



Royal College  
of Physicians

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# The medical registrar

## Empowering the unsung heroes of patient care

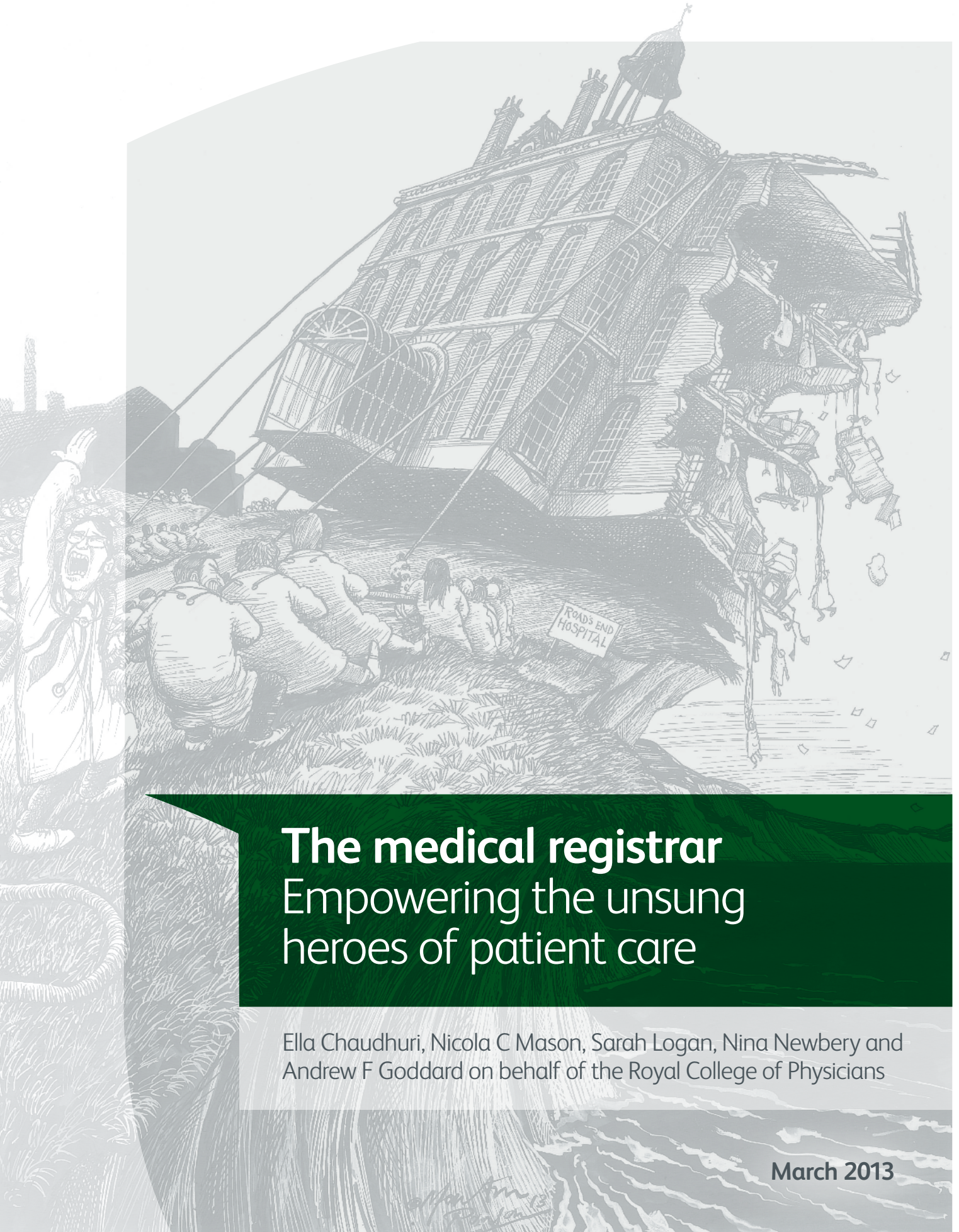
March 2013





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# The medical registrar

## Empowering the unsung heroes of patient care

Ella Chaudhuri, Nicola C Mason, Sarah Logan, Nina Newbery and  
Andrew F Goddard on behalf of the Royal College of Physicians

March 2013

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## Preface

This report is the culmination of a large programme of work carried out by the Medical Workforce Unit of the Royal College of Physicians (RCP) in 2011 and 2012. The report is aimed primarily at all hospital doctors who work with medical registrars, hospital managers, NHS leaders and policy makers. Importantly, the report is a synthesis of opinions gained from many hundreds of medical registrars practising today, both by electronic questionnaire and by focus groups held in all corners of the NHS. The report is 'for registrars by registrars'. It has been heartening to see the commitment of medical registrars in the UK to their patients and profession. I hope the NHS and profession can repay this commitment.

The report is broken down into chapters based on core themes identified from these sources. There are numerous recurrent themes and the report therefore repeats some of these in different chapters. The report describes the key problems facing medical registrars in the UK in 2012 and makes recommendations to resolve these problems. The executive summary contains the report's key recommendations, although additional recommendations are made in each chapter. Some of the solutions are simple and can be implemented by hospitals relatively easily. Other solutions are more challenging and will require system change.

Many of the practical solutions learned during the work for this report have been consolidated in a separate document, *Acute care toolkit no 7: The medical registrar on-call*, which will be published after this report by the RCP's Acute Medical Care Committee. The bulk of the work was done by three medical registrars based across the UK – Dr Ella Chaudhuri, Dr Nicky Mason and Dr Sarah Logan – working as clinical fellows in the unit. It has been a privilege to work with Ella, Nicky and Sarah on this project and their extraordinary hard work and enthusiasm shine through this report. The invaluable support of Nina Newbery, Darin Nagamootoo and Chris Phillips within the unit has also been essential to the project.

This work was funded in part by a grant from Skills for Health to improve 'Hospital at night' systems in England. I am grateful to Professor Wendy Reid and Tim Lund for their support and hope that the report will result in major improvements in the care and management of hospital patients both at night and at the weekend. The work has also been funded by the RCP as part of the Future Hospital Commission. I am grateful to all of the senior college officers for their support and helpful comments.

March 2013  
Director, Medical Workforce Unit

**Dr Andrew F Goddard**

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## Executive summary and recommendations

### Introduction

The medical registrar is the senior training grade for future hospital consultants in medicine. Evidence has accumulated over the past 3 years that this group of doctors is being critically pressurised by the increase in hospital admissions and changes to the working environment. Most other hospital doctors characterise medical registrars as the ‘workhorse’ of the hospital, particularly at night when they are usually the senior physician on site. Medical registrars themselves are concerned about their ability to provide safe, high-quality patient care and junior doctors are being put off general medical specialties by the prospect of becoming the medical registrar.

This report is the result of a year’s research by the Royal College of Physicians (RCP) from 2011 to 2012 using e-surveys and face-to-face interviews involving over 2,800 medical registrars throughout England. This research has confirmed worrying trends in the working lives of medical registrars but, more importantly, has allowed solutions to the problems to be identified.

### Improving the effectiveness of the medical registrar to maximise the quality of patient care

There is a wide variation in the working lives of medical registrars throughout the UK. Workload, team-working and interactions with other non-medical teams are the key areas where changes can be made to increase the effectiveness of the medical registrar and thus maximise the quality of patient care. Hospitals should realise the valuable resource they have in medical registrars as senior decision-makers and team leaders. Harnessing the potential of this resource will pay huge dividends in patient care both now and in the future. In the interests of the safe and efficient care of patients the RCP therefore recommends the following:

- 1 Hospitals should undertake an urgent comparative review of the workload of medical registrars and their associated medical teams and modify workforce allocation as indicated.
- 2 Hospitals should then regularly monitor the workload of medical registrars and provide additional resources to support them when the workload prevents safe patient care. Both nighttime and daytime activity must be monitored and rotas changed to optimise staffing throughout the day.
- 3 Hospitals should clearly define the roles expected of medical registrars using the framework laid out in this report. Clarity of purpose is essential for effective team-working.
- 4 Hospitals should reduce the burden of administrative and basic clinical tasks by appropriate redistribution of this work 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.

- 5 Hospitals should utilise electronic tools to facilitate communication and handover between the medical registrar and other members of the team.
- 6 The RCP should work with the NHS to provide guidance on acceptable staffing levels for a given workload, including the optimum number and appropriate grade of junior doctors necessary for a given volume of admissions, case mix, number of inpatients covered, and support provided for other specialties.
- 7 The Department of Health should support research to reassess the '4-hour target' in emergency medicine departments especially with regard to inappropriate admissions and impact on the medical registrar.
- 8 Non-medical specialties should reassess the mechanisms by which patients are referred for medical opinions both in-hours and out-of-hours. Hospitals should ensure that referrals are made to and from appropriately trained staff and to the most appropriate doctor, not always the medical registrar. Referrals to the medical registrar 'by default' should be reassessed.
- 9 Hospitals should ensure that the provision of adequate medical care for perioperative patients is included in the analysis of the workload of the medical registrar.

### Training the future medical consultants to ensure a legacy of high-quality care

Medical registrars and their junior medical colleagues are the future consultants of NHS hospitals. Their current training is far from perfect, particularly with regard to training in general medicine. Changes in working hours and full shift working has led to many doctors not seeing the outcome of their actions and the ward round being too busy to allow an adequate teaching experience. Furthermore, the workload of the medical registrar when on-call reduces the quality of specialty training, and results in dissatisfaction with training and resentment of the role of medical registrar by higher medical trainees. Relatively simple changes in the way training is organised would improve the training experience of medical registrars and their juniors. Therefore, the RCP recommends the following:

- 1 Hospitals should ensure that medical registrars and other trainees routinely attend the post-take review of all patients they have been involved with, including ward referral patients reviewed by registrars when on call.
- 2 Hospitals must ensure that medical registrars are able to maintain the practical skills which they are required to undertake, including specialty skills. Reducing their non-priority workload as described above will help this considerably.
- 3 Hospitals should make clear arrangements to ensure that there are appropriately skilled staff available at all times to perform all clinical procedures that might be required urgently.
- 4 Hospitals should organise rotas and staffing levels to allow core medical trainees to gain experience in the skills needed as a medical registrar. In particular, experience in managing acutely unwell medical patients under the supervision of registrars and consultants should be prioritised.
- 5 The Department of Health should reassess the value of the second year of foundation training for those wishing to specialise in hospital medicine. The benefits of extending core medical training should also be explored.

### Keeping the brightest and best doctors in hospital medicine

Medical registrars are among the brightest and best doctors in the NHS and they are extremely well respected by their peers. However, applications to higher medical training are falling, especially outside London. This is due to a negative perception of the role by more junior trainees, both with regard to



workload and training as outlined above and the feeling of being undervalued and poorly respected by senior hospital staff. Furthermore, the changing demographics of the medical training workforce have resulted in a desire among trainees for a better work–life balance which hospital medicine appears ill equipped to allow. The NHS must adapt to ensure that hospital medicine thrives and does not lose this precious workforce. The RCP therefore recommends the following:

- 1 The RCP should work with other stakeholders, including employers, commissioners and policy makers, to raise the profile and status of internal medicine (ie general medicine) to make it an attractive and appealing specialty to trainees and maintain the morale and commitment of the current workforce.
- 2 Hospitals should designate a clinical lead for internal medicine to champion the medical registrar and provide professional support for the role.
- 3 Hospitals must provide adequate facilities to support the medical registrar’s working environment, including dedicated space to work and rest.
- 4 Local education and training boards must promote flexible training posts for medical registrars to ensure that women are not dissuaded from entering the medical specialties.

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## Abbreviations

A&E	Accident and emergency
AMU	Acute medical unit (preferred term – see also MAU)
CCT	Certificate of completion of training
CCU	Coronary care unit
CSM	Clinical site manager
CT1	Core training/trainee year 1
CT2	Core training/trainee year 2
CMT	Core medical training/trainee
DGH	District general hospital
ECG	Electrocardiography/electrocardiogram
ED	Emergency department (preferred term – see also A&E)
F1	Foundation training/trainee year 1
F2	Foundation training/trainee year 2
GIM	General internal medicine
GP	General practice/practitioner
ICU	Intensive care unit
ITU	Intensive therapy unit
JRCPTB	Joint Royal Colleges of Physicians Training Board
MAU	Medical assessment/admissions unit
MET	Medical emergency team
MWU	Medical Workforce Unit, Royal College of Physicians
Med reg*	Medical registrar
PA	Programmed activities
PTWR	Post-take ward round
RCP	Royal College of Physicians
SHO*	Senior house officer (F2/CT1/CT2 equivalent)
UKFPO	United Kingdom Foundation Programme Office

\*See next page for more detailed definitions.

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## Definitions and terminology

- **Medical registrars (med reg):** specialty (ST3+) and specialist (SpR) doctors registered with the Joint Royal Colleges of Physicians Training Board (JRCPTB) for training in acute and/or general internal medicine. These are doctors in the latter stages of training to become consultants and who are specialising in hospital medicine (as opposed to general practice or surgery).
- **Senior house officers (SHOs):** these are doctors who have completed the first year of foundation training as doctors (F1s) but comprise many different types of trainee. SHOs include trainees in the second year of foundation training (F2s), either of the two years of core medical training (CT1 and CT2), and at any stage of general practice vocational training schemes (GPVTS). These ‘junior’ doctors, together with F1 doctors, are the trainees who work on most hospital medical wards under the supervision of medical registrars and consultants. The term ‘senior house officer’ is technically outdated but remains in common everyday use in hospitals by patients, nurses and other doctors. This report will therefore use the term ‘**SHO-level**’ when referring to any of the three types of trainee outlined above, and the term ‘**CMT**’ when referring specifically to core medical trainees.
- **‘Hospital at night’:** a concept that proposes that the way to achieve effective clinical care when staffing levels are lower out-of-hours is to have one or more multiprofessional teams who, between them, have the full range of skills and competences to meet patients’ immediate needs (see [www.nrls.npsa.nhs.uk/resources/?EntryId45=59820](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59820)).
- **Medical take:** hospital admissions under the care of the medical team over a defined period of time (usually 24 hours).
- **On call:** the time spent by hospital doctors providing out-of-hours care for patients, either as new admissions or those already in hospital. On-call can be from home (common for senior doctors) or as part of a shift rota ‘resident’ in hospital.
- **Internal medicine and general medicine:** the overall terms for describing the diagnoses, treatments and associated work undertaken by hospital physicians (as opposed to general practice or surgery). ‘Acute medicine’ describes the diagnosis and management of ‘general medicine’ patients when they first present to hospital. The training specifications for general medicine and some of acute medicine are described in the general internal medicine curriculum and there is a large overlap between general and acute medicine. These terms are interchangeable and confusing and this can be seen from the quotes from doctors in this report. Therefore, this report will use the phrase ‘**internal medicine**’ in the recommendations to refer to general and acute medicine as experienced by the medical registrar.



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# 1 Defining the role of the medical registrar

*I quite enjoy being the heart of the hospital so to speak, the person who can sort things out, deal with things.*

## Introduction

There is no formal definition of the roles and responsibilities of the medical registrar although there is general consensus in the medical profession that these need to be established.<sup>1</sup> Job descriptions are usually available for individual posts but tend to focus on specialty components and contractual issues.

## The role of the medical registrar

It was clear that many registrars still enjoy aspects of being a medical registrar out-of-hours. However, there was a unanimous feeling that the role had changed in recent years and that the burden of responsibilities was becoming less manageable. This view was consistent throughout all the groups and is supported by findings from preceding surveys of registrars, core medical and foundation year trainees.<sup>2–5</sup> Underpinning much of the discussion on roles was the lack of clarity as to what registrars felt was expected of them, a problem that has been highlighted in many previous studies.<sup>6</sup> The variability in the role from trust to trust combined with a lack of clear guidance has left registrars feeling confused and disenfranchised. The reasons for the change in role are explored in this section and those that follow. Medical registrars in the groups were excited and positive about being given the opportunity to define their role.

When asked what roles they most enjoyed, medical registrars cited leadership and caring for acutely unwell patients more frequently than any others. Other important and valued experiences reported by registrars on call were: the large diversity of clinical problems encountered on call; the unpredictability of the medical take; training more junior members of the team; and working together in a team to achieve a common goal. Most registrars felt that their time out-of-hours was when they had greatest opportunity to affect patient care.

*I enjoy the organisational part of being a medical registrar, particularly I find it satisfying on night shifts where you feel you are making progress, you are working as a team and being the team leader and team support. You can have a really busy night, but you can come out quite satisfied that you have managed to control the take, everyone has been seen and that's incredibly satisfying.*

*When you are shattered at the end of a night shift and you do the morning round and you manage to get involved in a lot of it, the consultant comes in early enough and you go round the MAU and you've worked really hard and you feel able to present and say, 'Here are my sickest patients. Let's see them first.' You feel like you know what is going on and once a few months' back one of the consultants said, 'That was really good, well done' and you feel 10 feet tall, yes that was well done.*

*If someone comes to you saying 'I just do not know what is going on' and you go and pick up one small detail in the history which puts everything else into one diagnosis, that makes you feel really good.*

However, when registrars were asked about their roles, a common response was, 'To be honest I don't know what the role is anymore, I really do not'. Registrars felt confused as to what their most important roles are. This is in part due to the increasing number of roles that they are expected to assume and in part due to the changing role of the consultant and of other members of the medical take team.

