater autonomy.

Responses to this question echoed previous findings, highlighting a strong demand for clearer progression routes, development opportunities and recognition of experience across SAS careers.

How SAS roles are perceived

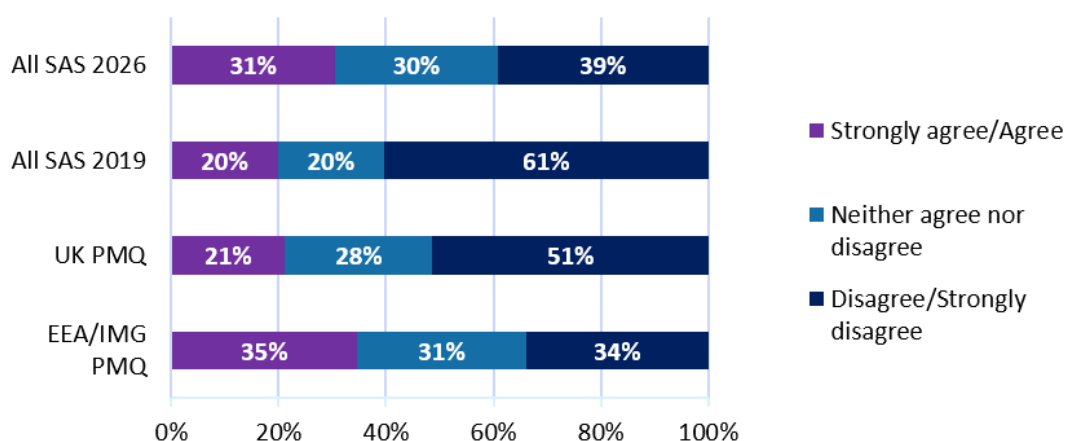
The survey concluded by asking respondents whether the role of SAS doctor is viewed as a positive career choice within the medical workforce (Figure 25).

The results suggest that although perceptions have improved substantially since 2019, negative views remain widespread. In 2019, 61% disagreed that SAS roles were viewed positively within the medical workforce. In 2026, this figure decreased to 39%.

Nevertheless, only 31% agreed that SAS careers are viewed positively. And UK PMQ doctors were particularly negative, with over half (51%) disagreeing with the statement. EEA and IMG SAS doctors expressed slightly more positive views, with 35% agreeing and 34% disagreeing.

The survey, as in 2019, illustrates that many SAS doctors don't feel their role receives the appropriate recognition within the wider medical workforce.

Figure 25: The role of SAS doctor is viewed as a positive career choice within the medical workforce – 2026 vs 2019 and by PMQ



SAS doctors – key findings

The 2026 survey findings portray a highly experienced, committed SAS workforce. SAS doctors contribute extensively to clinical services, training and leadership. They generally value the stability and work-life balance these careers can provide.

However, the survey also highlights persistent challenges. Access to career development opportunities remains uneven, particularly for internationally qualified doctors. Many specialty doctors expressed a desire to move onto a specialist contract but reported being unable to do so despite meeting the eligibility criteria. Concerns about discrimination, burnout, bullying, and a lack of recognition continue to affect a substantial proportion of the workforce.

The findings also demonstrate the importance these doctors place on career progression alongside a desire for greater recognition of the contribution SAS doctors make to healthcare delivery across the UK.

Taken together, the findings reinforce the importance of career development, equitable access to learning opportunities, inclusive working environments and sustained support throughout SAS doctors' careers. Addressing these priorities will be essential to enabling SAS doctors to thrive, realise their full potential and continue making a vital contribution to the UK healthcare system.

Conclusion:

Supporting careers and recognising the contribution of SAS and LE doctors

The survey findings reinforce the significant contribution that locally employed and SAS doctors make to healthcare across the UK. They are an experienced and committed part of the medical workforce, playing essential roles in service delivery, education, leadership and patient care. The findings also highlight strong ambitions for professional development, with many doctors seeking opportunities to broaden their skills, progress their careers and contribute more widely.

However, the survey points to a number of persistent challenges. Access to training, development and progression is not experienced equally by all doctors, with internationally qualified doctors reporting greater barriers to opportunities, career progression and workplace inclusion. Many doctors continue to face unclear career pathways, limited progression opportunities, employment insecurity and uncertainty about their long-term prospects. At the same time, experiences of burnout, workplace stress, discrimination, bullying and a lack of recognition continue to affect a substantial proportion of respondents.

