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From the editor

Let's hear it for the medical registrar!

What proportion of an electorate needs to vote, or what proportion of recipients of a questionnaire needs to reply, for results to be regarded as valid? And what proportion of doctors replies to questionnaires anyway? One answer is that a 40% response rate for a population of over 2,000 provides 95% certainty with a 3% uncertainty margin,[1] and that in surveys of that size, for physicians receiving questionnaires by mail, the response rate is ~52%.[2]

So Andrew Goddard and his colleagues are to be congratulated on the survey which they performed on the experiences and expectations of medical registrars in 2010, as reported in this issue of the journal (pp 532–5). There are no grounds for recourse to arguments about sample size which might invalidate the findings, and unfortunately those findings make depressing reading. From the perspective of medical registrars 'clinical medicine in England is in poor health'. While phrases such as 'wakeup call' are part of every journalist's bag of clichés, it seems truly apposite here.

What has gone wrong – or has it always been so? And what can – indeed must – be done about it?

Grafting these validated survey findings with other less rigorous sources of opinion, it seems clear that the imposition of the European Work Time Directive (EWTD) caused a deterioration in job satisfaction. While there are published studies which take an optimistic view of the impact of the directive on hospital practice,[3] there is a wealth of evidence, including this survey, that training is felt to have deteriorated since the EWTD's introduction.[4,5] However, surveys also indicate that the concept of a 48-hour week is welcomed by doctors in the training grades; even those minor revisions to EWTD that might be implemented in Brussels to complex court judgements on the exact nature of on-call work and rest periods seem remote in time. Furthermore, it is much too easy a path to attribute all the dissatisfaction among medical registrars to a European directive.

Anxieties and dissatisfaction appear to centre around three areas: involvement in acute medicine, job prospects, and the possibility of 'new types of consultant working' – the grade that scarcely dare speak its name, the sub-consultant. Each of these is an area in which there are definable issues on which both 'action now' and forward planning are desirable.

Dissatisfaction concerning acute medicine among the registrar grade probably reflects many different issues. One is clearly the diversion of time and effort from their specialty training – the latter fortunately an area of substantial satisfaction in Goddard's survey. Entwined with this appears to be the heat and burden – not so much of the day but of the night – involved in the duties of an on-call medical registrar. The role of the medical registrar in the acute take, even if tempered in some hospitals by greater consultant involvement, has steadily grown in recent years. One major problem is the instability and fragility of the rotas in which they work, with excessive internal cover or inadequate external locums. There may be some prospect of amelioration in the future, as increasing numbers of UK medical graduates enter the job market following the expansion of medical schools in the last decade; for that to occur, however, a physicianly career needs to remain an attractive prospect. And it will only remain attractive in the current structure if more junior trainees wish to become medical registrars.

Consider the other pressures on the medical registrar at night. Emergency admissions have increased and are continuing to increase. Length of stay is falling, so continuity between the patients they looked after when last on an overnight shift and the next time is virtually non-existent. The handover arrangements may be relatively poor. The support from other medical grades and particularly other specialties may be lacking or insubstantial. The medical registrar has become the first port of call not only for acute medical admissions, but increasingly for problems on surgical wards. It is scarcely surprising that there are increasing reports that the more junior trainees in foundation years or core medical training look at the hard-pressed registrar's role and say – 'not for me'.

To the economic planner, there seems to be an inexorable logic: too much work for x workers, so y workers (where x>y) are needed. Link that to the concept of a training grade: medical registrars turn into consultants don't they? So consultant numbers increase. UK plc is not well off, so…. There are two possible ends to that sentence which the reader will readily appreciate – poorer remuneration, or an alternative intermediate grade of fully trained doctors working at a sub-consultant grade.

To the manpower planner, the logic may be different. There has been a steady increase in the number of UK graduates leaving medical school. While there are ameliorating factors

(feminisation of the workforce leading to more part-time working, medical career prospects outside the NHS), it is likely that both the hospital and general practitioner services will be able to call on a greater number of fully trained doctors in the future. Does that imply more consultants, or a different career grade?

To the healthcare planner, a third logic applies. Too many small hospitals, too many rotas – so further concentrations of emergency work and expertise are required. The smaller number of rotas can be filled without damaging gaps, and changes in staffing structure could avoid the hardship and disadvantages of the single hard-pressed registrar. This poses the question, what is that staffing structure to be?

All these arguments emphasise that physicians – current and more importantly future – should decide what sort of career structure and what sort of work pattern is most effective to deliver services and fulfil the reasonable career aspirations of the medical workforce. These are issues in which bodies such as the British Medical Association will be deeply involved, but they are also issues in which the Royal College of Physicians needs to lead.

One example of current forward thinking involves a different aspect of career planning for service provision, and one directly relevant to another area of concern flagged up by Goddard's survey. It is unsurprising that the topic of job prospects for different specialties should engender concern – it has always been so. But specific issues of today – the move planned of care resources out of hospitals and into the community, and the power of general practice commissioning and its imputed stance about hospital medicine, clearly compound that anxiety. One area that needs clear thinking is the relationship between acute medicine and specialist medicine. The UK has benefited from an economic and versatile solution over many years, with consultants combining acute and specialty work; the growth of acute medicine as a specialty in its own right – albeit still small – is widely seen as having improved emergency care of medical patients, but the eventual paradigm of care between the acute physician, the specialist and the specialist with a continuing generalist role remains unresolved. Generalism – the development of the internal medicine physician who bears primary responsibility for a patient in hospital, receiving the majority of patients who are admitted from acute medical wards – is a model which bears a close examination. The role of the specialist is then in the true sense a consultant to such patients, with as a result the specialist being left unfettered time for special procedures and outpatient care; the model allows the patient with multiple comorbidities to be cared for by an expert in just that – the patient with general medical problems.

Does a generalist model with specialist input constitute better care for most patients? Will different funding streams force radical changes in the way hospitals are run? While the answer to the former is 'don't know', the answer to the latter is pretty clearly 'yes'. We should spare more than a thought for the hard-pressed medical registrars on whom the service depends now, and who will deliver the inevitable changes as future leaders.

Reference

1 www.greatbrook.com/survey_statistical_confidence.htm
2 Cummings SM, Savitz LA, Konrad TR. Reported response rates to mailed physician questionnaires. *Health Serv Res* 2001;35:1347–55.
3 Cappuccio FP, Bakewell A, Taggart FM *et al.* Implementing a 48 h EWTD-compliant rota for junior doctors in the UK does not compromise patients' safety: assessor-blind pilot comparison. *QJM* 2009;102:271–82.
4 Mann C. Response to: Implementing a 48 h EWTD-compliant rota for junior doctors in the UK does not compromise patients' safety: assessor-blind pilot comparison. *QJM* 2009;102:298.
5 Dobson R. A response to Cappuccio F *et al.*: 'Implementing a 48 h EWTD-compliant rota for junior doctors in the UK does not compromise patients' safety: assessor blind pilot comparison'. *QJM* 2009;102:297–8.

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