*I think you can't actually work out the role of a medical registrar ... they're trying to figure out the consultant's role ...*

Lack of clarity about the registrar's responsibilities made it difficult for them to be assertive and delegate appropriately. They were expected to be 'all things to all people' which they did not feel was realistic and was one of the reasons that they are perceived by other trainees as having a difficult, unsatisfying role.

Registrars would like their roles to be clearly outlined when they start at a new trust. This would provide them with the confidence to speak out when they felt that too much was being asked of them and would empower them to delegate tasks that impact on their ability to carry out their priority roles.

*An induction document for medical registrars coming into the trust saying these are your expected roles, and these are the other equivalent specialists available for you to refer to – so that we have got clear guidance from the start.*

Throughout the focus groups, there was consistency in what medical registrars felt their priority and non-priority roles should be (see Box 1). The ability to fulfil the priority roles was felt to be crucial to patient care and safety.

Most of these roles are covered in more depth later in this report (eg chapter 5, Training and supervision of the medical registrar). The following will be discussed here:

- 1 Leadership and supervision
- 2 Being a senior medical clinical decision-maker
- 3 The changing role of the medical registrar
- 4 Non-priority roles

**Box 1. Roles of the medical registrar.****Priority roles and responsibilities**

- 1 Leadership and supervision
  - a Leadership of the medical take team
  - b Supervision and support to junior medical doctors
  - c Leadership of handover processes
  - d Ensuring appropriate communication and escalation to the medical consultant on call
  - e Communication with senior members of the wider team, including senior nurses and managers
- 2 Being a senior medical clinical decision-maker
  - a Awareness of, and supervision of care for, the most acutely unwell, and/or complex patients with medical problems
  - b Medical specialty clinical support and advice to non-medical specialty teams, including GPs and emergency physicians
- 3 Training
  - a Being proactive in seeking training opportunities and ensuring ongoing professional development
  - b Taking an active role in training junior doctors

**Non-priority roles**

These are roles that should be designated to other less experienced or less skilled members of the team.

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

**1 Leadership and supervision**

Medical registrars unanimously felt that leading the take team was one of the most important roles they fulfil when on-call. This was something they felt was vital to patient safety.

*I think the priority of the medical registrar should be to make sure that the sick patients are appropriately managed and that the juniors are properly supported.*

As part of this leadership role medical registrars felt that they needed to be able to supervise and train junior doctors in the team. This encompassed reviewing their clerkings, making decisions on ongoing management of these patients and teaching them procedures. Medical registrars felt that their effective leadership in handover was particularly important. The role of the registrar in communicating with and escalating problems to the medical consultant on call was seen as key. The interaction between registrar and consultant was explored in depth in all the groups and reflects the enormous impact that both roles have on each other and on patient safety. There was often confusion as to respective leadership roles particularly when those roles varied between in and out-of-hours (see chapters 2 and 5 on teamwork and training).



*I could organise myself better if I knew what the consultant was doing.*

As part of the leadership role, registrars frequently referred to the importance of good communication with the wider medical team, including clinical site practitioners, emergency department (ED) consultants, medical managers etc. The ability to interact and liaise with a variety of different team members, often with different agendas, was felt to be an important part of leading the medical team.

## 2 Being a senior medical clinical decision-maker

As well as leading the take team, medical registrars felt that they fulfilled the important role of a senior clinical decision-maker out-of-hours for the whole trust. Advising non-medical specialties, such as surgical teams, ED and GPs, was seen as a priority. In addition to the obvious benefits for patients, valuable training opportunities arose from this role.

An awareness of, and involvement in, the care of all patients with acute or complex medical problems in a trust out-of-hours was seen as a key role. An overview of the problems in a trust empowers registrars in their decision making and prioritising, hence optimising care for all patients, for example when liaising with intensive care, radiology and clinical site managers.

## 3 The changing role of the medical registrar

Medical registrars gave a number of reasons why their role had changed over recent years. Firstly, there was a perception that the workload of the medical team on call was increasing, and this had a major impact on their role. The number of admissions combined with the pressure from the ED to see patients early (often within 4 hours) made medical registrars feel obliged to clerk patients to reduce waiting times, rather than focus on higher priorities (see chapter 3, Workload).

*It often feels like you are being expected to be all things, both see all the patients, take all the referrals and manage problems.*

*The clerking role we perform could easily be done by other people and would leave us free to manage the take better.*

The increase in the number of admissions has a knock-on effect on the out-of-hours workload in terms of procedures and reviews. If the daytime medical registrar has not been able to meet a heavy workload demand during working hours, the remaining tasks are often delegated to the out-of-hours registrar with consequent effects on patient safety.

*Far too often you can get taken away from your leadership role either by clerking, by reviewing [patients] or by doing procedures, so for example coming on to a night shift and being handed over two lumbar punctures, all the SHOs looking blank and saying they can't do them but that takes you away from leading. If there is a load of patients that need clerking that drags you away from knowing what's going on elsewhere in the hospital.*

Medical registrars often cited the change in competence and professionalism of the juniors on their own team as a reason for a change in their role. This had effects on the overall workload for the team and also the need for registrar review of patients. There was unanimous agreement that reviewing acutely sick

medical patients was and always has been the role of the registrar but that reviewing every admitted patient was a new expectation compared with the role of the registrar previously as reported by senior trainees and consultants. This had arisen due to concern about the competence of more junior members of the team.

This was also seen as a problem in the non-medical specialties. Registrars felt that advising other specialties, though an important priority, had become more challenging as the competence of non-medical specialists in managing medical problems had changed from historical levels.

The role of the registrar is underpinned by the role of the on-call medical consultant. Many registrars felt that the confusion over respective roles was a fundamental reason why the medical registrar's role had changed (see chapter 2 on Teamwork). In many trusts the situation is complicated further by the role of acute medical consultants and other medical consultants involved in admitting medical patients (for example acute geriatricians). Some medical registrars felt disempowered in their leadership role by the increasing consultant presence and their changing role. The 12-hour 7-day consultant presence currently being promoted has clear patient safety benefits but, interestingly, consultant presence was often felt to have a negative impact on a registrar's ability to lead the medical take.

*[If we are] overstaffed with consultants [it leaves] the registrar as very much an SHO in clerking and actually you are just there to process patients rather than making decisions.*

*... the fragmentation of the leadership and more and more the emphasis on the consultant during the day at this trust ... I think, certainly as a new registrar, I find it really difficult to know exactly what my role is. ...*

Therefore a careful balance will need to be struck to ensure that medical registrars are empowered to work at a 'consultant' level whilst at the same time ensuring close supervision by consultants to maximise patient safety.

## 4 Non-priority roles

In all the focus groups registrars gave examples of roles that were not as appropriate for them and better performed by other members of the team. Many felt that they should occasionally perform these roles but that they should not take precedence over their priority tasks. There were numerous examples of where the pressure to take on more of these roles had affected their ability to lead the take, have an overview and be involved with the acutely sick patients within a trust.

One of the most frequently mentioned problems was the amount of time they spent on routine clerking of medical admissions. Many registrars reported that although they were often not actively encouraged to do this by the consultants on call they felt compelled to take on this role. As mentioned earlier, this was in part due to an increasing number of admissions and in part due to the numbers of junior doctors available and changes in their competence and attitudes towards patients and colleagues.

Medical registrars thought it was important to lead by example, including clerking when not busy elsewhere. However, the majority of registrars felt they were unable to maintain an overview of the take when they were also having to clerk. Also frequent interruptions because of their other roles (such as taking telephone calls from GPs or the ED) made it difficult to perform the task efficiently.

Registrars also reported that they were increasingly being asked to become involved in routine bed management decisions, patient transfers and decisions about end-of-life care. Although they felt it was important to be involved in advising on appropriate levels and location of care for critically ill or acutely unwell patients under their care, it was inappropriate to be involved in predictable transfers of stable patients. Furthermore, frustration was expressed that predictable decisions about patient management were not put in place by patients' daytime teams.

*... enormously frustrating because what they're [clinical site managers] wanting you to do is take responsibility for a patient you've not met before. You then have to go and review notes and blood results and it all takes away from other roles.*

In some cases the medical registrars were being expected to do tasks such as cannulation, blood tests, performing ECGs and phoning to request basic tests, which clearly detracted from time spent on higher priorities.

*[At] the current trust I work in, you can't call the radiology registrar or even the radiographer on call, unless it is the medical registrar who does it. You can't do it out-of-hours, you can't call the lab technician for xanthochromia screen unless it is a medical registrar that does it.*

Medical registrars felt that other members of the wider team could take on many of these lower level tasks. Out-of-hours support from nursing staff and allied medical professional, for example, would allow them to focus on their priority roles.

The importance of their role leading a multidisciplinary team out-of-hours was consistently emphasised in all groups. The promotion of this concept within a trust as the most important duty of the medical registrar would then empower them to organise and delegate to their team as appropriate.

## Recommendations

- 1 Hospitals should clearly define the roles expected of medical registrars using the framework laid out in this report. Clarity of purpose is essential for effective team-working.
- 2 Hospitals should reduce the burden of administrative and basic clinical tasks by appropriate redistribution of this work 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.
- 3 The RCP should promote the roles and responsibilities of the medical registrar as laid out in this report to all regions of the UK and work with NHS employers to ensure that these roles are maintained and protected.
- 4 The NHS should work towards a 12-hour 7-day consultant presence in hospitals to promote safe delivery of patient care and maximise the opportunities for learning and leadership by the medical registrar.



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## 2 Teamwork

*... there's a problem needs solving, and again that is quite rewarding, when you are actually leading that team.*

### Introduction

Chapter 1 outlined the roles and responsibilities of the medical registrar, and teamwork was a strong theme throughout. This chapter will focus on the relationships and specific roles medical registrars have within the team.

Many medical registrars commented that the teamwork aspect of their on-calls was key to their enjoyment of the job. Many found it rewarding to lead a team effectively through a difficult or busy shift.

*You might be in real trouble with beds or really busy but everyone kind of battens down the hatches and works together.*

*[On] night shifts being able to be responsible for the whole team, sounds like it is too much responsibility, but actually it is not because you can work together and you can make the system work really well.*

The importance of an effective team structure and teamwork ethic was consistently emphasised by registrars across the country. Unfortunately this appeared to be inconsistently achieved and was felt to have a significant impact on key issues such as patient safety and junior doctors' training, as well as staff morale.

In most deaneries registrars were able to identify a trust that had a particularly good on-call system, and good teamwork and communication were what set these trusts apart. Medical registrars' experiences from these trusts were invaluable in helping to identify solutions to the difficulties faced by other trusts. The main determinants of more successful teamwork were:

- 1 Clear roles and responsibilities within the team structure
  - a The roles played by the consultant
  - b The roles played by junior doctors
  - c The roles played by allied health professionals
- 2 Knowing your team members (eg who they are, levels of experience, training needs)
- 3 Good communication
- 4 Good infrastructure and support services
- 5 Good relationships with hospital management

## 1 Clear roles and responsibilities within the team structure

The majority of medical registrars viewed their team as multidisciplinary. There were differences between different hospitals, and individuals, regarding who constituted members of the medical on-call team.

The 'core' team was most consistently described as including:

- medical staff
  - junior doctors in the on-call team
  - consultants on call
- senior nurses
  - acute medical unit (AMU) lead nurse
  - clinical site managers/bed managers
  - acute response nurses
  - night nurse practitioners.

Examples of other important members of the wider team include:

- allied health professionals, eg rapid response teams
- AMU nurses and care assistants
- ED staff (particularly the lead nurse/coordinator)
- other medical subspecialty on-call registrars, eg cardiology
- other specialty teams, eg general surgery (depending on the 'Hospital at night' set-up)
- hospital managers.

Lack of clarity about the roles and responsibilities of team members was frequently reported in the focus groups. This was contributing to poor teamwork and difficulties for medical registrars in running efficient and effective on-call teams.

Many registrars were not aware of any documentation within their hospitals that outlined the roles and responsibilities of the members of the on-call team. If it exists it is, in general, not easily accessible and rarely covered in hospital inductions. Changes over recent years were felt to have affected the traditional roles of members of the team. These include less experienced senior house officer equivalent grade doctors (SHO level – see Definitions at beginning of report), increased nursing roles, the advent of acute medical consultants, as well as an ever-changing and increasing workload. Medical registrars asked for a 'clear definition of roles and responsibilities of all members of the on-call team'. They felt that if roles were more clearly defined they could lead the team and prioritise their time more effectively. Their job would become more manageable and ultimately patient safety would improve.

Examples of where this clarity had clearly improved the functioning of teams in certain hospitals were given.

*The nurses have very clear roles, like they won't turn their nose up if you ask them to do an ECG or take bloods, and they have dedicated healthcare assistants who put in venflons, ... it leaves everyone [doctors] a bit more free to see the patients.*

*There are clear kind of rules about who the registrar ... should and shouldn't be seeing, ... rather than the registrar being dragged off the unit [AMU].*

*Everybody was given a card at the beginning of the shift where the F1's responsibilities were X, Y, Z, the SHO's ... this is what you do on the shift.*

### The roles played by the consultant

In many AMUs there seemed to be lack of clarity over what the roles of the general medical consultant and acute medical consultants were. The roles were often felt to be determined by the individual consultant, rather than the department, resulting in inconsistency between shifts. This also made it difficult for medical registrars to understand their own role within the team.

*We almost need to have clear roles for general medical consultants, acute medical unit consultants and the registrar, because the crossover between acute medical consultants in the day and the registrar is completely unclear. And so if those two roles were really well defined it would mean that we know what we are doing.*

*It depends on the personality of the registrar and the personality of the consultant ... I think that it's quite nice having that all written down as a guidance ... People know their role.*

Medical registrars thought that the consultants' key roles were providing timely senior reviews of patient management plans as well as supervising and training junior doctors.

*Primary role of the consultant really is to validate and ratify the management plan.*

Medical registrars reported an increased consultant presence during normal working hours (9am–5pm) on most AMUs. This move was generally acknowledged to be a positive one and there were examples where this change has had clear benefits to patient care and medical registrar training.

*... part of getting the skill set of leading the take and delegating, it is harder to do that unless during the day when the consultant is there, they actually actively take on the role in teaching you how to run the take, which some consultants do – they let you lead and ask you to direct the take, as it were, under supervision.*

Medical registrars value consultants extending the hours for post-take reviews until later in the evening, for example 9pm. This extra time for senior patient reviews makes the medical registrar's work more manageable through the evening and into the night, improving patient safety. Additionally, medical registrars felt that 'the consultant being around on a weekend makes a big difference'.

*If you had a ward round in the evening, of everybody that had been clerked, it would dramatically reduce the workload of the registrar.*

*We used to go into a night shift and there would be 18 to 20 reg reviews to do ... but now they have two consultants from 5 to about 8, and some will stay until the handover at 9 which massively cuts down the workload.*



However, where consultants took over the leadership role during the day, this was experienced as a negative effect. Registrars wanted to retain the leadership role during the day and use consultant supervision to develop leadership skills that they would depend on out-of-hours, and when they became consultants. Valuable training opportunities were lost when the medical registrar was effectively demoted to SHO level.

*One of the biggest threats to our training [is that] the consultants basically start taking over a lot of the senior more complicated roles of the registrar. The registrar then gets downgraded to a clerking machine because the consultant reviews all the patients.*

*There isn't a consultant running the take at night, you are just there doing the whole lot and you haven't had that experience in the day.*

If consultants take over leadership during the day, medical registrars then have to regain the respect and seniority they need to perform effectively out-of-hours. Further, if no one person has a clear overview of activities, it causes difficulties when the consultant finishes, leaving the registrar without key information, for example about the sickest patients and the workload. This can be confusing for the on-call team as well as other teams in the hospital.

*... more MAU consultants coming in, so sometimes they are floating in, they are floating out, they are seeing some patients, they are not seeing other patients.*

*Nurses are now answering to the consultants and that's why I think a lot of the day time the communication isn't coming [to us].*

*Then all of a sudden when everyone leaves, you have no idea what's gone on because you haven't got the bleep or you haven't been in that role and then for the next 4 or 5 hours you are it.*

When asked whether a consultant presence was needed at night, medical registrars said that their difficulties at night related to workload and an additional senior decision-maker was not necessarily the solution. Fulfilling this senior role would be manageable if there were sufficient staff to take on the lower priority tasks, so an additional SHO-level doctor at night would be the most valuable addition to the medical team.

