



Acute care toolkit 8: The medical registrar on call: Maximising clinical experience, training and patient care Nov 2013

There is a looming crisis in medical care, as described in the RCP report *Hospitals on the edge? The time for action*.¹ The medical registrar is integral to patient safety, especially out of hours when they are often the most senior physician on site. The medical registrars provide clinical leadership and oversee care for patients with acute and complex medical problems.

In order to achieve high-quality patient care, medical registrars need to be empowered to prioritise their roles. They need adequate supervision and training, while working within an effective team structure.

Background

The medical registrar is perceived by many to be the medical 'workhorse' of the hospital. The expertise of the on-call medical registrar is relied upon heavily by many hospital and community teams. Registrars, however, are concerned about their ability to provide safe, high-quality patient care as their workload increases. Despite being passionate about patient care, morale among medical registrars is low and they feel undervalued. Junior doctors are being put off general medical specialities by the prospect of becoming the medical registrar.^{2,3}

An urgent re-evaluation of this role is needed if we are to provide high-quality acute care while recruiting, training and, crucially, retaining future consultants in general internal medicine. The RCP's vision of the role of medical registrars is described in the 2013 report *The medical registrar: Empowering the unsung heroes of patient care*.⁴

This toolkit offers recommendations that will improve the role of the medical registrar on call, with some examples of how this can be done in practice. Many of these

recommendations have been incorporated into the Future Hospital Commission report for the RCP.⁵

Workload

Roles and responsibilities

Issues

The lack of a definition of the roles of the medical registrar has caused confusion and wide variation in practice and expectations across the UK. Medical registrars spend large amounts of time performing non-priority tasks that would be more appropriately carried out by other members of the team. Reducing the burden of this work is crucial to ensure they can perform their priority roles to a high standard and in a timely manner.

Recommendations

- > There should be a named consultant physician who 'champions the medical registrar' in each trust. This champion, supported by a hospital manager, would

Box 1 Roles of the medical registrar

> Priority roles and responsibilities

1 Leadership and supervision

- > Leadership of the medical take team.
- > Supervision and support to junior medical doctors.
- > Leadership of handover processes.
- > Ensuring appropriate communication and escalation to the medical consultant on call.
- > Communication with senior members of the wider team, including senior nurses and managers.
- > Performing complex clinical procedures.

2 Being a senior medical clinical decision-maker

- > Awareness of, and supervision of care for, the most acutely unwell and/or complex patients with medical problems.
- > Specialty clinical support and advice to non-medical specialty teams, including general practitioners and staff in the emergency department.

3 Training

- > Being proactive in seeking training opportunities and ensuring ongoing professional development.
- > Taking an active role in training junior doctors.
- > Supervising junior doctors performing practical clinical procedures.

> Non-priority roles

These are roles that are more appropriately designated to less experienced or less skilled members of the multidisciplinary team. For example:

- 1 Routine clerking of unselected internal medical (or medical specialty) admissions.
- 2 Basic clinical tasks including venepuncture, cannulation, performing electrocardiograms.
- 3 Routine administrative tasks.
- 4 Facilitating routine bed moves.

be responsible for objectively assessing the roles and responsibilities of medical registrars in each trust, ensuring these are safe and manageable.

- > The roles and responsibilities of medical registrars should be clearly defined using the framework in box 1 (left). This should be easily accessible on the trust intranet.
- > The burden of administrative and basic clinical tasks should be redistributed to other staff. Freeing up the medical registrar from these 'non-priority' jobs will allow them to care for the most unwell patients and improve clinical outcomes.

Medical registrar interactions with other teams

Issues

Many clinical teams rely on support and advice from the medical registrar. Good working relationships between teams are crucial to patient safety. There is a wide variation in referral processes to the medical registrar, particularly at night. This results in over-reliance on the medical registrar for the care of patients in non-medical specialties. Referrals are increasingly made directly to the medical registrar by junior staff, in the absence of senior review or decision-making within the responsible clinical team. Furthermore, criteria for admission or determining specialty responsibility vary widely and can be unclear, resulting in medicine being used inappropriately as a default option for non-medical presentations. As a consequence, the medical registrar is often burdened with unnecessary, late or poor-quality referrals, to the detriment of patient care.

Recommendations

Inpatient referrals to the medical team:

- > The mechanisms for referring patients under the care of non-medical specialties (eg obstetrics, general surgery) for medical opinions – both in hours and out of hours – should be reviewed. Referral protocols and clinical pathways should be agreed.
- > 'Buddy' arrangements linking consultant-led medical teams with surgical wards provide reliable access to a consultant opinion and continuing physician care seven days a week. This considerably reduces the burden on the medical registrar.⁶ Anticipating the need for a medical opinion, and ensuring the request is made in hours, can help relieve the pressure on the medical registrar and prevent crises out of hours.

