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The medical registrar's experience of acute medicine on call: an ethnographic study

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Aims

To develop an understanding of the medical registrar's experience of acute medicine on-call from their perspective.

Methods

The research methodology was ethnography. Two researchers were involved in the data collection – a GP trainee and a university researcher. Three trusts within the north of England were used for recruitment. Observations of eight registrars took place June 2014 – February 2015 during acute on-call shifts. A total of 86.5 hours of observation data was collected. Following the shifts, interviews were conducted with participants to reflect on the observations made. Results were inputted into NVivo and coded to identify themes.

Results

Four themes were identified from the data. First was a mismatch between the perception of what makes the job difficult by junior doctors encountered during shift observations, and what was actually observed; specifically around perceived bleep numbers, lack of senior support and clinical uncertainty. Bleeps occurred on average 1.5 times an hour, while consultant support was referenced 62 times and had a positive impact on morale. There were no 'uncontrollable' situations witnessed on any of the observations or situations where the magnitude of bleeps actually caused patient care to stop. Second was humour, which was the most recurring code – it was used to enhance group cohesion and as a way to cope with stress. Third was defaulting to the medical registrar by individual staff members and other specialties, which was a particular source of frustration while on shift and was also echoed in interview. A contributory factor was found to be a lack of role definition regarding where the responsibility of the registrar lies. Fourth was identifying how the registrars felt that the job could be improved through junior training, workload redistribution and role definition.

Conclusions

Defaulting is a result of the changing hierarchy within medicine; increasingly the hierarchy has become steeper, with more emphasis being on decisions being made from the top down. This disempowers lower ranks and makes them more dependent on senior levels. The registrar is viewed as a bridge within the social network of the hospital between the other specialties and is subsequently seen as the link for patients who require interactions with multiple individuals. Redistributing responsibility and tasks among lower ranks would ease pressure on registrars by providing more links within the network, as well as empowering juniors and enabling them to develop important decision-making skills. ■

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