*The problem is that you've got shedloads to clerk, you know, the consultant will be there but they would be clerking, you know, what's the point?*

*... just want the on-call consultants on the phone ... [they] don't necessarily have to be in the building.*

*... you know how there's talk of you're more likely to die if you're admitted to hospital over the weekend and the solution is to bring in more consultants over the weekend, do you think that that could be prevented by having say more SHOs on the ground ... SHOs to pick up the problems before they even need to reach up to consultant ... overall that would be a lot cheaper as well.*

Thus, there is a genuine risk of conflict between the roles of the medical registrar and the consultant. Furthermore, although increased presence of consultants has many benefits, there is also a risk that medical registrars will be disempowered and thus unable to develop the skills they will require as

consultants. The working relationship between registrars and consultants in internal medicine needs very careful management to ensure that patient safety is maintained both in the present and in the future.

### The roles played by junior doctors

Over recent years the roles and responsibilities of SHO-level doctors have changed.<sup>7</sup> Senior nursing staff have taken on some of these, whilst others have been escalated up to registrars and consultants (for reasons, see Chapter 6, Training and supervision of junior doctors).

*So this role has changed over time. I remember being an SHO, my registrar was in bed. I would do the central lines and I would do the chest drains and I would do the pleural taps. I wouldn't wake up my registrar. Whereas, now that those skills are lost as an SHO, the registrar has to do it.*

*Yes there has been a significant shift, because when I was a house officer, my SHO used to run the take and the reg used to come down from clinic or wherever, whereas now either the registrar or the consultant runs the take.*

*The jobs that SHOs did once are now just getting escalated up.*

As discussed, medical registrars would value up-to-date documentation from AMUs outlining junior doctors' roles and defining professional standards. Some roles would be shared, for example 'clerking', whereas others can be more individual-specific, for example 'SHO A is responsible for ensuring the PTWR list is ready for the consultant'. Medical registrars emphasised the importance of instilling a good team ethos including maintaining flexibility between roles in response to workload. For example, it was not appropriate for a 'ward cover' SHO to wait in the mess when the wards were quiet if there were patients needing to be clerked.

Medical registrars had often enjoyed working with outstanding SHOs in hospitals across the country. They also recognised that SHO-level doctors are a heterogeneous group with varying levels of experience and capability, and different areas of interest. Despite this they felt that there should be consistency in the basic roles SHO-level doctors were expected to fulfil on call, irrespective of their training pathway. For example, it was inappropriate, and unprofessional, for general practice trainees to opt out of performing procedures on call. Although medical registrars recognised the importance of addressing an individual's training needs, they also thought that junior doctors should provide essential services. An SHO-level doctor performing a lumbar puncture can free the medical registrar to review unwell or complex patients more promptly.

*You get a lot of GP trainees who are junior doctors and they don't seem to be that interested a lot of the time in learning how to do procedures.*

*... even if that is not your life long career ... there are some basic things that you do as a doctor, you know, you always do clerking, you finish it with an impression and plan, and you finish it with that. And that's a given.*

Medical registrars highlighted the increasing difference in experience between SHO-level doctors in different grades and training programmes. Changes in training structure, such as the foundation programme and GP programmes, were felt to have resulted in increasing disparity between different groups of SHOs. In many hospitals, F2s (foundation year 2 doctors), GP trainees and CT2s (core medical

trainees, year 2) will work on the same SHO rota and this can have a significant impact on how the team functions on a given shift. Medical registrars said that rotas should take this into account so that the experience of a team is more balanced from one day to the next, instead of two F2s working one night and two CT2s the next. Some medical registrars questioned whether F2s should be on SHO-level rotas at all, or whether there should be a minimum numbers of months of general medical experience a doctor has to have done before working on an SHO-level rota.

*F2s are on SHO rotas, I know it is not right, because they potentially have done 4 months medicine by that time. I know it used to be like that in the past, but it is entirely different now.*

*Perhaps there could be more structure in the rota ... so it is a bit more equal.*

There was a lot of discussion about increasing inefficiency among junior doctors in performing essential tasks, especially clerking. Although training is important, all junior doctors should have a sense of duty to provide a service. It was felt to be unacceptable for SHO-level doctors to take indefinite amounts of time to clerk a patient, because when junior doctors are not able to meet the demands of 'the take' the medical registrar has to clerk more people. They then do not have time to provide supervision, or review those clerked by the junior doctors, and patient safety is compromised. Medical registrars would value some guidance on how long SHO-level doctors (potentially broken down by grade) should take for an average clerking.

*When I first arrived there, the average clerking time by one of the juniors was 3.5 hours. I can confirm to you at no point in my entire life has it taken me 3.5 hours.*

*... they had not seen enough people and I said they should aim for one an hour and they said that that was too much and I was bullying.*

*On average 5 or 6 [clerkings] from an SHO and 2 or 3 from a house officer, that's not useful. It is not useful for their training, it's not useful for anything ... And you are running around like the mad hatter trying to put out all the fires ...*

*There should be guidelines regarding clerking for the juniors, so that they know on average how many patients they should be clerking per shift.*

## **The roles played by allied health professionals**

Allied health professionals were widely acknowledged by medical registrars as highly valued members of the on-call team. In particular, experienced senior nursing staff were frequently mentioned as important members. When on-call teams included allied health professionals with clear roles they relieved some of the burden of work from the doctors, enabling better use of medical staff's time and ultimately improving patient safety.

*Night nurse practitioners ... I think they're great, I think it takes a huge pressure off the F1s and us as well.*

*... but the hospital at night team was invaluable, because you are working with expert nursing staff and you were able to delegate and divide and conquer.*

*If you have got that sort of support, it makes your life a lot easier and then it means that you have saved 5, 10, 15 minutes and that 15 minutes can be spent on the next sick patient.*

Medical registrars felt non-medical staff were under-utilised by hospitals. In particular they could help by performing more of the basic procedures (eg phlebotomy, electrocardiograms (ECGs)) and administrative tasks, especially out-of-hours when medical staffing is minimal.

*It makes such a massive difference to your night if you have got a clinical support worker that can do the venflons and can do ECGs for you and take the bloods from the admissions and stuff like that, so the SHO is not on the ward all night and I am not the only person clerking admissions. I think support is such an important thing and that would be so much easier to put into place than giving us more doctors.*

*... but then having to spend half an hour or more travelling around the hospital trying to organise a bunch of investigations that the patient quite clearly needs. Now that seems really inefficient and a job that doesn't require a degree in medicine ...*

When asked what would help reduce their unmanageable workload, registrars said:

*I think probably support staff especially in places where there are not as many people on at night ...*

*If we had a phlebotomist who did all the bloods and a pharmacist who could get a detailed drugs history straightaway from GPs ...*

There was little experience of other extended roles for allied health professionals, such as nurses clerking and physician's assistants, and those few experiences seemed to vary greatly so no conclusions could be drawn.

## 2 Knowing your team members

Medical registrars recognised the importance of knowing the members of the team they worked with on call.

*As you get to know your juniors it's much easier because you know what they are capable of.*

*... in terms of being able to do a bit of teaching, in terms of knowing what to expect from your team, in terms of being able to be efficient and delegate and go 'right I know this person can handle this patient they're fine for half an hour. I can go and focus on something else'.*

*Best medical registrar job that I did was with the same SHO for three months at a time ... I did very few on calls without the same SHO by my side all the way through and that made a huge difference.*

Unfortunately since the introduction of working in shift patterns there is less continuity of staffing within medical teams.

*If you're familiar with your nurses as well as your doctors you really can just work as a team. And for some reason I just didn't feel that in a lot of hospitals.*

*You are never on call with the same people. You never have a chance to build up a rapport.*

*You get to know them over the course of three nights. So on the first night you have never met any of them, or met them only in passing in the corridor, by night two you know them a bit better, by night three and four you are happy with them. But every time I'm on call I'm on call with someone different. And that's the problem.*

Medical registrars gave several examples of how the lack of continuity among junior doctors has affected the on-call team. They found it difficult to effectively lead and supervise a team when they did not know the capabilities or training needs of their junior staff. In that situation, inefficiencies result. It is difficult to delegate safely until you are aware of an individual's capabilities, especially as the experience of SHO-level doctors can vary so greatly. If your junior team is constantly changing it is difficult to identify their unmet training needs and address them. Similarly some medical registrars admitted that they were less motivated to invest time teaching junior doctors during a busy on-call if they did not know them and were unlikely to work with them regularly. They perceived this attitude among some consultants as well.

*It actually takes until the middle of your third night out of four, to actually be certain whether the SHO you have got really is any good or not.*

*... and the thing is the first time you work with someone, half of the battle is working out what they know and what they don't know and how good they are with patients and how much you can trust of what they're presenting being the whole story.*

*We don't know who the juniors are so we feel less responsible for their training.*

*... and the consultants often don't know who the reg is. I don't know the name of the consultant I'm on call with half the time. No wonder they feel less responsible for our training – it's that lack of team environment.*

There is a perception that junior doctors are less motivated to work hard when their team members change from one shift to the next.

*They're not getting that motivation – 'I know if I work really hard ... my reg will go out of their way they will find me something fun to do' – and that's kind of gone.*

*When I was an SHO, what I would do is go on take for my team ... I wanted to be seen to be really good at managing patients.*

More importantly, from a patient safety perspective, medical registrars had genuine concerns that they are frequently not made aware when they have 'trainees in difficulty' under their supervision. This is discussed further in chapter 6, Training and supervision of junior doctors.



### 3 Good communication

Medical registrars discussed key features of a good handover process. These were consistent with the RCP handover toolkit<sup>8</sup> and therefore not explored in detail within this report. It is worth noting, however, that medical registrars consistently emphasised the importance of effective formal handover processes for patient safety, teamwork and training. They felt that formal handovers should occur at least twice daily, which is not happening in many trusts. They found handovers particularly useful when they were multidisciplinary, in particular involving senior nursing staff, and when evening handovers included representatives from the other main specialties.

*... compulsory structured handover morning and night so that everybody knows what's going on and we know where the problems are and we can allocate the team.*

*We want protected handover times and not just haphazard handovers, where people are handing over individually.*

*Sometimes what the senior nursing staff are able to help us with is absolutely invaluable, but you don't always get the chance to spend time with them to talk about it.*

Medical registrars frequently commented that they lose track of who is on their team at any one time. Many found this a real challenge to leading an effective team. The problem particularly occurs if there is no formal handover meeting at times when major staffing changes occur, or when individuals start shifts at a different time from the majority of the team (eg twilight shifts). Few hospitals have formal processes in place to ensure that junior doctors make contact with the team leader (usually the medical registrar) at the beginning and end of each shift. This lack of communication exacerbates the difficulties medical registrars face when they do not have continuity of junior doctors on their teams. Poor communication from management, eg not notifying the registrar about staff sickness or gaps in rotas, adds to the confusion.

*Unwieldy number of juniors starting at different times and [you] don't know who they are and their competences.*

*As a med reg you're not being told what's going on, you're not aware of who's coming in, you haven't got that information that allows you to have that pivotal role.*

*In some places you know the people who are working with you from 9 until 10 o'clock, you know when your on-call finishes. In other places you don't know who's coming, who's going, who's seeing what and therefore it is very difficult at times to know how to manage it.*

Medical registrars thought that regular formal handovers, with new team members always making contact with the team leader at the start and end of shifts, would have several benefits. In addition to handing over patients, it provides opportunities to communicate on key issues such as workload and staffing, to distribute jobs and to clarify responsibilities. It is also an opportunity for the team leader to explore the junior doctor's previous medical experience and training needs and judge the level of supervision they may require.

*If you have got the initial good handover at 9 o'clock and you have actually seen who you are on with, you will have an idea as to where the sick patients are ...*

*I think it would be really useful, if it was part of everyone's responsibility at the beginning of the shift to find their team leader and if that is done brilliant, ... because it is very difficult to coordinate the team if you don't know who they are.*

*One of the things that has been suggested, and is very much in its infancy, is a kind of training contract, so that at the start of every shift the consultant that is on would do a five-minute session with the team for the day, ... and agree some form of learning need for each trainee for that shift.*

Medical registrars find it difficult to lead the take effectively when communication from management is poor, for example regarding escalation policies or staffing issues. Additionally, problems are caused when critical information is being fed through different members of the team (eg referrals), especially when there is no easily accessible information database for them to refer to.

*I find management of the take very difficult to do when you are expected to do it without knowing what's going on in the hospital. So you would have the responsibility, but you are not given the information you need to fulfil that responsibility because nurses take referrals, because consultants are dealing with half of the take and then you are dealing with the other half.*

*You are given that responsibility of the management of the take, which you think is your responsibility yet you don't have the resources to do that, because you don't have a vision of what's going on, you do not take the referrals as other consultants and other people [have been] dealing with things on the day, you have no idea.*

There were several examples of information technology being used with great effect to improve communication within AMUs. In particular, some trusts have very well designed computerised admissions lists. Medical registrars identified some desired features for 'medical admissions lists':

- live shared database: ie interactive and accessible from multiple points in the hospital in real time
- referral details: time of referral, referral source and who accepted the referral
- patient information: relevant clinical information, patient alerts, early warning system (EWS) score (or equivalent), time of arrival in hospital and patient location (kept up-to-date)
- patient care: name, grade and contact details of clerking doctor; time of medical assessment
- follow-up: outstanding results, investigations and specialty reviews, senior review or PTWR status, appropriate specialty ward
- inpatient referrals: facility to register inpatient referrals/reviews, their outcomes, medical consultant review status.

*... one thing that we really want to put in [to the guideline] is that there is no way it is acceptable for the take list to be a piece of paper. It needs to be a computerised list.*

*[We need an] electronic system with clear concise handover information on it that is accessible for every staff member ...*

*In some hospitals (my current one) the medical registrar holds a book and you walk around with a massive book that you basically have to write your referrals down so there's no link; there's no sense, so if someone else has taken a referral, say, your consultant spoke to a GP, unless they can get hold of you and if you're getting bleeped left, right and centre they may not get hold of you for about half an hour ...*

*In [hospital x] they have got a very very simple system on the computer. It has the time when the phone call or A&E referral was taken and it has a bit of blurb about the patient's presenting complaint. It will say A&E referral so it will have the EWS or whatever scoring system they have. So that even though you haven't taken that call, you can look at the system, see where the sick patients are, get your team, you can congregate around the computer for 10 seconds and say you go there, you go there, you go there, I am going to catch you up in 20 minutes. And you can really be a great leader and it is incredibly simple.*

Medical registrars thought it was essential for each member of the team to have a personal communication device and for contact details to be readily available to the whole team each shift. There are a few hospitals across the country where on-call doctors are not routinely provided with bleeps, or alternative communication devices, making communication a real barrier to safe and efficient patient care. Mobile phones have been introduced as a generally preferred alternative to bleeps in several hospitals (as long as good telephone reception is ensured in all clinical areas).

#### 4 Good infrastructure and support services

Medical registrars value proximity between the AMU, ED and acute services such as radiology. Significant distances pose unnecessary barriers to safe and efficient patient care. The introduction of AMUs in the majority of hospitals in England was acknowledged as a positive change in acute care; they are greatly missed in the few hospitals that do not have one.

*The problem we have is that MAU and A&E are actually quite a long way apart. It meant you often spent quite a lot of time dashing between the two just to find out what was going on.*

*When they moved to the new hospital they decided not to have an MAU. So the medics ... have half of A&E majors to see their patients, and from there they go to various medical wards and short-stay wards, and 'help!' the hospital is huge and sprawling.*

Essential computer software or paperwork required to process medical patients is often not available in EDs leading to inefficiencies. The lack of discharge forms or discharge software in EDs is perceived to be a deterrent to discharge in some hospitals where 'it is easier to get them through MAU and then discharge them'. Medical registrars acknowledged that there were often difficulties accessing certain diagnostic services out-of-hours.

*Logistical support, access to that, access to radiology, all of these things. You need to fight to get a CT scan out of ours. It is depressing.*

Information about the availability of such services could be hard to find, especially those that helped avoid admissions, such as specialty rapid access clinics. Such information would be a valuable addition to the induction process and should be readily available to them on call.

*Having an induction process ... where we are informed of all the alternatives to admission for patients to medicine including the rapid access chest pain clinic, gastro ... .*

*How many times have people sat down and said, 'These are the other things that we have to avoid admission ... there's a TIA service ... and this is how you can find out the details to refer' – because I've never had that and actually that would really help.*

## 5 Good relationships with hospital management

Patient safety relies on good leadership and clinical skills, but also on sound processes and services. In some trusts medical registrars had opportunities to be involved in key management issues, but in many trusts good communication with management had not been established. There were examples of poor information flow on individual shifts as well as at a wider directorate and trust level. Medical registrars were frequently not involved in the development of hospital policies that directly affected them. Medical registrars felt that they were often in a good position to identify problems and solutions within the hospital but were rarely consulted.<sup>9</sup>

Solutions were explored and examples of good practice shared. Some trusts had regular management meetings to which registrars were invited, which established a clear communication link with management.