Medical specialty admissions:

- > There should be policies clarifying which primary presenting complaints should be admitted under which specialty team, both for medical and non-medical specialties. These should be easily available in all emergency departments and agreed by all clinical teams and the medical director.
- > Referrals for admission under the medical team should be made to someone with adequate clinical experience and knowledge of alternative management strategies. An administrator who is not qualified to make clinical decisions should not accept referrals.

Case study 1

In our trust, an arrangement widely perceived as helpful is that non-emergency referrals from other departments (eg vascular surgery) are made to the medical team who care for the medical outliers on that ward (eg diabetes and endocrinology). Questions about matters such as anticoagulation and renal dysfunction can be resolved by the ‘consultant-led buddy team’, rather than the medical registrar on call. ■

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Matching staffing to workload

An objective assessment of the workload of the medical team will allow for redesign of rotas and staffing levels. This is fundamental to measuring the quality of the medical service in the hospital and should become one of the routine measures that is audited.⁷

- > Staffing levels should be allocated in parallel with assessment of workload and patient flow. Regular audits of the workload being handed over to night teams should be carried out, and daytime staffing adjusted accordingly.
- > The impact of participation in general medical rotas on specialty training needs to be taken into account when designing rotas (see table 1).

Teamwork

Issues

Effective teamworking is key to the provision of excellent patient care. Leadership of the multidisciplinary team is a core role of the medical registrar. Clarity of roles of members of the medical team is often lacking, and registrars report feeling disempowered and confused as to who was the key decision-maker in hours and out of hours. The working relationship between the on-call medical registrar and consultant is variable, with some consultants relegating the registrar to a very junior team member and others leaving the registrar feeling unsupported. The ‘senior house officer’ equivalent grade is now much more varied. Doctors in their second foundation year, general practice trainees and core medical trainees are commonly expected to perform the same job, despite the vast difference in competencies. This, combined with loss of traditional team structures, has resulted in the medical registrar being unsure of the knowledge, skills and competencies of their team.

Recommendations

- > Trust induction should include clear guidance with respect to the structure of the general medical rota and the roles of all members of the on-call medical team, including consultants.
- > Leadership of the on-call medical team should be transparent and consistent during normal working hours and out of hours.
- > Handover should be formalised, take place twice daily, be multidisciplinary, and implemented with reference to the RCP handover toolkit⁸ (see box 2).
- > Team working can be improved by working a full shift rota with consistency in the members of the team (see case study 2).
- > Members of the on-call team should be responsible for making formal contact with their team leader (usually the medical registrar) at the start of every shift, either at handover or on an individual basis. This should be used as an opportunity for:
 - + clinical handover
 - + communicating on non-clinical issues eg beds, staffing
 - + exchanging contact details
 - + identifying specific training needs and assessing levels of supervision required by junior doctors on the team.
- > Effective communication is essential to good teamwork. Processes should be in place to ensure the flow of information, and technology should be used to facilitate this:
 - + computerised admission lists
 - + use of mobile phones rather than pagers.

Case study 2

We get our general medical training by working on the acute medical unit in blocks of four weeks at a time. We are always on call with the same team of juniors and consultants, whom we work with over a six-month period. When I go into a night shift I can plan what I am going to ask the juniors to do, as I know their competencies and experience. I genuinely enjoy my acute medical unit blocks as I feel I am leading a team effectively and we are all learning from each other. The consultants on call get to know our abilities and can be as hands-off or hands-on as necessary. As a team we go through our previous admissions when we are less busy and we get to find out what happened to patients and feedback to each other. ■

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‘Effective teamworking is key to the provision of excellent patient care. Leadership of the multidisciplinary team is a core role of the medical registrar. Clarity of roles of members of the medical team is often unclear, and registrars reported feeling disempowered and confused as to who was the key decision-maker in hours and out of hours.’

‘Probably the first thing to go when you are busy is teaching and training of others.’¹

Training and supervision

Issues

In the 2011 survey of registrars, 38% rated their training in general medicine as good or excellent, compared with 75% in their specialty. Only 60% of registrars felt that their training adequately prepared them for a general medicine consultant post.⁹ Registrars depend on their on-call shifts to receive much of their general medical training, yet many training opportunities are not being used. Despite medical registrars considering the post-take ward round as a valuable learning opportunity, changing shift patterns have resulted in the erosion of this ward round and lack of opportunities to receive feedback.¹⁰ On the other hand, the general medical registrar role can negatively affect specialty training because of the proportion of time spent on call or post take.