Taken together, these findings suggest that organisations have an opportunity to make better use of the skills, experience and aspirations of these doctors by creating more supportive, inclusive and flexible working environments.

This requires action from employers now, alongside longer-term action from policymakers, system leaders and the GMC.

What employers can do now

There are practical steps that employers can take now to improve the experiences and career development of SAS and locally employed doctors. These include:

- ensuring eligible SAS doctors have access to specialist contracts
- funding access to appropriate e-portfolios
- improving awareness and availability of educational, supervisory and leadership opportunities
- ensuring staff not only have procedures for reporting concerns but feel safe using them and are confident that concerns will be acted on.

Employers should also work towards longer-term improvements by:

- developing transparent career pathways for SAS and locally employed doctors
- improving access to progression and leadership roles
- strengthening appraisal, induction and mentoring arrangements
- reducing employment uncertainty wherever possible.

More broadly, policymakers and system leaders should ensure that workforce, education and career frameworks better reflect the diversity of modern medical careers. This means supporting flexible routes for development and progression, recognising skills and expertise gained outside

traditional training pathways, and addressing inequalities in workplace experiences.

What we will do next

We will build on these findings in two ways.

First, we will undertake further analysis to explore whether particular groups within the SAS and locally employed workforce face particular challenges or barriers. While this report has focused on differences associated with primary medical qualification, factors such as career stage, specialty, demographic characteristics and working pattern may also influence doctors' experiences and career outcomes.

Second, these insights will inform our wider review of standards and outcomes in medical education and training, helping us identify where we can support better career development and employment models.

The survey has given voice to a vital but often under-recognised part of the workforce. To realise the full benefits of this contribution, SAS and locally employed doctors must be included in the conversations and decisions that shape services. Supporting their development, inclusion and progression will benefit not only these doctors, but also patients, organisations and the future workforce.

Accessing the survey data

[Our online reporting tool](#) allows users to explore all the survey questions by country, region, trust/board, specialty, PMQ and demographic characteristics.

Annex A: Survey methodology

Survey development

The 2026 specialty, associate specialist and specialist (SAS) and locally employed (LE) doctor survey was developed following a comprehensive review of the questionnaire used in the 2019 survey. The aim of the review was to ensure that the survey reflected the current experiences, challenges and priorities of doctors working in SAS and LE roles across the UK.

The review process incorporated extensive feedback from stakeholder organisations representing SAS and LE doctors. This included professional membership bodies, royal colleges, NHS organisations, healthcare employers, regulators, medical education and training bodies, advocacy networks, and equality-focused groups.

This collaborative approach helped ensure that the survey questions remained relevant and accurately captured the realities of contemporary practice.

Target population and sampling approach

The General Medical Council (GMC) register was used as the primary sampling frame. The GMC register is the most comprehensive and reliable source of information for identifying doctors who are licensed to practise in the UK.

Doctors were eligible for invitation if they:

- held a licence to practise in the UK
- were not in a recognised postgraduate training programme
- were not included on either the specialist register or GP register.

A total of **81,796 doctors** meeting these criteria were invited to participate via email.

Recognising that some doctors working in SAS or LE roles have specialist or GP registration and would not be captured through the primary sampling frame, an open web link was also made available.

Data collection

The survey was administered online and remained open for six weeks between **21st April and 3rd June 2026**.

Invited doctors received an email containing a link to the survey. Participants accessing the survey via the open web link were also able to complete the questionnaire during the same period.

Participation was voluntary and responses were submitted electronically.

Data validation and cleaning

To ensure the quality and integrity of the data collected, respondents were asked to provide their:

- GMC number
- name
- date of birth.

These details were used only to validate the data and match responses to demographic information we already hold. Following closure of the survey, responses were validated, duplicate submissions were identified and removed, and the dataset was cleaned prior to analysis.

Final analytical sample size:

- 5,359 respondents working in a SAS role
- 5,221 respondents working in a locally employed role
- 1,125 respondents not working or working outside of medicine but seeking a clinical role. These respondents completed a short survey about their medical background and future intentions.

Response data for all questions for each group [is available on the education data tool](#).

Analysis and reporting

To enable timely reporting of the findings, analysis was undertaken using the validated survey dataset and results were summarised at a high level.

The findings presented in this report are based on descriptive analysis of the survey responses. Statistical significance testing was not undertaken, and therefore caution should be exercised when interpreting differences between groups, as it cannot be determined whether observed differences are statistically significant or may have arisen by chance.

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