*... registrars should have the opportunity on a regular basis, monthly, or two monthly, or whatever, to feed back to management and senior clinicians within the hospital. Because when you work on the ground you know how it works, you know what the problems are. And I think that puts us in a fairly good position to be able to comment and feed back.*

One trust had an excellent example of how to improve communication and relationships between management and clinicians with a daily management meeting:

*The entire medical department in a large tertiary hospital had a morning meeting, which was led by the clinical director of medicine. All the juniors and whichever consultants were on the take that day turned up and there was a five-minute handover. The role of it was to highlight issues – not patient-specific issues – but what had gone wrong, in order for the hospital at every level, both at consultant level and senior management clinical level, to be aware of that, and it worked phenomenally well. They absolutely nipped things in the bud. If there was a particular ward that was causing problems, they went in before it became a [larger] problem. The early intervention at not just consultant level but at senior clinical management level meant things were sorted so much sooner.*

## Recommendations

- 1 Hospitals should ensure that work patterns and rotas are developed which promote a team ethos and a sense of joint ownership of patients by all members of the team.
- 2 Hospitals and consultants should work together to ensure sufficient consultant time is made available so that the medical registrar can be supported and empowered in their leadership role.
- 3 Hospitals should have clear documentation as to the roles of all members of the on-call medical team including consultants. These should be developed in consultation with clinicians, should be easily accessible, regularly reviewed and updated, and include professional standards.

- 4 Basic clinical procedures and administrative tasks should be performed by allied health professionals and development of such posts should be a priority.
- 5 Handover should be formalised, take place twice daily, be multidisciplinary, and be implemented with reference to the RCP handover toolkit. Members of the on-call team who do not start shifts at formal handover times should be responsible for making formal contact with their team leader (usually the medical registrar).
- 6 Formal contact with the team leader, either at handover or on an individual basis, should be used as an opportunity for:
  - a clinical handover
  - b communicating on non-clinical issues impacting on the shift, eg beds available, staffing
  - c exchanging contact details, eg bleep numbers
  - d identifying specific training needs and assessing levels of supervision required by individual junior doctors on the team.
- 7 Hospitals should utilise electronic tools to facilitate communication and handover between the medical registrar and other members of the team.
- 8 Communication between hospital management and the medical registrars should be maximised; for example, by the appointment of a medical registrar representative for each hospital or trust; representation by junior doctors on appropriate committees; and consultation with medical registrars on policies and services which involve them, and in particular those that will impact directly on their roles and responsibilities. There should be regular formal opportunities for medical registrars to feed back to hospital trust management to improve patient care and working practices.



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## 3 Workload

*We are already working 200% of our capacity; we haven't got enough flexibility. The biggest problem is massive workload.*

### Introduction

The most common reason cited by junior doctors for not wanting to be a medical registrar is the excessive workload.<sup>2</sup> This has been described as being higher than for registrars in other specialties and associated with stress. 25% of medical registrars described their workload as unmanageable and 66% described it as heavy,<sup>2</sup> so the post has become less desirable in terms of work–life balance, which deters junior doctors from applying to medical registrar posts.

The current workforce policy is for a reduction in the number of medical registrar training numbers and an increase in GP trainees.<sup>10</sup> There is unlikely to be any increase in the number of hours junior doctors can work in the UK in the near future, but there has been a steady increase in hospital admissions year on year in the past decade. All of these factors will result in an increasing workload for the medical registrar.

The vast majority of medical registrars believed that the volume and intensity of their workload while on call was often overwhelming, and that the pressures and expectations of the medical registrar have been increasing over time.

The increased workload was attributed to:

- 1 Expanding roles and responsibilities
- 2 Medical admissions: increasing demand
- 3 Shift patterns and rota design
- 4 Medical support to other teams
- 5 Inadequate rest periods
- 6 Staffing levels

### 1 Expanding roles and responsibilities

One of the main problems cited revolved around a steady accumulation of roles. Many of these are discussed in more detail in chapter 1, The role of the medical registrar. Medical registrars are regarded as competent senior decision-makers and are therefore the default point of contact and communication for

many teams, protocols and procedures. These roles individually are perhaps not unreasonable or inappropriate, but to expect one medical registrar to perform all of them is unrealistic and potentially detrimental to patient care and safety.

*Other things have been piled on to the registrar role over the past 10 years, so the registrar is now on the MET team, on the arrest team, on the A&E bleep, on the ITU, and has to see routine patients, ill patients on the ward and the patients in A&E.*

*... they want to get the most senior person. So the A&E people say, well you know, we've had some problems recently, so we want the medical registrar to see all the patients and then somebody else says, we're going to have this medical emergency team and ... we want the medical registrar to do that and then someone else will come along and say, well the cardiology registrar is off site, so if there is an acute problem on CCU then the medical registrar needs to go there. And that's the thing, none of them are unreasonable in isolation, it's just when you put all of those into a job description, it is unreasonable.*

There is no gatekeeper monitoring what is expected of the medical registrar out-of-hours. Registrars felt that there should be an assessment of their workload in each hospital and there should be adequate staffing to ensure that this could be delivered safely. Also, appropriate reallocation of specific roles to other members of the hospital team should be considered.

In view of the expanding roles and workload, protocols that escalate to the medical registrar should be rationalised. There should be registrar representation when decisions are made regarding protocols that require default escalation to the on-call medical registrar to ensure manageability and patient safety. Medical registrars would like to be authorised to prioritise their most critical roles.

## 2 Medical admissions: increasing demand

There was a widely held perception that the medical take is becoming busier with increasing numbers of admissions and that medical teams are struggling to keep up with the workload. Many registrars were concerned that, as a direct consequence of this, they were unable to provide the type of care they would have liked to deliver.

*I had 30 patients to review. It was a ridiculous number. I was unsafe ... I can put my hands up. I think the clerkings were not good enough because people were just wanting to get through the clerkings they were handing over. I think the reviews were not the best I could do. I think that's because of the work. I think medicine is unsafe at the moment.*

Some of the increasing demand was thought to be related to other teams being reluctant to accept patients under their care (as discussed in chapter 4, Interactions with other teams), and medicine providing the default option. Many perceived that general medicine has become the dumping ground of the hospital and a means for other teams to deflect their workload. Unfortunately, this perception has an extremely negative impact on the morale of medical registrars.

*... the medical reg often does get used as the dumping ground for when there are other jobs that other people don't want to do.*

*We are not lackeys for other specialties, which I think is what irritates us.*

Many thought that junior doctors were becoming less experienced and requiring more guidance with clinical management of patients and procedural skills,<sup>7,11</sup> which is increasing the demand on medical registrars (see chapter 5, Training and supervision of junior doctors).

*I increasingly find I am a technician. You know if there is a lumbar puncture to do or a chest drain, no one else can do it, it is only you who is the one that is going to do it.*

Many believed that 4-hour targets in the ED and a lack of engagement by senior ED staff meant that fewer patients were fully assessed and managed at the front door of the hospital. It was also suggested that it was far easier in practice to admit patients than to discharge them from the ED.

*I did my first medical reg on call seven years ago or something like that and it's changed enormously I think in terms of what's expected of you and the main thing that I've noticed has been the volume. You know the fact that anyone feels that they can call you for seemingly anything and that includes providing advice for people who may go home from A&E because the A&E SHOs will defer to you because there isn't senior support there.*

*Even the [ED] consultants will refer patients that don't need to be admitted and a lot of that is driven by having to move people through quickly, which is completely counterintuitive, because it is going to cost more money in the long run, the fact they have been admitted to a medical unit.*

*Unfortunately, they don't actually have discharge summary forms in A&E, you just physically can't do it; it is easier to get them through MAU and then discharge them.*

Many medical registrars would like to be able to increase their role in providing a medical opinion in the ED that would help facilitate discharges but because of multiple demands on them throughout the hospital, often they are unable to do this and patients are unnecessarily admitted to hospital. Even when they are able to provide this 'advisory' service, the registrar may then be left with all the responsibility, including the discharge paperwork and other administrative tasks.

*You might have the opportunity to go round to A&E to see the patient and to say, 'Well actually I think that they can go home, I don't think you need to keep them in', but you never have time to do that. It is easier to say, 'Well just put them on the list'.*

*Even if you do see them, they still assume that it's your responsibility to organise their discharge, because I have been round multiple times to try prevent admissions and then they'll tell me that I have to sit and do the electronic discharge summary for the patient that I've advised them on.*

It was also acknowledged that the complexity of the patients admitted to the general medical take is increasing with frail, elderly patients with multiple comorbidities making up a large proportion. This in turn places more demand on the initial assessment and management.

*Volume is going to be increased over the next however many years, because we are getting older and people are living longer, yet we are not set up to handle that.*

Many reported that tasks that could be performed during the day are often passed on to the out-of-hours team. This included decision-making about escalation of care, which the responsible team should

do during normal working hours when relatives are available. Some trusts have tackled this problem by completing care escalation plan sheets for all their inpatients. Some non-urgent procedures, for example, lumbar punctures and diagnostic pleural aspirates, are also delayed to out-of-hours. This increases the workload out-of-hours, can cause delays in discharge, and potentially means a procedure is carried out under suboptimal conditions.

*[You may be seeing] a patient for the very first time, without knowing the background, without knowing the family circumstances, without knowing the social circumstances, without knowing the patient's own wishes, who is moribund and can't respond to you. I think this has to be decided during the daytime when all the facts and information are available to make a sensible decision, which wouldn't then put you in a difficult situation later on.*

*... in [hospital x], they have at the front of every patient's chart a care escalation plan sheet rather than just resusc, which tells you whether they are for inotropes, intravenous or enteral feeding and all that. It is a big thing which makes your life easier when it's 2 o'clock in the middle of the night.*

### 3 Shift patterns and rota design

During the focus groups, medical registrars frequently reflected on staffing patterns and rota design. It is evident that there is a wide range of different shift and rota patterns across the country. Hospitals have different constraints to deal with depending on their size, number of sites, specialty on-call services and the numbers of junior doctors of different grades available. There also seem to be some personal preferences regarding rota styles. It is therefore not possible to recommend a specific rota design to 'fit all'. Some common concerns and general principles for effective rota design are discussed below.

The most common concerns were that medical divisions were generally understaffed out-of-hours and that staffing was poorly matched to workload. The period between approximately 4pm and 11pm was perceived to be the busiest period on most AMUs. The resulting backlog due to inadequate staffing at these times impacted on the night team who felt they were catching up all night. Without this backlog, they felt that night shifts would be much more manageable.

*During the working day it is very well staffed, it is the 5 to 10 period where it is under staffed.*

*The absolute key thing that you need to be auditing is the number handed over on the night take because it tells you whether your daytime staffing is right.*

*It is not unusual to get 12, 13, 14, 20 patients handed over when you are on a night shift.*

Extra evening staff or twilight shifts were felt to be an effective way to improve staffing during the busiest period of the day as well.

*I think we should be looking at twilight working shifts in acute medicine as well. And the reason why I say that is because we see, and I am sure that all of you see this, that the majority of the take actually comes in after 12 o'clock and we have at least 3 or 4 doctors already sitting there between 9 to 12 doing nothing.*

*Different shifts can help, like twilight shifts, and having more doctors up until about two o'clock in the morning and then less after that.*

*Increasing the junior staff at those peak hours, which will obviously be 6 in the evening until 11, would help.*

Fairly consistently, the 'take team' had staff shortages, with insufficient numbers of junior doctors to clerk. This results in long delays for medical patients waiting to be assessed, raising patient safety concerns. Also, a frequent consequence is that unnecessary admissions, as patients, often elderly, are not being assessed until the night.

*The problem though is the volume of patients, that's what most of us run up against, that you arrive to a night shift and you have got 20 patients or you have got 10 or 15 patients waiting to be clerked and then get lots that they want you to review ... you need more people physically there to clerk.*

*And there's a fair proportion of those people that, if you had seen them at 6 o'clock in the evening, could have gone home.*

*We have one SHO and one F1 with us and if we [medical registrars] weren't clerking patients overnight, no one would get clerked.*

There were not enough medical registrar numbers in the average hospital to provide two registrars on call. However, if there had been adequate junior doctor and allied health professional staffing, and if their roles were better clarified and prioritised, then the workload might become feasible for one medical registrar anyway. If hospitals had sufficient numbers to double up staffing for limited numbers of hours per week then weekend days were identified as the most beneficial time to do this. Ideally, the best way to split workload would be one registrar to cover admissions, including ED, and the second registrar to cover the inpatients, including referrals from other specialties.

*It would be great if there were two [medical registrars] but that is never going to happen.*

*Certainly weekends I would have thought ... are probably more stressful than the night shift ... I think an extra reg on 9 until 5 on a Saturday and Sunday makes a huge difference ...*

Medical registrars across the country are experiencing gaps on their rotas and have concerns about how this is being dealt with in some hospitals. There is pressure on many of them to increase the frequency of their on-calls to fill these gaps, which may have a detrimental effect on their training. This is because the quality of training delivered on call is felt to be poor and increased time on call results in less specialty training time.

Also, most rotas run on minimal staffing levels and out-of-hours medical teams feel stretched, often to breaking point, on the average shift. This does not leave any slack in the system for shifts that are busier than average or to deal with sickness or gaps left unfilled in rotas, raising patient safety concerns.



## 4 Medical support to other teams

A significant proportion of the increasing workload of the medical registrar arose from the need to provide medical support to other teams. These issues will be discussed in chapter 4.

## 5 Inadequate rest periods

The majority of medical registrars reported that it is often impossible to have adequate rest periods during on-call shifts. This has the potential to impact negatively on patient care and staff morale. Many registrars commented that because they were expected to work at full capacity for 12- to 13-hour shifts, often performing routine tasks, there was a danger that they would not be able to perform optimally when there was a real medical emergency. Registrars would value rest facilities and the opportunity to take breaks overnight.

*I don't think any of us get any breaks.*

*If you look at the way they do it on ITU, they are much better supported ... the general mindset of ITU consultants is if the registrar is not that busy, you should go and have 2 hours' sleep, because there will be a crisis at some point, in which you need to be focused and sharp and on the ball ... not that we are going to run them ragged around MAU, the ward, until they collapse and then expect them to rise like a phoenix from the ashes at 8 in the morning and deal with some massive disaster.*

## 6 Staffing levels

Many registrars wanted guidance on acceptable staffing levels for a given workload, including the number and appropriate grade of junior doctors required for a given volume of admissions, number of inpatients covered and support provided for other specialties.

*There has to be some kind of general guidance to how many people safely a team can clerk. So if there is a team of two and you know the take is exactly 30, 35 patients every night, you cannot deal with it. There should be something that says, 8 to 10 patients per person can be clerked in 12 hours. More than that it is actually unsafe.*

*It is the acuity of patients – you could have 8 patients with DVT, you could finish them off in an hour and a half. If you have got 8 patients who are all dying with multi-system failure, that's not manageable.*

## Recommendations

- 1 Hospitals should undertake an urgent comparative review of the workload of medical registrars and their associated medical teams and modify workforce allocation as indicated.
- 2 Hospitals should then regularly monitor the workload of medical registrars and provide additional resources to support them when the workload prevents safe patient care. Both nighttime and daytime activity must be monitored and rotas changed to optimise staffing throughout the day. There should be a named individual, ideally medically trained, responsible for such monitoring.
- 3 Regular audits of the workload being handed over to night teams should be carried out and daytime staffing adjusted accordingly.

- 4 Hospitals should enable medical registrars to prioritise providing a specialist opinion by freeing them from lower priority roles. This will improve patient care and avoid unnecessary admissions.
- 5 The RCP should work with the NHS to provide guidance on acceptable staffing levels for a given workload, including the optimum number and appropriate grade of junior doctors necessary for a given volume of admissions, case mix, number of inpatients covered and support provided for other specialties.
- 6 Hospitals should ensure that the provision of adequate medical care for perioperative patients is included in the analysis of the workload of the medical registrar.
- 7 The Department of Health should support research to reassess the '4-hour' target in emergency medicine departments especially with regard to inappropriate admissions and impact on the medical registrar.

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## 4 Interactions with other teams

*I think supporting other specialties at nighttime is quite good ... that's very satisfying to be able to help everyone out to sort out their sick patients as well as your own, when you have time to do it.*

### Introduction

The vast majority of medical registrars in the focus groups believed that providing support for other specialty teams dealing with acute medical problems within the hospital is crucial to patient safety. Most registrars also find this an enjoyable and rewarding role, provided they are adequately resourced. Equally, medical registrars acknowledged that they value the support of other teams, in particular in the emergency department and other medical specialties.