Recommendations

- > Medical registrars must routinely attend the post-take review of all patients they have been involved with. A mechanism should be in place for consultant review of patients seen as ward referrals.
- > Procedural training (eg central venous cannulation and lumbar puncture) for medical registrars should be available in every hospital to ensure patient safety out of hours. Simulation techniques should be promoted.
- > Extended consultant presence should be used to enhance the many training opportunities that exist out of hours.
- > Contact with consultants from different specialties is valuable and should be promoted.
- > Registrar training will be improved by routine and regular:
 - + consultants directly observing ward rounds led by the registrar
 - + arrangements whereby clinical information (diagnosis, outcomes) are fed back to the admitting registrar, with IT systems to support this process (eg forwarding discharge summaries by email and the facility to create lists of selected patients to follow their clinical course)
 - + one-to-one meetings with supervising consultants regarding performance for registrars working as the ‘on-call’ medical registrar.
- > Any processes that increase continuity of care and help junior doctors follow up their patients’ outcomes must be promoted.
- > The clinical lead for acute medicine should implement a teaching programme dedicated to acute take scenarios and based on the general internal medicine curriculum.¹¹

(approximately two applicants per post) are significantly lower than those in other specialties, such as anaesthesia, acute care common stem and core surgical training.³ Numerous vacancies have appeared in medical training programmes nationally.

One-third of registrars surveyed had thought about dropping out of general internal medicine in the six months prior to being surveyed.² The survey of medical registrars also identified that while 3,838 registrars are achieving dual certification in general internal medicine (54.4% of all registrars in 2011), only 1,597 would choose consultant posts with a general medicine commitment.

The psychosocial work environment influences the health of the workforce. Poorer psychological (and physical) health is associated with poor control over workload, lack of support, lack of role clarity, high work demands and effort–reward imbalance.¹²

The evidence is clear that poor health in NHS staff is associated with adverse patient outcomes.^{13,14}

Recommendations

- > Medical registrars should be actively encouraged to take part in quality improvement projects in the trust. Adequate time should be allocated to this within working hours.
- > There should be an expectation that at least one trainee will attend management meetings.
- > All members of the medical team should be able to have adequate rest periods in a quiet, comfortable rest room.
- > Core medical trainees should gain experience in the skills needed as a medical registrar (eg assume the role under supervision when the registrar is reviewing patients with the consultant). In particular, more experience in managing acutely unwell medical patients is needed. This will make the prospect of applying for a medical registrar role less daunting.
- > The designated consultant physician ‘champion’ of the medical registrar and the lead hospital manager should be responsible for providing support and promoting a healthy work–life balance for the registrars. ■

Case study 3

Twice a week at 8am everyone goes to ‘morning report’. Consultants attend as it is part of their job plan and usually there are 20–30 doctors and students. Patients admitted over the previous few days are presented; there is a lively informal debate where trainees can participate as much as they wish. Interesting cases are fed back and it is a useful opportunity to handover a patient to a specialty team. I always learn something new and it is a great way to start the day. ■

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Recruitment and retention

Issues

Training in general medicine is a rite of passage for every doctor in the UK. Most junior doctors seem to enjoy at least some part of that experience but are put off being a medical registrar on call. Competition ratios for applications to core medical training



Table 1: Frequency of participation in the general medical rota

To be used as a guide, depending on how many weekdays are available for specialty training per annum

Frequency of participation in general medical rota	Weekdays available for specialty training per annum*
1:8	108–65
1:9	123–69
1:10	134–72
1:11	144–75

* Based on 32 days of annual leave and 20 days of study leave per annum. Dependent on type of rota and number of night shifts worked.

Box 2: Safe and effective handover



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This is the eighth in a series of acute care toolkits published by the RCP:

- Toolkit 1: Handover, May 2011.
- Toolkit 2: High-quality acute care, October 2011.
- Toolkit 3: Acute medical care for frail older people, March 2012.
- Toolkit 4: Delivering a 12-hour, 7-day consultant presence on the acute medical unit, October 2012.
- Toolkit 5: Teaching on the acute medical unit, November 2012.
- Toolkit 6: The medical patient at risk: recognition and care of the seriously ill or deteriorating medical patient, May 2013.
- Toolkit 7: Acute oncology on the acute medical unit, October 2013.

The toolkits can be accessed online at www.rcplondon.ac.uk/resources/acute-care-toolkits

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