

THE MEDICAL REGISTRAR ROLE– RESTORING ITS STATUS AND JOB SATISFACTION

The Royal College of Physicians of Edinburgh is aware of the pressures on acute medical registrars, particularly at night and weekends. The 'Med Reg' should be an individual who is at least at ST3 level of training with MRCP(UK), although it is recognised that more junior physicians (such as Core Medical Trainees (CMT), preferably with MRCP(UK)) also take on this role in smaller hospitals. The medical registrar's role on the acute take has historically and appropriately been to manage those presenting with acute medical illness, as a competent decision-maker. This is a key part of training for the consultants of the future, who will be responsible for running the acute take. However the nature of this role has changed over time and we strongly believe it is important to reaffirm and support the medical registrar's role in relation to the acute take.

Previous surveys have demonstrated that unfavourable perceptions of the medical registrar role contribute to the decision by a significant proportion of Foundation doctors and CMT, not to continue training in the medical specialties, or to avoid those which incorporate General (Internal) Medicine Training (GIM) training. This may partly explain the disappointing recruitment to ST3 posts in Acute Medicine and Geriatric Medicine for August 2014. Going forward, we believe there are a number of actions that can be taken to support and improve the role of the acute medical registrar, including the inter-relationship with Hospital at Night (H@N). These take account of the feedback from the CMT survey, organised by JRCPTB in 2013 (see additional reading).

1) Review of patients between the Medical Registrar and supervising Consultant

The Med Reg will only gain competence if they have the opportunity to present and review the patients they have assessed and managed to the duty Consultant, so that appropriate feedback can be provided. This is also a key patient safety issue. If it does not occur, night shifts become simply service provision and valuable training opportunities are squandered. We would suggest:

- There should be contact (by phone if not in person) between the Consultant and Med Reg at the start of each shift, particularly in large units where the consultant and trainee may not be known to one

another. The Med Reg should be aware of clear lines of escalation, and how to contact the duty consultant.

- Medical registrar shifts and Consultant ward rounds in Acute Medical Units should overlap sufficiently to allow time for patients admitted or who caused concern overnight, to be presented and feedback provided.
- Medical Registrars should be given opportunities to lead the post-take ward round with the duty Consultant present, to allow subsequent feedback not only on patient management but also leadership and team-working.

2) Supported acting up as Medical Registrar

In the recent national CMT survey, only 51% of trainees exiting the CMT programme felt sufficiently prepared to take on the role of the 'Med Reg'. There is a clear need to improve the transition between CMT and higher specialist training. All CMTs must be adequately prepared to manage the unselected medical take and acutely unwell patients. In order to develop the clinical, procedural and leadership skills necessary to do this, we suggest that:

- When based in Acute Medicine in CMT, there is an initial 'STR apprenticeship' phase consisting of regular protected time e.g. a half day a week to shadow the Med Reg on call.
- Subsequently, this should be extended to short supported periods of 'acting up' when they hold the 'Med Reg' bleep, paired with a senior medical registrar (or consultant) who is officially on call and available on site for support and advice. It is recognised that this may prove challenging to organise in smaller units and other approaches may have to be considered.
- Shadowing and acting up should occur at regular weekly or fortnightly intervals when based in Acute Medicine, to build up skills and confidence over time and prevent skill fade.
- Acting up periods could be extended to cover out of hours/overnight on call with the support of an STR or consultant on site, as the trainee's skills and confidence develop, and MRCP(UK) is gained.

- Procedural competences must be reviewed early in CMT, and training provided to ensure these are met and maintained. Simulation based training is an important way of learning skills, but competence within the workplace also needs to be ensured. All procedural competences should be reviewed again at the end of CMT2 to ensure they have been attained.
- All CMTs should have some exposure to ITU or medical HDU, and ideally this should be in the form of a short attachment.

3) Rota design and notice provided

Much disillusionment comes from the limited ability to plan a personal life around work. While all accept that out of hours working is integral to a physician's role, it is demoralising to have only a few weeks' notice of a rota, making it difficult to plan leave and family events. The GMC Trainee Survey (2014) found that a significant proportion of CMTs receive their rota with less than one month's notice. Medical registrars also report that, because of the workload, full weekends (Friday/Saturday/Sunday) on duty are now exhausting, although this provides better continuity of patient care. It is not possible to be prescriptive as different hospitals have different needs and rota complexities, but we suggest:

- Rotas should be provided at least six weeks in advance to allow notice for clinic cancellations. They should ideally cover a minimum period of 4 months.
- There should be consultant and trainee input into rota design and time provided in job plans for this activity.
- Efforts should be made to ensure a degree of continuity in team-working between trainees and consultants, to facilitate support and feedback.
- Until workload issues have been addressed, consideration should be given to splitting weekend duties in discussion with local trainees.