*... especially doing nights you feel very much depended upon and that's a nice feeling when you feel you can offer help, offer advice, especially obs and gynae, surgical teams.*

*It makes a massive difference to your working life out-of-hours if you can have a respectful working relationship with your intensive care team, your surgical team, your A&E team.*

There were, however, a number of important areas in which medical registrars believed patient care could be improved and the role of the medical registrar could be optimised:

- 1 The medical take: referrals and admissions
- 2 The emergency department: interactions and expectations
- 3 Non-medical specialties: interactions and expectations
- 4 Medical specialties: interactions and expectations
- 5 'Hospital at night': leading the team

### 1 The medical take: referrals and admissions

Most registrars felt that the general medical take had become a default referral pathway for a wide variety of problems that are not primarily acute or general medicine. Many registrars thought that their specialty opinion was often not fully respected. Also, they often found it difficult to say no, even if they believed that they were not the most appropriate specialist to review a patient, or that a patient would be more appropriately managed under another specialty team. There was a general feeling that due to an overriding sense of professionalism, medical teams often felt obliged to care for patients outside their area of expertise, out of concern for what the alternative care options might be.

*Everyone just expects us to say yes to everything because we are the sort of people that cannot let a person deteriorate on the ward and we do have a duty of care and we take the referrals from A&E because orthopaedics will not take them, neurosurgery will not take them.*

The majority of medical registrars thought that a document produced by each trust clarifying which primary presenting complaints should be admitted under which specialty team would be extremely valuable and improve efficiency. This would be particularly helpful for 'grey' cases, which frequently cause debate between teams, for example patients with acute pancreatitis, head injuries, and fractures or joint problems leading to immobility.

*There needs to be a list produced from a lead in each specialty of what conditions are distinctly theirs, so that when somebody comes in that is already known to have a surgical problem, they will go direct to the surgeons, not be passed through us, and that might reduce our take considerably.*

There were a number of concerns about the process of receiving referrals, with wide variations in practice both regionally and locally. In some trusts, there was no clinically trained person involved in the referral process, for example, names were added to an electronic or paper list in ED, or an administrator added GP referrals to a list in the AMU. Consequently, important clinical information was often not communicated and patients might be admitted under an inappropriate specialty team. In other trusts, where there was clinical involvement, multiple members of the team often took referrals simultaneously. This caused difficulties in communication and coordination, and may potentially give rise to errors. Registrars reported that even when there was a clinical handover, the clinical information given to the medical team was often inadequate.

*I've worked in two places where ... the GP rings up, goes to a non-medical professional ... and they just write the name down in a book and then they're 'to come in' (TCI) so there's absolutely no interaction between GP and medical team which I think is appalling.*

*I know in certain trusts you now have different members of the team taking referrals, so registrars don't necessarily know what's going on everywhere.*

Medical registrars all agreed that a clear referral process should exist. An open access list that was not actively managed by the medical team was not felt to be appropriate (see chapter 2, Teamwork, for more on medical take lists). It was also agreed that referrals should be taken by somebody with adequate clinical experience (senior nurse, SHO or registrar) and not an administrator. However, there was no clear consensus on precisely how the referral process should work and who should be involved.

Several registrars believed that if they were to take referrals directly, this would enable them to have a better overview of the medical take, give advice to improve patient care prior to being seen by a medical doctor, and help avoid some admissions, particularly from ED. On the other hand, others pointed out that they would then spend so much time on the telephone, they would not be able to fulfil their clinical priorities.

*I like taking referrals because I like to have an overview of what's coming in.*

*I like to know what A&E are referring because we had very inappropriate, very, very, very inappropriate referrals from A&E ... whereas you know we admit fractures ... we've admitted triple As that are leaking and it's like enough now.*

*I don't know how time-wise it works but if you've only got one medical registrar in hospital taking all the referrals, plus trying to lead, plus trying to do the orthopaedic wards, plus seeing the sick patients, then you don't actually have time, and if you are the person who is seeing the sickest patients, then to break away from those patients to take mundane 'I've got a patients with COPD and they've had meds whatever but they need to stay overnight' or something to that effect, it's not a very good use of our time.*

Many registrars had good experiences of senior AMU nurses and SHO-level doctors taking referrals, and several thought this was good training for such doctors. However, it was also acknowledged that these doctors would then have less time for clerking. Some registrars reported that in their experience in different systems, very few admissions from primary care were actually prevented by discussing them with a senior doctor.

*The MAU sister was about the only person that we thought, besides a member of medical team, could do it.*

*The SHO used to be on the phone to A&E all morning, you were on the phone to the GPs all morning and no-one was seeing any of the patients and it was just insane.*

*I worked the first half of the year, where they had the usual system where the medical registrar takes all the GP calls and the SHOs took all of the A&E phone calls and then they changed it so that the nurse practitioners took all of the GP calls and I have to say you found we had no real increase in the number of GP admissions. They almost all were appropriate or they were almost all things you would probably have brought in ... it was a lot better for the medical registrar because you could actually then do a day managing the take and managing your juniors and make sure everybody was getting seen.*

If registrars are not taking referrals directly, there was general agreement that there should be a clear escalation process to the medical registrar for patients who are acutely unwell, have complex problems, are potentially dischargeable, or where the appropriateness of medical specialty admission is unclear.

## 2 The emergency department: interactions and expectations

Several medical registrars reported a good working relationship with their colleagues in the ED in particular hospitals. However, there were a number of cases of patients allegedly not being adequately assessed or managed in the ED before being referred to the general medical take. These cases, some of which involved a lack of basic investigations such as venepuncture, ECG recording and cardiac monitoring, raise significant patient safety concerns. Many registrars expressed concern that often, due to 4-hour targets, patients were transferred out of the ED 'unsorted' and then experience inappropriately long waits in the AMU because the medical team are unaware of the outstanding issues and busy dealing with other admissions.

*There is such a level of uncertainty about what is going on with those people [referred by ED], because they haven't actually been properly, well they have been triaged, but they haven't been properly assessed and managed.*

*So in our particular A&E then the clinical aid doesn't come and do their blood, the nurse doesn't come and do their ECG ... they've been left there for such a long time, and we don't have enough time to*



*actually go down to A&E just to see because we have priorities looking after and reviewing patients. And it just compromises the patient's care.*

Many registrars reported an increasing tendency for junior doctors in the ED to directly involve the medical registrar, rather than their own senior doctors, in decision-making about emergency care and potential discharges. In some cases this seemed an appropriate use of the medical registrar's time, but in many cases it was clear that decisions should have been made by ED seniors. Inappropriate referrals such as these result in an unnecessary burden on the medical registrar's workload.

*They consider the medical registrar as their senior, instead of going to the A&E registrar.*

*They told me that there's no middle grade after ... midnight so therefore I was the most senior in A&E for all A&E patients, as med reg as well ... I said 'No, that's not my contract. I'm not trained in A&E. I've never done A&E in my life. I've got no intention of doing it. Medical patients can be discussed with me and referred in the normal way. I'm not staying in A&E to supervise the juniors – that's not my role' and that goes on quite a lot.*

The majority of registrars believed that the emergency/acute care interface could be significantly improved. Clear processes should be established to prioritise patient care and make the best of available staff and resources. One of the key issues raised in the focus groups related to the availability of senior clinical decision-makers in the ED and how this could be improved, particularly at night. Many postulated the need to instil a greater sense of ownership and responsibility for patients among the ED team. Several registrars described a need for improved medical training for ED teams or better integration of emergency and acute medical staff. A few registrars had experience of some practical ways of reducing duplication and improving integration including using joint paperwork and rotating junior doctors between ED and AMU.

*I think maybe just encouraging ... more decision making in A&E and changing the way that A&E practise ...*

*... but also ED staffing at night, means that if they are very junior ... it means that every CT head for instance that they would have to go up through a medical registrar again, so I would say that a more senior ED doctor should be available at all hours.*

*If you want A&E to sort out medical patients better than they are, then you either have to train A&E in medicine better, or you have to integrate medicine with A&E, one of those two things really.*

### 3 Non-medical specialties: interactions and expectations

The vast majority of medical registrars reported that a significant proportion of their workload was spent providing care for patients under non-medical specialty teams, mainly surgical teams. Surgical junior doctors often contacted medical registrars directly for support, rather than their own seniors, because they were less accessible, eg in theatre or non-resident.

Many registrars felt that the ramifications of this are significant. Firstly, a junior doctor may not recognise that a patient may have physiological disturbance secondary to a surgical complication. These patients are often referred as 'sick' to the medical registrar when in fact it would be in the patient's best

interest to be seen urgently by the relevant surgical specialist. Secondly, many of the problems referred are common medical postoperative complications which surgical registrars should be competent to manage. Moreover, the patient remains under the care of a surgical consultant and so any opinion provided by a medical registrar should be regarded as advice but the ultimate responsibility for the patient remains with the consultant, who may not even be aware that their patient is unwell.

*I get phoned to see surgical patients before surgical reg has been called but I do not think that is appropriate.*

*... surgical juniors ring me directly having not gone up part of their chain of command first, but I think there's often a reluctance to disturb some of them because of the shift patterns they work on, because they're maybe at home and on call from home, whereas I am physically in the hospital.*

*I get phoned about everything regardless of whether it is medical or surgical. As soon as a patient is ill, I will get phoned by outreach, anaesthetists, surgical SHO, whoever is on call.*

*There is a lot of animosity often between people who are in bed and perhaps we are up here and we are being driven hard overnight.*

The vast majority of medical registrars would value a system of appropriate escalation to the responsible senior members of the referring team, before contacting medical registrars. There were contrasting views on the precise definition of 'appropriate escalation' with some registrars feeling strongly that all such referrals to the medical registrar should be generated by a surgical registrar or consultant. Conversely, many registrars felt that as long as the referral was appropriate, they did not mind if it came from an SHO-level doctor. However, medical registrars were unanimous that if a patient was critically unwell, they did not wish to introduce protocol-driven delays to their involvement in patient care.

*I think that because of the workload at a district hospital we actually got the medical director to insist that if the surgical registrar did not ring us and actually came and saw the patient, we would not go and see them ...*

*I want the surgical registrars to be just as busy as us and seeing their patients but they are often in theatre and off doing other things but you have often got a very junior person looking after a very, very sick patient and ... just because they are not our sick patients in our directorate I think the F1 has often phoned us completely floundering, and I think it is our duty as a doctor to go and see that patient and not demand that they are seen by someone else.*

*It should be a proper escalation for the call, especially from surgery or orthopaedics – perhaps just have core trainees or registrars referring to us, as opposed to F1s from surgery calling directly the hospital night reg, which happens a lot.*

Registrars also highlighted the need to maximise the use of other resources in the hospital, in particular for non-urgent referrals that could be managed more routinely during normal working hours. There were several examples of how this had been achieved in different trusts. Some had employed a 'buddy' system whereby surgical and medical ward teams were paired so that routine reviews could take place between the two teams. In some trusts there were nominated specialty registrars or consultants available during the day to provide a specialty opinion or non-urgent review. Increased input from specialised

services such as orthogeriatrics has been successful in several trusts. In some hospitals, they had a second on-call registrar or consultant who received ward referrals. There should be clarity of the process of obtaining a medical opinion within a hospital when such supportive strategies exist.

*Buddy systems so that each surgical ward is paired with a medical ward so that they will always use their buddy, and it's normally the medical ward that would automatically cover outliers for that ward. So there's a natural link between those two registrars and they will just mop those patients up on the outlying ward round on a daily basis.*

*Having the consultant or registrar, some nominated speciality person on the end of the phone, so that people know that ... if they've got a patient with cardiology problems, they don't ring the medical reg, they ring the cardiologist of the week who's on the phone and they're accessible ...*

*The difficulty is when you are then perhaps saying to the surgeons, 'Well we only want the real priority ones to go to the medical reg and anything else can be a written referral'. You are then asking them to make that judgement and actually that might be an inappropriate call on their part and you get a really sick patient who is a paper referral that is inappropriate.*

*They have made a great leap in [x hospital] I think ... you can force orthopaedics to take people with fractures, who can't go home ... that's a fully accepted system because of the orthogeriatric service.*

Registrars also said that there were often surgical in patients who were reviewed on multiple separate occasions by different on-call medical registrars, without a clear process to enable one medical team to oversee the whole of the patient's care. This led to fragmentation of care and a lack of follow-up. Medical cover of patients under the care of obstetrics and gynaecology was mentioned specifically as an area where arrangements were often unclear. Medical registrars called for a formal system of follow-up for patients who had been reviewed by the on-call medical registrar to improve continuity of care. Examples of how this could be achieved were the use of buddy systems, or remaining under the care of the on-call medical consultant of the day.

*And I think obs and gynae is a particularly big problem because I've never worked anywhere that has any sort of policy for who from a medical point of view takes any sort of responsibility for birthing.*

*There need to be clear referral pathways that are defined locally in terms of specialty-to-specialty referrals, who takes patients over and how that happens, because at the moment that's not there.*

There were numerous debates about how safe and sustainable care could be delivered to patients under non-medical specialties but who require medical input. Some thought that perioperative medicine might become a subspecialty in itself. Some believed this could be delivered by anaesthetists and intensivists, while others thought it should be part of the domain of acute and general medicine.

*There is a lot more expectation that the medical team get involved, which is probably right, to give expert care for the medical problems.*

*... whether acute medicine will expand into the area of providing acute medical care for surgical patients and try to be a bit more proactive in that area.*

*If we were simply better engaged with the intensivists that might lighten some of our workload and burden.*

Many registrars commented on a perceived disparity between expectations from different specialties as to the appropriate level of seniority of a reviewing doctor. In their view, other teams expected a medical opinion from a registrar or above, but frequently an F2 or SHO-level doctor would provide a surgical, orthopaedic or anaesthetic opinion to the medical team. A reciprocal system would be appreciated.

*If they refer to us, we are expected at the registrar grade to review other people's specialties whereas the specialties are very happy to send someone more junior.*

*If I wanted an SHO to come I would phone the SHO ... it needs to be an equivalent system.*

#### 4 Medical specialties: interactions and expectations

Medical registrars reported that they are frequently asked to take clinical responsibility for patients under the care of other medical specialty teams when the specialty registrar is non-resident on call, unavailable for some other reason, or may not even have been contacted by their junior doctors or ward staff.

*I am the one that gets called for every sick patient on every ward regardless and that includes oncology when the oncology registrar is not there. It includes cardiology when the cardiology registrar is in theatre and wherever they go.*

*When I think ... about acute medicine or general medicine, I actually think the other specialties need to raise their game ... a lot of specialties have almost divorced themselves from acute medicine in some hospitals ... Other medical specialties like cardiology ... gastroenterology ... have moved away from it and the medical registrar ... is the person who is the first point of call for any of these other things when it's a real stretch ...*

There was a sense of despondency that many specialty registrars work 24-hour on-call shifts during which they are non-resident because of staffing levels and in order to protect their training. Meanwhile, general medical registrars are facing an overwhelming workload and specialty patients are subjected to long delays before being seen. Some questioned whether this was an appropriate use of the medical registrar's time. Medical registrars would value clarity regarding clinical responsibility and escalation of care of patients under medical specialties that have non-resident on-call registrars, for example, cardiology, oncology and haematology.

*I think there is this thing where people have mistaken the fact that you may be eligible to go home when you are on call as being some sort of God given right that you go home and under no circumstances shall you come back.*

*With subspecialties such as oncology and haematology ... often because the medical registrar is the person that's actually on site, things get defaulted to them ... because people are scared to call somebody that's home or are scared to call somebody in.*

## 5 'Hospital at night': leading the team

Most medical registrars acknowledged that the initial concept and intended design of 'Hospital at night' had clear benefits. Some registrars with experience of working as the clinical leader in well-developed 'Hospital at night' teams found that in this role they were able to provide good support for junior doctors and maintain an overview of the hospital. They could also manage the resources in their team so that junior staff could be reallocated and work be divided evenly and appropriately.

*Certainly where I worked at [hospital x] we had a very good 'Hospital at night' policy in that everyone sat down, all the team sat down ... you knew the sickest patients because outreach would make sure you had been told about them.*

*And you are responsible for the entire hospital at night, initially you think, why am I responsible for the surgical SHO at night. However, it is a great support for the surgical SHO who doesn't have a surgical reg and you can also pool staff.*

Despite this, they reported extremely variable experiences of 'Hospital at night' across the country. Its success seems very dependent on how trusts have interpreted and implemented the concept, and in particular on how much other specialties choose to participate. Unfortunately, more often than not, non-medical specialties (and other medical specialties) had not bought into the intended model. Medical registrars thought that their workload and responsibilities at night had simply expanded as they provided ever more senior support to nurses and junior doctors in other specialties, whose registrars were increasingly non-resident overnight. Non-medical junior doctors did not reciprocally contribute to the 'Hospital at night' team in the way medicine had hoped. This resulted in a one-way stream of work towards medicine in many hospitals, mainly directed towards the already over-burdened medical registrar.

*So all the other bits have got lost like ... having surgeons contributing to those rotas and all these other members that never got into it, so it is just a medical 'Hospital at night' team.*

*Juniors from the other specialties would come [to 'Hospital at night' handover], but not necessarily the registrars. And it seemed to be a way of just handing over the sick patients to the medical registrar, without the senior in that specialty really getting involved.*

More consideration should be given to using other skilled members of staff at night; for example, anaesthetists could perform more procedures.

*'Hospital at night' was supposed to be looking at the workload overnight and looking at the competencies of the staff that were on there. Now it just so happens that for whatever reasons, we have taken the turn that the only person who is deemed competent to do most of the work is the medical registrar, he's the only person. So you have either got to resource that post by putting more medical registrars on, or you have got to upskill the other people who are on site at night, so they are competent to do this other workload.*

In general, medical registrars found effective teamwork with senior nurses was one of the more successful aspects of 'Hospital at night' and valued the contribution of nursing staff.

*... the hospital at night team was invaluable, because you were working with expert nursing staff and you were able to delegate ...*

However, there were a few examples of where 'Hospital at night' structures have resulted in loss of, or confusion over, team leadership and disempowerment of the medical registrar. These medical registrars felt restricted in their ability to organise their teams and prioritise work as they deemed appropriate. They felt that if they were to be given responsibility for patients' clinical care then they should be granted the authority to decide how their team could best deliver this.

*Hospital at night set-up can lead to the med reg being undermined and disempowered and nurses distribute the workload.*

*They [nurses/CSMs] are not flexible and don't leave the authority to the registrar at times.*

*... a bit more autonomy like we used to have so rather than have a nurse tell me at 3 in the morning that the orthopaedic houseman is busy and I have to go ... I should be able to turn round and say no that's not acceptable.*

Most medical registrars believed that if they are expected to act as team leader in the hospital overnight, they should be resourced appropriately and empowered to manage the team's resources. They would value an ethos of teamwork, support and professionalism promoted across all specialties. This will promote better and safer patient care.

## Recommendations

- 1 Hospitals should ensure that medical registrars and other trainees routinely attend the post-take review of all patients they have been involved with, including ward referral patients reviewed by registrars when on call.
- 2 Non-medical specialties should reassess the mechanisms by which patients are referred for medical opinions both in-hours and out-of-hours. Hospitals should ensure that referrals are made to and from appropriately trained staff and not always the medical registrar. Referrals to the medical registrar 'by default' should be reassessed.
- 3 Non-urgent referrals for medical opinions should be made during normal working hours.
- 4 Hospitals should have a clear documented policy clarifying which primary presenting complaints should be admitted under which specialty team, both for medicine and the non-medical specialties.
- 5 Hospitals should have a clear policy to ensure that patients seen by an on-call medical registrar can be followed up by a specific medical team to improve continuity of care.
- 6 Hospitals should work with medical specialties that have non-resident on-call registrars to ensure clarity regarding clinical responsibility and escalation of care of patients under their care.
- 7 The RCP, Society for Acute Medicine and College of Emergency Medicine should work together to develop the emergency/acute care interface to establish processes that prioritise patient care and make the best of available staff and resources.
- 8 The RCP and surgical royal colleges should work together to consider how safe and sustainable care can be delivered to patients under non-medical specialties but requiring medical input, eg perioperative patients.



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## 5 Training and supervision of the medical registrar

*I could certainly say, in the time I have been a registrar, which is 4 or 5 years now, in comparison to when I was an SHO, I don't think I've received any particular progression in my general medicine training.*

### Introduction

The numerous high-quality opportunities for training that arise out-of-hours were recognised by medical registrars throughout England. The majority reported that there were occasions where they had received excellent training and supervision. The importance of acquiring key skills such as leadership, decision making, diagnostic and management skills that are required of a medical consultant was understood and appreciated. Although only a minority felt their role out-of-hours was solely service provision, the majority reported that insufficient training was delivered during on-call shifts. Registrars would like to feel empowered and supported in accessing training opportunities.

Many of the knowledge, skills and behaviours described in the general internal medicine (GIM) curriculum (2009)<sup>12</sup> are competences that can only be achieved while working out-of-hours dealing with acute admissions. There is little mention in the curriculum on when and where these training opportunities exist. Registrars in the groups rarely referenced the curriculum with regard to their training requirements. Registrars reported that they were training to be consultants of the future and as such they used the consultants on call as their role models.

Medical registrars outlined where they saw the best training opportunities in general medicine. They acknowledged that much of their training in general medicine is experiential and that their training requirements change as they progress through the grade. The RCP survey in 2011 established that only 38% of registrars felt that their training in general medicine was good or excellent compared to 75% in their main specialty.<sup>4</sup> In the focus groups we sought to tease out the reasons for this and highlight the training opportunities that exist whilst working out-of-hours.

The training and supervision concerns fell into the following areas:

- 1 The role of the medical consultant
- 2 Feedback and review of admitted patients
- 3 Review and feedback on advice about referrals from other specialties
- 4 The importance of peer-to-peer learning
- 5 Training in leadership and management

6 The impact on specialty training

7 Training in procedures

## 1 The role of the medical consultant

The majority of registrars reported that consultants play a pivotal role in their training. In particular they valued receiving direct feedback from the on-call consultant as well as the opportunity to observe the consultant reviewing patients post-take. Other examples of supervision methods and training opportunities included communication over the phone, observation of junior doctor training techniques, appraisal after a shift, and joint assessment of patients. The majority reported that greater consultant presence has the potential to enhance registrar training, as well as improve patient safety.

In general they viewed consultant presence out-of-hours and at weekends positively, with respect to patient safety and training. There were ideal opportunities for experiential training, particularly when there was a consultant there to give direct feedback. An example of this was given: when patients are reviewed together by both registrar and consultant.

Registrars also value the opportunity to learn from consultants from a variety of different medical specialties.

*I learn a lot more about diabetes when I'm on with the diabetologist or about gastro when I'm on with the gastroenterologist and I think that's now the educational part of my medical take.*

However, it was widely acknowledged that 'training is the first thing to go when it is busy'. In particular, the workload had a more serious impact on registrar training than on the training of more junior members of the team. Some registrars reported this was due to the change in the professionalism that they saw in their juniors (see chapter 6, Training and supervision of junior doctors).

Registrars reported that the pressures on consultants to see patients early in their admission often resulted in training opportunities being missed. Some registrars reported that their training in leadership, reviewing patients, formulating management plans and decision-making was negatively affected by the way increased consultant presence had been utilised out-of-hours.

*Working in a system which is very heavily consultant populated during the day did not leave me feeling that I was adequately prepared to run a take as a consultant.*

*... one of the biggest threats to our training [was that] the consultants basically start taking over a lot of the senior more complicated roles of the registrar. The registrar then gets downgraded to a clerking machine because the consultant reviews all the patients.*

A minority of registrars thought that occasionally consultants did not feel confident in training them in general medicine, particularly if they were not involved regularly in admissions. Some medical registrars training in GIM did not have educational or clinical supervisors who were practising general medicine. This could mean that they did not appreciate some of the difficulties medical registrars were facing and might not be best placed to supervise their GIM training.

## 2 Feedback and review of admitted patients

The importance of the PTWR as a means of training junior doctors is well recognised.<sup>8,12–13</sup> In the 2011 registrar survey, 97% of registrars believed that reviewing patients they had admitted with a consultant, usually on a PTWR, was important for GIM training.<sup>4</sup> The structure of the round, time to attend the round and opportunity to lead the PTWR were all areas that registrars felt were key to their training.

*I learn the most from presenting patients to consultants whose opinions I respect.*

*I think the best training I had was in early years when I did post-take rounds and there were excellent consultants and I really felt that I was an apprentice.*

In many hospitals there has been a move away from a designated PTWR at a certain time. The term ‘rolling PTWR’ is often used where a consultant will see a patient a few hours after they are admitted with or without the junior who first saw the patient, and often without the registrar.

*Apart from when you're on nights, you don't do any post-take ward rounds with consultants, so you do not see anything about what happens to those patients you saw. You are purely just a clerking machine; you have absolutely no idea what happened.*

The rolling PTWR introduces challenges to the training of registrars when compared to a ward round at a designated time which the registrar is expected to attend. Ideally this time should be ‘bleep free’. This could be achieved either by overlapping registrar shifts whereby the next registrar has taken over the referrals bleep or by asking a senior core medical trainee who can use this as a training opportunity.

*We need to have a definite overlap between shifts, so you have a bleep-free period to do the post-take ward round and to get feedback.*

Registrars often reported that the main time they attended the PTWR was after a night shift. In many cases attendance is not compulsory as it is at the end of a shift. Some registrars chose to attend out of a sense of professionalism and responsibility for their own training, but this was not the best time for training as registrars were tired.

Ultimately review of patients with a consultant needs to be achieved in whatever format the post-take review occurs. At present registrars across the country are struggling to attend PTWRs and would value consultant support and encouragement to achieve this, rather than assuming that it is adding to their workload. The majority view was that this opportunity has the greatest potential for training as well as offering some continuity for patients.

Consultant observation of the registrar acting up on the PTWR was considered an invaluable training opportunity by those registrars who had experienced it.

*Part of getting the skill set of leading the take and delegating, it is harder to do that unless during the day when the consultant is there, they actually actively take on the role in teaching you how to run the take, which some consultants do, they let you lead and ask you to direct the take, as it were, under supervision.*

A defined point in the shift where the consultant and registrar discuss patients was seen as beneficial for patient safety out-of-hours and for registrar support and supervision.

*A routine 10 o'clock phone call where you weren't feeling like you were disturbing the consultant, you were just having a phone call to let them know and they could say 'Are there any sick patients?' and if you had a little niggle of a question you could run it past them. And there have been lots of occasions where I haven't phoned them because I have thought that I have been perfectly capable of dealing with it, but if I had had a 10 o'clock phone call, I might have asked and they might have instituted something different.*

Feedback on a registrar's competence at reviewing referrals and medical admissions was frequently raised as a problem within the focus groups. In hospitals where there was no PTWR and registrars did their weekly on-call and then returned to their specialty they felt frustrated at not knowing what had happened to the patients or whether they had made the right decisions.

Most registrars reported investing time and effort into finding out about the patients they had been involved with. They felt that this kind of self-directed learning should be facilitated by their trusts. In some cases registrars would spend time emailing the consultant under whose care the patient had ended up or reviewing the notes when they were next on the ward. Many registrars raised the idea of the discharge summary being emailed to the registrar who had admitted the patient.

*Electronic discharge letter – I think it would be really useful if there could be a system whereby if you admitted them you got a copy of the discharge letter.*

Some trusts used a morning report whereby patients admitted over the previous 24 hours were discussed and often triaged to other specialties. This usually took an hour at the start of the day. This concept was seen as an extremely valuable training opportunity, particularly if chaired by an enthusiastic consultant who used the time to teach.

### 3 Review and feedback on advice about referrals from other specialties

Non-medical specialty referrals were regarded by many as a missed training opportunity. Registrars reported that in many cases there was no formal process through which the on-call consultant would supervise the registrar in their reviews of such patients. Registrars reported that often there would be a succession of registrar reviews out-of-hours with no additional senior medical input during the day. This clearly has implications in terms of patient safety, as there is no senior clinician overseeing continuity of medical input. Registrars reported that such referrals were one of their high-priority roles yet they received very little feedback as to whether they were doing it well (see chapter 4, Interactions with other teams).

*As the medical team, if we have seen patients during our on-call as a referral from another specialty, these patients should also be [seen] post-take [or] at least be seen by the consultant on call.*

Appraisal of registrars during their time in general medicine was often reported as scant, with one notable exception. In one trust there was a monthly consultant meeting to discuss medical registrars' progress after which they received individual feedback from their educational supervisor. This was highly valued by registrars. Another suggestion was email feedback from the consultants who had been on call with the registrar.

*We should have consultant-led post-take ward rounds and then a definite sit down, feedback at the end, to let us know how we are doing and how we are progressing and the opportunity to present cases one on one, and not being rushed for time because the consultant has got to rush off.*

#### 4 The importance of peer-to-peer learning

Many acknowledged that the interaction with registrars from different specialties was a useful training opportunity. Discussion about patients at handover meetings or during a shift when there are two registrars working was a key way in which registrars learnt experientially. Some registrars felt they would like this peer learning to be recognised and structured into their working week. For example, many would value a scheduled lunchtime meeting where registrars could meet and discuss cases.

*We ask each other questions and we are all from different specialties and if there is something I am not sure about, I have learned a lot from the different people that I am on with.*

#### 5 Training in leadership and management

The importance all registrars ascribed to gaining good leadership skills cannot be overemphasised. There are many leadership training opportunities out-of-hours: leading cardiac arrest calls, leading the take team, and in many cases leading a multidisciplinary out-of-hours team within a trust. Many registrars felt that this was not given adequate recognition as a training requirement.

Similarly the need for leadership training for effective handover was widely acknowledged. Registrars reported that a structured handover, particularly in the evening prior to a night shift, was a valuable learning opportunity. Registrars enjoyed this opportunity to lead a multidisciplinary team and were keen to promote this as a key part of improving patient safety and their development in leadership.

Medical management was an area where registrars felt they needed more training. Many felt that they should have a role in managerial decisions with regard to general medicine in a trust, and that their contribution to trust policies would be mutually beneficial. A regular meeting with members of the medical directorate was something many registrars felt would offer them training and experience of the management issues that they would face as consultants.

#### 6 The impact on specialty training

Some registrars reported that too much time spent doing medical on-calls had a negative impact on their medical specialty training. This was particularly a problem in those specialties where a procedural skill, such as endoscopy or bronchoscopy, is required.

*Cap the frequency of on-call shifts to ensure specialty training is protected. Locums should be used when there are gaps on the rota, not increase the frequency for the med regs.*

A minority of registrars in the focus groups felt they were unlikely to practise general medicine as a consultant due to the rise of the acute medicine specialty. These registrars did not see their work as a medical registrar as a training opportunity for their future career.

*I am training to do a job that my consultants aren't doing ... It has become very obvious now with the growth of acute medical units and acute medical consultants that that's not going to be what we are doing [working as general medical consultant] and often I feel a sense of futility ... it [time working as general medical registrar on call] is actually interfering in time that could potentially be spent in gaining sub-speciality skills, which are actually going to get me a consultancy job.*

## 7 Training in procedures

Training and competence in procedures was an area of debate amongst registrars. Opinion was divided over the importance of being able to do procedures such as central venous cannulation. Some felt that this was something all medical registrars should feel competent in and should be able to teach to juniors, while others felt that many such procedures were best left to intensivists who had more experience. Some procedures, such as chest drain insertion, were universally recognised as required out-of-hours. Yet some registrars had concerns about maintaining their skills in procedures that they did not perform regularly. Changing guidance and trust policies on the role of imaging in many procedures left many registrars feeling confused as to what they should and should not be doing out-of-hours.

*Increasingly you are encouraged not to do lines and the chest drains even if it is during the day.*

*... but when you go out to the DGH you are not ultrasound competent, and it is the middle of the night and you are doing it, you know, sort of on your own, having not done many during the day.*

## Recommendations

- 1 Hospitals must ensure that medical registrars are able to maintain the practical skills that they are required to undertake, including specialty skills. Reducing their non-priority workload as described above will help this considerably.
- 2 Extended consultant presence should be utilised to enhance the many training opportunities that exist out-of-hours. In particular, contact with consultants from different specialties is valuable and should be promoted.
- 3 Hospitals should make clear arrangements to ensure that there are appropriately skilled staff available at all times to perform all clinical procedures that might be required urgently.
- 4 Registrar training will be improved by routine and regular: directly observed ward rounds led by the registrar; distribution of discharge summaries of patients reviewed by registrars to those registrars; and one-to-one meetings with supervising consultants regarding performance for registrars working as the 'on-call' medical registrar.
- 5 The RCP should work with curricula developers to increase the prominence of leadership and management skills as a key part of medical registrar training.
- 6 The RCP and local education and training boards should work together to ensure that internal medicine training and specialist training are balanced with service delivery. Hospitals must avoid registrar on-call rotas that jeopardise this balance.



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## 6 Training and supervision of junior doctors

*I want more time with my SHOs, teaching them how to do lumbar punctures and things. At the moment, I think that probably the first thing to go when you are busy is teaching and training of others.*

### Introduction

It was acknowledged by medical registrars across the country that there are tremendous, and sometimes unique, learning opportunities for junior doctors during on-call shifts. Medical registrars find their role in supervising and teaching junior doctors rewarding and enjoyable.

However, medical registrars were concerned that many of these training opportunities were not being utilised and that some have been lost in recent years, for a variety of reasons:

- 1 Changes to the consultant post-take ward round
- 2 Loss of continuity of care
- 3 Increasing workload
- 4 Reduction in responsibilities
- 5 Supervision of junior doctors 'in difficulty'

### 1 Changes to the consultant post-take ward round

The most consistent concern was the loss of the PTWR as a valuable training tool. The feedback, teaching and skills obtained by watching a skilled clinician assess your patient on a PTWR were considered by medical registrars as one of the most valuable learning opportunities for junior doctors of all grades. Importantly, patient care also benefited from junior doctors attending the PTWR. It allowed continuity of patient care, drove up the standard of clerking, ensured the opportunity to discuss subtle, but often relevant, details poorly conveyed on paper, and resulted in a more rapid and effective implementation of the management plan.