4) H@N and filtering/screening of calls by other specialties

The medical registrar's workload is a key issue and reflects increasing service demands. The development of hospital at night (H@N), designed to improve safety within the inpatient bed complement throughout hospitals, has created additional challenges. It appears that in some medium and large health service

organisations, the medical registrar's ability to run the acute take has been impeded and in many cases almost subsumed by their duties on H@N, with implications for patient safety. Some report that the volume of calls may be such that they can barely leave the phone to see patients. The Med Reg is frequently seen as the first port of call for help with acute in-patient issues, particularly in surgical wards when more senior staff are busy in theatre. Other calls are simply inappropriate or administrative, and could be dealt with by a senior nurse.

We recognise however, that it is appropriate that H@N is supported by a medical registrar and that in smaller hospitals with fewer admissions, it may be appropriate to merge this with the acute take. However this requires careful consideration and planning. In larger organisations, we believe that running the acute take and running H@N are two distinct roles.

We would suggest:

- The roles of the Med Reg on H@N and the acute take are separated in larger organisations, but with post-shift handover to a consultant by both.
- Consideration of senior nurse-led triage of calls – this already occurs at night on H@N in many places and works well.
- Improved guidance to other specialties on appropriate calls to the Med Reg, and other sources of help for acutely sick patients. Consultants and managers should support the Med Reg in rejecting inappropriate calls.
- In larger hospitals, a designated medical liaison team for surgical specialties could be considered during the working day. This model already exists for older people on orthopaedic wards on some sites, provided by Medicine of the Elderly. However, it is recognised that this has workforce implications and may be challenging to deliver.

This statement has been endorsed by the Royal College of Physicians of London and the Royal College of Physicians and Surgeons of Glasgow. In order to take this forward, the three Royal Colleges of Physicians are forming a working group to progress these proposals.

Appendix

The roles and responsibilities of the medical registrar⁷

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) 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

Additional Reading

- 1 Tasker F, Newbery N, Burr B, Goddard AF. Survey of core medical trainees in the United Kingdom 2013 – inconsistencies in training experience and competing with service demands. *Clin Med* 2014; 14: 149–56. https://www.rcplondon.ac.uk/sites/default/files/cmt_survey_of_junior_doctors_clin_med_april_2014.pdf
- 2 RCP/RCPE/RCPSG. *Supporting the acute take: advice for NHS trusts and local health boards*. https://www.rcplondon.ac.uk/sites/default/files/supporting_the_acute_take_-_final_statement.pdf
- 3 Acute medicine Consensus Statement: Improving quality of care through effective patient flow - now it's everyone's business! *J R Coll Physicians Edinb* 2013; 43(Suppl 20): 57–67. http://www.rcpe.ac.uk/sites/default/files/files/supplement20_rcpe_acutemed_2013.pdf
- 4 Royal College of Physicians (London). *Acute medical care. The right person, in the right setting – first time*. Report of the Acute Medicine Task Force. London: RCP; 2007. https://www.rcplondon.ac.uk/sites/default/files/documents/acute_medical_care_final_for_web.pdf
- 5 Royal College of Physicians (London). *Acute care toolkit 8: The medical registrar on call: Maximising clinical experience, training and patient care*. London: RCP; 2013. https://www.rcplondon.ac.uk/sites/default/files/act8_registrars.pdf
- 6 British Medical Association. *Safe Handover: Safe Patients. Guidance on clinical handover for clinicians and managers*. London: BMA; 2004. <http://bma.org.uk/-/media/files/pdfs/practical%20advice%20at%20work/contracts/safe%20handover%20safe%20patients.pdf>
- 7 Royal College of Physicians (London). *The medical registrar: empowering the unsung heroes of patient care*. London: RCP; 2013. https://www.rcplondon.ac.uk/sites/default/files/future-medical-registrar_1.pdf

Working Group Membership

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