*I find that [the PTWR] is the most beneficial learning opportunity.*

*I think it's the post-take ward round, I think it's where SHOs learn to be competent in doing medicine, I think it's where they get the praise and the self esteem in their rotation.*

It was widely reported that junior doctors were struggling to get the chance to present their patients on PTWRs. Frequently examples were given of consultants reviewing patients on their own or accompanied by a junior doctor who had not met the patient before. Some medical registrars reported frustration on morning PTWRs because consultants would insist on seeing patients in bed order, rather than reviewing the night team's patients.

*It's no good for them [consultants] to go off and see a patient on their own without giving any feedback to the person who clerked that patient.*

*[SHOs] don't go round on a post-take ward round and I think that's got to be the worst on-take experience for them because it is just very unsatisfying; you are the machine that does all the work, you don't get any feedback out of it, you don't get any learning out of it and it must be really unsatisfying.*

*They don't want to be dragged around the bay of 9 patients that they haven't seen, because they are staying late and not learning anything productive ... what they want is feedback on the ones they've seen.*

It was acknowledged that the increasing workload on call has, unfortunately, made it unrealistic for many hospitals to continue the traditional PTWR format of the entire team attending the ward round. However, it is realistic and extremely beneficial to ensure that the doctor(s) who has assessed the patient is present. This has been successfully achieved in hospitals by ensuring bleep numbers are readily available to the consultant and junior doctors coordinating a 'tag' system, eg bleep the next junior doctor when you start to present your final patient. Greater recognition of the importance of PTWRs was needed and should be taken into account when designing shift patterns for both junior doctors and consultants.

*If they did clerk and properly make a plan and present it, then they would have ownership of the patient and understand what's going on medically.*

*I think the SHOs are absolutely excellent but if you're just doing an 8 till 4 shift and you don't do a post-take round as a group and guide the consultant from patient to patient there's no ownership.*

*If they [changed] the rota to make it 10.30 to 10.30 night shift you could get more of the post-take ward round ...*

## 2 Loss of continuity of care

Due to the move towards shift-based working patterns, junior doctors do not have the opportunity to see the outcomes of their investigations or management first hand. They may even have to hand over before basic initial results are available. It was acknowledged that junior doctors themselves could be more proactive in reviewing their patients' outcomes. Electronic discharge summaries enable junior doctors to access information about their patients' admissions, and having the facility to request that a discharge summary, or radiology report, is emailed to you would be extremely useful.

*It's getting an opportunity to follow the patients you've admitted and to find out later how you managed with this generally.*

*Everybody could be emailed a discharge summary of the patient they admitted. How good would that be.*

*I have a list. I have no idea who my patients are; they change from day to day ...*

### 3 Increasing workload

As stated above, training is often the first thing to be compromised when it gets busy. Although in the short term this may be necessary to prioritise patient safety, it is not beneficial for patients in the longer term if standards of training decline. It is important that staffing and workload are better matched so that doctors can develop new skills and train during their on-call shifts.

*When you are busy and you know that you could ... put the chest drain in in 15 minutes ... you know you've got like 10 waiting, are you going to do it or are you going to let your junior do it?*

*... [I clerk] all the people that I know I'm going to end up seeing anyway but that impacts on their training opportunities because you say 'oh I'll just see this one' because you know they're going to be complicated to sort out.*

### 4 Reduction in responsibilities

Over recent years SHO-level doctors have lost many of their traditional responsibilities and roles to more senior doctors.

*Those jobs that they did once are now just getting escalated up.*

*I think these days that unless you are a registrar or consultant you [don't feel] responsible for anybody or anything.*

This is perceived by medical registrars to be having a detrimental effect on SHO-level training. One of their main concerns was that on-call junior doctors are no longer being allowed the exposure they need to complex or acutely unwell patients. For example, SHO-level doctors are not seeing patients in resuscitation because the medical registrar is bleeped directly and EDs expect these patients to be seen directly by medical registrars.

*Juniors at night are just doing menial tasks and they are not getting anywhere, they are not getting to see the acutely unwell patients.*

*Often SHOs now are not going down to resus because the registrar just gets the bleep.*

Junior doctors are getting much more prompt senior reviews of their patients. Although this has great potential to increase learning opportunities, medical registrars observe that the opposite often results. This is because, as discussed already, they are often not present to learn from the senior review/PTWR. Also, early senior input unfortunately discourages many junior doctors from developing their own management plans or making decisions.

*There are some fantastic SHOs. However, they are reluctant to take the step to make that final decision about what's happening about that patient because they have in their head the patient is going to have senior review, so they hold back, because they know that the registrar is going to see the patient.*

*The problem now is, no junior doctor is making a plan, or a diagnosis or a decision. What they do is, they just take a history, they re-present and they do the post-take and then the whole plan is done by the consultant.*

SHO-level doctors are less commonly involved in receiving referrals or coordinating the admissions process so they are not gaining skills in triaging, prioritising or leadership. Regrettably, medical registrars perceived that reducing SHO-level doctors' responsibilities was resulting in lack of ownership over their patients and this could impact on patient care.

*Yes there has been a significant shift, because when I was a house officer, my SHO used to run the take and the reg used to come down from clinic or wherever, whereas now either the registrar or the consultant runs the take, the SHO has no clue about what is going on around them.*

*We need to be careful that we don't treat SHOs and house officers just as jobs people, because they don't learn to prioritise anymore because that prioritisation is taken away from them because they don't take the leads, so they don't know how to prioritise and then when you actually get more senior, you have to learn judgement things and they can't judge what's important and what's not.*

In order to address the impact these shifts in responsibilities is having on training it is important to understand why they have occurred. This was explored in the focus groups. Firstly, recent changes to training have resulted in less experienced SHO-level doctors. Contributing factors include the introduction of the European Working Time Directive (EWTD), many hospitals taking F1 doctors off medical nights, and the variability in F2 training. This loss of experience in the earlier years of training has resulted in reduced expectations of SHOs and a gradual shift of some of their traditional responsibilities to registrars and consultants.

*And my training was amazing ... then I see some of these poor SHOs coming through, I mean it's not their fault, it's just the way the system has changed, you know, with the European Working Time Directive.*

*I think the foundation programme has a lot to answer for, I think it's a waste of time. I don't see anyone at the end of that prepared for anything.*

*The abilities of juniors to cope with general medical problems on the wards have gone down dramatically and so, I don't know whether it's a confidence thing or a knowledge thing, but we are getting increasing numbers of phone calls from juniors on the wards; 'I don't know what to do about this, I don't know what to do about that'.*

Unfortunately some registrars also thought that some junior doctors themselves were avoiding taking on certain roles and responsibilities to the detriment of their own training. This change in attitude meant that these roles and responsibilities were escalated to more senior doctors. Medical registrars thought that some junior doctors needed to take more responsibility for their own training.

*... I don't feel as though people are willing to take the responsibility ... 'the registrar is my boss, so they are responsible, I just do my bit'. ... I think that's a very detrimental shift in attitude actually and I think it is endemic.*

*There used to be a time when I was proud as an SHO to do all these procedures for my registrar, not to burden them because I knew how busy they were. I was proud to say, I can do this, I can do this safely. Now, there is not the same attitude.*

*Anything complicated – 'Oh the medical reg will sort out, I'm a GP trainee'.*

*I think we need to have some responsibility for the juniors to go to those registrars during daylight hours and saying, 'This is what I want to learn. When you have one, will you page me?'*

Reduction in junior doctors' responsibilities has also occurred in response to pressure from the public, and professional bodies, for care to be increasingly consultant led and delivered. Additionally, other specialties increasingly expect (or demand) medical reviews of their patients to be done directly by a medical registrar or consultant.

*The government think it's brilliant that a registrar or consultant sees the patient, acutely, whereas my view is slightly different because SHOs won't learn unless they see sick patients.*

*[Medical registrar to junior doctor] 'Do you want to go down first [to resus] just to see what's going on, I'll see you later.' And that's part of managing the take and having a teaching role. But I have then been rung by the A&E consultant saying, 'Why did you send your SHO out?'*

The loss of training opportunities due to increasing workload and reduction of SHO responsibilities is often driven by justifiable motives, ie to improve patient safety. Certainly, it can be a difficult balance to strike – to ensure patient safety whilst giving junior doctors the challenges they require to develop necessary skills.

*There is a problem that we face a lot of the time which is patient safety and what is right for the patients, and not necessarily what is right for our training. But that is an important issue, so from a patient safety point of view, ... how do we come to a compromise between those two things.*

There was widespread concern that core medical training (CMT) is increasingly inadequate preparation for the medical registrar role. They felt that the training structure compared badly to that of many other specialties, and that senior CMTs should be given more training, support and guidance to improve the transition to medical registrar. Suggestions included that, under the supervision of the on-call medical registrar, CT2s could spend time carrying the on-call registrar bleep, review acutely unwell patients in ED resus or on surgical wards, review F1 clerkings and lead cardiac arrest teams.

*I mean there's no actual training, there's no training pathway to be a general medical registrar.*

*I think a lot of them feel under-prepared to be general medical registrar on call because I think in core medical training ... so few of them get exposed to critical care, they don't feel they really know how to look after sick people. Almost none of them can put a central line in ... .*

*My SHO has got PACES and he hardly knew where resus was ... you know that is absolutely terrible because in 6 months' time he is going to be a registrar and he has not received any appropriate training in dealing with acutely unwell people who have just come in the front door.*

*... and the step up to being registrar is really quite scary and quite daunting ... I think perhaps somewhere in those guidelines there needs to be something about that period – maybe the last six months of ST2 when you have got your PACES and becoming a registrar – and some sort of guideline around that.*

It was felt that the balance between patient safety and good quality training would be better achieved if medical registrars had more time to supervise junior doctors. For example, they could initially see resuscitation patients together with an SHO-level doctor, then progress to allowing the SHO-level doctor to do the initial assessment, with the understanding that the medical registrar's workload would enable him or her to join the SHO when needed to perform a senior review. Also, if medical registrars knew their juniors better (as discussed previously) they could safely increase the individual SHO-level doctor's responsibilities according to their capabilities, instead of holding everyone back by default.

*So I took them down and we did tandem clerking, so we would take turns and so they would take history and I would observe. I could give them feedback then and there.*

## 5 Supervision of junior doctors 'in difficulty'

Medical registrars expressed anxieties about trainees 'in difficulty' and patient safety. They were often not informed that one of the junior doctors under their supervision was struggling, so it took time to recognise that a trainee needed extra supervision or could not take on the required workload. The resulting inadequate supervision might not only affect patient care but also deny the junior doctor the training they needed to improve. In the interests of patient safety, medical registrars would like processes in place that ensure they are informed when they are supervising a trainee in difficulty. Additionally, some felt that trainees in difficulty should be made supernumerary, as there is not enough slack in the system to provide increased supervision and compensate for their inefficiencies during a busy on-call.

*We have got a couple of SHOs in difficulty in [our hospital] at the moment and a lot of people know who they are, but a lot of people don't ... I think it is terrifying the idea that that person might turn up to an on call and the registrar thinks that they are an SHO, 'off you go', when actually absolutely every single thing that they do needs to be supervised.*

## Recommendations

- 1 Hospitals should organise rotas and staffing levels to allow core medical trainees to gain experience in the skills needed as a medical registrar. In particular, experience in managing acutely unwell medical patients under the supervision of registrars and consultants should be prioritised.
- 2 There should be an expectation and established process to ensure that all junior doctors present their clerked patients to the consultant and receive feedback and training.
- 3 Hospitals should promote processes that increase continuity of care and help junior doctors follow-up their patient's outcomes. These include:
  - a attendance on post-take ward rounds



- b utilising information technology such as automated emailing of investigation results and discharge summaries
  - c senior clinicians actively encouraging junior doctors to follow up their patients' outcomes.
- 4 Local education and training boards (LETBs) should put systems in place to ensure that registrars and consultants are informed when supervising trainees 'in difficulty'. LETBs should also consider whether trainees in difficulty should be made supernumerary on on-call rotas.
- 5 The Department of Health should reassess the value of the second year of foundation training for those wishing to specialise in hospital medicine. The benefits of extending core medical training should also be explored.

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## 7 Recruitment and retention

*... the excellent SHOs are all going into general practice. You say, 'What are you doing?' 'I don't want to be a medical registrar on call' and you think it is terrible, because these are excellent people that we are losing.*

### Introduction

Recruitment of doctors into the medical specialties has become increasingly difficult. Competition ratios for applications to core medical training are also lower than any other hospital-based specialty and approximately equal to general practice.<sup>14</sup> When F2 doctors were asked if they intended to pursue a career in hospital medicine, only 27% were definite about doing so.<sup>2</sup> When asked what factors influenced their choice to pursue a career in medicine, the majority (81.4%) felt that the work–life balance as a medical registrar was a deterring feature. Of more concern, only 76.5% of CMTs definitely planned to continue in hospital medicine. Current medical registrars of both genders have also considered leaving medicine, with 8.5% of 2,026 registrars surveyed in 2011 planning to leave the medical profession completely.

Medical registrars involved in focus groups across the country acknowledged problems with recruitment and retention to general medical specialties locally. Many were extremely concerned by these worrying trends and aspired to make general medicine as attractive as possible in order to encourage the very best trainees to apply and remain within the specialty.

*People don't really do medicine any more, do they? It is a massive problem.*

*It is a competitive market now and we are going to have to make it – quite rightly I think – attractive for people to come into to get good trainees and good people.*

Medical registrars recognised reasons why junior doctors might perceive general medicine to be an unattractive specialty and identified three key areas where medical trainees might be influenced to reconsider their career options:

- 1 Junior doctor perceptions
- 2 Feeling valued and respected
- 3 Leadership in general medicine

## 1 Junior doctor perceptions

Some registrars recalled that as SHOs they had felt concerned and anxious that they were underprepared to become registrars. Most others had at least had conversations with current CMTs who were worried about taking the step up in seniority. Issues regarding training have been discussed in chapter 6, Training and supervision of junior doctors. Reassuringly, however, most registrars believed in retrospect that they were better prepared for the clinical aspects of being a medical registrar than they had realised and that it was the non-clinical roles of the job that were more challenging.

*They just openly say 'I enjoy medicine but I do not want to be a medical registrar thank you very much' and they go and do something else.*

*The thing that put me off was being a medical registrar – although it is not as bad as I thought it would be all the time. You might have horrible shifts but if you are on a normal rota they do not come that often so I think that it's not as bad as you think.*

*I remember when I was an SHO, the one thing you are worried about is that 'oh I am not going to be able to do the procedures, oh I am not going to be able to cope with the patients'. As you do a few more years you will realise that it is not that that is the problem. It is just the complete time management, which to be fair is prioritisation, and being pulled in different directions and that is something that you cannot ever prepare yourself for ... it is just like a general thing that people do not understand until they have done it.*

Several registrars acknowledged that their on-call role was often perceived as being extremely stressful by junior doctors and that this might be a deterring factor. A number of registrars suggested that CMTs' experience of on-calls did not include seeing the acutely unwell patients, or getting feedback on their own patients and consequently they were not encouraged to enjoy the variety and complexity of general medicine. Many believed that juniors were potentially overly influenced by observing the medical registrar on call and did not have enough exposure to them at other times.

*A lot of the SHOs, their impression is just the stressed-out medical registrar on call and they don't see what they do the rest of the time.*

*If the SHOs don't get the experience of going and seeing sick referrals in A&E based wards, I think they are not going to get the enjoyment. They are not going to see what the medical reg does and they are not going to want to become a medical reg.*

*I think it's the post-take ward round, I think it's where SHOs learn to be competent in doing medicine; I think it's where they get the praise and the self-esteem in their rotation ... I think coming on, clerking, writing something, walking away, doesn't really endear them to a career in medicine.*

## 2 Feeling valued and respected

Registrars nationwide commented on a sense of low morale amongst general medical registrars and juniors. Much of this appeared to arise from feeling undervalued as medical professionals and a perception that their professionalism, roles and responsibilities, clinical knowledge and skills were not always respected within the hospital. The 'dumping ground' phenomenon, the inability to 'say no', the

expanding roles, the ever-increasing workload and expectation to provide senior cover for other specialties, without an increase in resources or support, were all taking their toll on the morale of medical registrars. The potential negative impact on the welfare of the workforce and recruitment and retention within general medicine should not be underestimated.

*It is quite clear that most of the specialties laugh at medics ... because they know we are working harder than anyone else, they know we are taking the flack for everyone and ... you are not given a pat on the back, it is not worthwhile at all at the moment.*

*People are just not staying in medicine and there are lots of different reasons, but some of the main ones are the lack of support and there's lack of flexibility in medicine; people don't see how you can have the work-life balance. You see the job that the registrar is doing and lots of people don't want to do that, they think it's too much, too overwhelming.*

*I think the feeling that you are undervalued as a whole by the system is completely true ... the [hospital] trust as a whole, not your consultants, but the trust as a whole, you are a very small cog and they really don't care how unhappy you are.*

Most medical registrars reported that they were keen to take on more responsibility. Most wished to be recognised as team leaders and were keen to embrace the seniority that traditionally came with being a medical registrar. However, several people gave examples of how they felt their leadership role was sometimes undermined and seniority not respected.

*I don't think juniors mind working hard; I think if they feel as though they are working hard, and they are respected for it, and valued, then they will be happy to do it. But I think we all, when we are on call, are a bit downtrodden and a bit grumpy and harassed – every time the bleep goes you think, 'Oh!'*

The majority of registrars were frustrated that although they were working at full capacity to fulfil all their roles, many hospital trusts struggled to provide even the most basic facilities. Common issues raised were a lack of adequate workspace, no rest facilities, nowhere to get food or drink during night shifts, no on-site car parking for on-call workers finishing out-of-hours.

*There is nowhere for registrars, let alone SHOs, to work. You don't have office space that is your own that is not multi-used for other things.*

*You know, if you want a rest, why do you have to go and sit on a patient couch because that's the only place where you can go and get peace and quiet for half an hour. There should be somewhere with a comfortable seat that you can go.*

*The fact that you can work a 13-hour shift and not have anywhere to go and get food overnight is sort of ridiculous and you wouldn't expect it in any other profession.*

*Being entitled to car parking permit would be really nice. Being allowed to park on-site as the medical registrar on call would be delightful.*

Many registrars had experience of disparate rates of pay for internal locums, where medical registrars were being paid lower rates than surgical registrars or other specialty registrars. A few registrars

expressed frustration over inequalities in workload and intensity amongst different registrars receiving the same income but, for the most part, money was not a motivating factor; inequality was the main concern.

Another issue raised in a few deaneries related to opportunities to train flexibly. Those with experience of flexible training remarked that there were several practical restrictions to doing this and they were more attracted to other specialties, such as general practice, where there were recognised pathways and better financial rewards for part-time work.

*Can I just make one point as a mum of two who works full-time? I think it is really unattractive at the moment (flexible training) because it is 50–50 [in this region] and I think when it was 60–40 or 70–30 a lot more people did flexible training.*

*GP is very attractive to women if you want to work part-time. Of course it is – you get paid about the same as we do full-time for doing that [medical specialty].*

### 3 Leadership in internal medicine

A common perception amongst medical registrars was that, in most hospitals, there is no real champion for internal medicine. As such, they felt they often lacked support and encouragement in their work and training, impacting negatively on morale.

*General medicine does not exist as a proud speciality.*

*General medicine has no prestige, does it?*

*[In] many places there is nobody who is responsible in the medium to long term for the take, the well-being of the medical registrar out-of-hours, there is no leadership.*

*There is this big thing that all the other specialties are supported by their seniors, especially in surgery, paediatrics, obstetrics and gynaecology, the ones with training. In medicine, you are not really supported, not encouraged by your seniors.*

Acute medical services were recognised by most registrars as having a profound impact on their ability to fulfil their roles. Unfortunately, several registrars in each region reported that poorly developed acute medical services are unsupportive and often unappealing places to work.

*What you enjoy doing is giving good acute care and yet, in this region anyway, people aren't choosing to work in acute medical departments.*

*I wonder if it is something about the way that the acute processes are set up that makes it an unattractive speciality.*

Many registrars recognised the need to promote 'generalism' within a hospital, and could foresee that this might enable an AMU to be a focus for excellent clinical care and training.

*The few places where I have actually enjoyed being a medical reg and been encouraged are places where I think a hospital has valued the admissions unit. If they have seen it as a problem they decided to work on it and they have put resources into it, so they felt motivated.*

Several registrars reported that due to a lack of support and leadership, when they tried to approach their seniors to report problems or suggest solutions, they were frequently not listened to and problems persisted.

*... as a group [medical registrars] we tried to approach it in a constructive manner by speaking to them [consultants] and so on, and then it just fell on deaf ears.*

*It is being interested in what is happening and that then has improved your role. It's at a much higher level, at the consultant and the management level.*

The profile and quality of working life of medical registrars and consultants must improve in order to make general medicine an attractive and appealing specialty to trainees and maintain the morale and commitment of the current workforce.

*I think they [junior doctors] need to see us being valued and treated as professionals and being somebody that they want to be in a few years' time, and I don't think they always do – they see us being a bit fed up.*

*We need to rebrand and remarket!*

## Recommendations

- 1 The RCP should work with other stakeholders, including employers, commissioners and policy makers to raise the profile and status of internal medicine (ie general medicine) to make it an attractive and appealing specialty to trainees and maintain the morale and commitment of the current workforce.
- 2 Hospitals should designate a clinical lead for internal medicine to champion the medical registrar and provide professional support for the role.
- 3 Hospitals must provide adequate facilities to support the medical registrar's working environment, including dedicated space to work and rest.
- 4 Local education and training boards must promote flexible training posts for medical registrars to ensure that women are not dissuaded from entering the medical specialties.



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## Appendix 1 Methods and demography

### Methods

The first stage of the project involved preliminary discussion forums to identify and validate key themes and ideas. The forums consulted were the Royal College of Physicians (RCP) New Consultants Committee, RCP Regional Advisers Committee, RCP Trainees Committee, heads of schools for medicine in England, RCP Patient and Carer Network, medical registrars from the Severn Deanery and representatives from RCP Edinburgh. Ethical approval was sought and granted by the University of Bristol.

The project was divided into two stages: (1) electronic surveys; (2) focus groups.

#### Electronic surveys: August 2011 to November 2011

Three electronic surveys were distributed, using Vovici software, via email to different training groups as follows:

- 1 Medical registrars, both specialty (ST3–ST7) and specialist (SpR), in England and Scotland were identified from the Joint Royal Colleges of Physicians Training Board (JRCPTB) database and sent a survey on 20 October 2011. Weekly reminder emails were sent for four weeks after which the survey was closed and analysed.
- 2 Year 1 (CT1) and year 2 (CT2) core medical trainees in England and Scotland were identified by the JRCPTB database and sent a survey on 23 September 2011. Fortnightly reminder emails were sent for four weeks after which the survey was closed and analysed.
- 3 Foundation year 2 doctors (F2) in England were approached via the UK Foundation Programme Office (UKFPO) on 9 November 2011 and survey surveys were distributed at the discretion of regional foundation programme directors.

The surveys explored several themes including: enjoyment of medicine; overall satisfaction; career aspirations; deterring and attracting factors; perceptions of the medical registrar. The surveys are available on the RCP website.

F2 survey: [www.rcpworkforce.com/se.ashx?s=253122AC3FC24E59](http://www.rcpworkforce.com/se.ashx?s=253122AC3FC24E59)

CMT survey: [www.rcpworkforce.com/se.ashx?s=253122AC3FC24E66](http://www.rcpworkforce.com/se.ashx?s=253122AC3FC24E66)

Registrar survey: [www.rcpworkforce.com/se.ashx?s=253122AC3FC24E89](http://www.rcpworkforce.com/se.ashx?s=253122AC3FC24E89)

## Focus groups

The second stage of the project was targeted solely at medical registrars. Focus groups were held in all 14 deaneries in England between January and June 2012. The focus groups were composed of medical registrars from specialties involved in acute admissions.

All trainees who had worked as a medical registrar in acute admissions were welcome to attend a focus group. In some regions a regional trainee, usually nominated by the RCP consultant representative for that region, would notify trainees by email. Further promotion of the project came from articles in *Clinical Medicine*<sup>1,15</sup> and email notification from the RCP to those attending teach-ins in London. Some deaneries were able to notify all trainees in GIM and acute medicine by email or promotion on deanery-specific websites.

Focus groups were held in regional venues throughout the country. They were usually incorporated into a registrar training day in general medicine. All those attending the training day were notified in advance and invited to attend. The group would frequently take place during lunch or at the end of the day. Two focus groups were held in trusts within which all the participants were currently working, but they had all had experience of other trusts in the region. Two focus groups were held at the RCP before a teach-in evening event. Focus group size was planned as 15 participants, as larger groups have been shown to be less effective for qualitative research.<sup>16</sup> In regions where there was great interest in the project, more than one focus group was held.

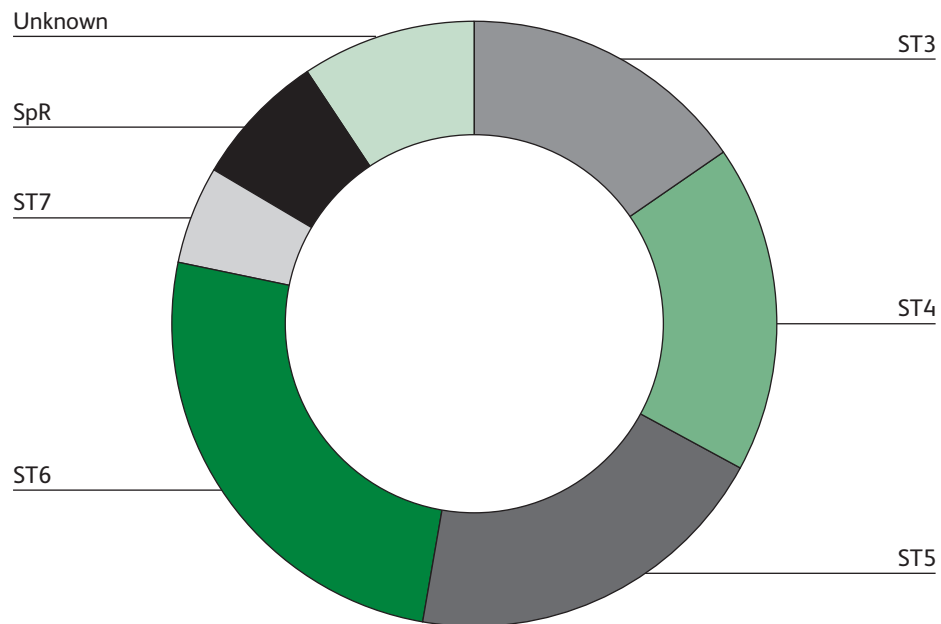
One of the Medical Workforce Unit clinical fellows facilitated each group. Their role was to guide discussion whilst not actively contributing. Participants were asked to sign a consent form with respect to recording and future analysis of the discussion. There was a short opening presentation to explain the aims and basis of the project followed by discussion, which lasted around 60 minutes. The open discussions were recorded and subsequently transcribed by DICTATEIT. Participant names and trust names were anonymous in the transcripts.

The clinical fellows conducted thematic analysis on the transcripts. Each group was facilitated and analysed by different clinical fellows. As the focus groups progressed the discussions evolved as an iterative process. This allowed for further exploration of recurring problematic themes in some of the latter groups.

## Demographic data

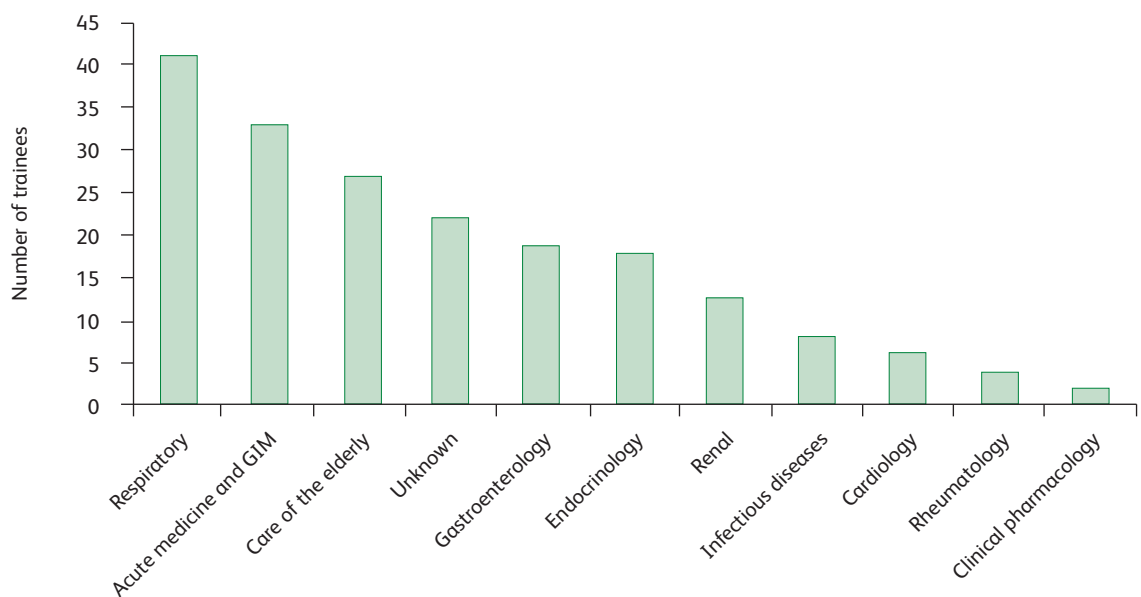
There were 193 participants in the focus groups. On average there were 13 per group (range 5–18). Women made up 59% of the groups with six (3%) working less than full time. Of those who provided data (n=171), most (130, 76%) had had experience of working in both a DGH and a teaching hospital. Thirty-one (18%) had only worked in a DGH and ten (6%) had only worked in a teaching hospital. Most of the trainees had had at least two years' experience of working as a medical registrar (60% were at specialist trainee level 5 or above) (see Fig 1).

The specialties most strongly represented were respiratory medicine, acute medicine and care of the elderly (see Fig 2). Figure 3 shows the number of participants in each deanery.

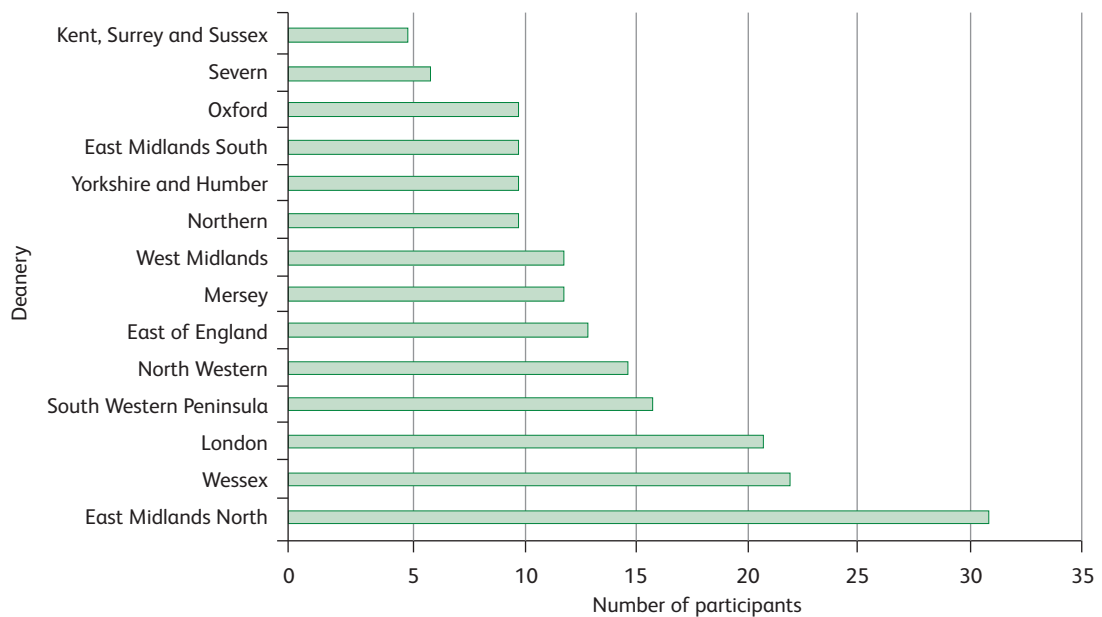


**Fig 1 Grade of trainees in focus groups**

According to the JRCPTB census 2011,<sup>12</sup> there are approximately 4,000 trainees hoping to obtain a certificate of completion of training (CCT) in general medicine. The response rate to the electronic survey was 33%. These results will be presented elsewhere.<sup>2,3,8</sup>



**Fig 2 Specialty CCT of trainees in focus groups**



**Fig 3 Number of participants in each deanery**

Although 46.6% of all medical registrars are women, the relative number of women accrediting in general internal medicine is likely to be smaller (women in the acute medicine specialty account for 37.9%).<sup>12</sup> It is therefore a little surprising that 59% of the focus groups were women. The numbers working less than full time are underrepresented at 3% compared to 10.0% across all specialties. This is likely to reflect childcare commitments as many groups were held at the end of the day. The specialty CCT of participants in the focus groups reflects the relative contribution of these specialties to acute admissions.

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