Whither or wither the medical registrar?

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ABSTRACT

In 2013, the Royal College of Physicians published *The medical registrar: empowering the unsung heroes of patient care*. This report showed that workload, teamwork, training and flexibility were the key factors in determining job satisfaction and morale for medical registrars. Since the report, some progress has been made in each of these four areas. Reduction in workload by development of new parts of the hospital workforce has started and the junior doctors' industrial action has forced the NHS and employers to look afresh at both workload and training aspects. The creation of chief registrars and guardians of safe working has started to create a supporting framework to improve professional working lives and training. Teamwork and support from consultants is perhaps the biggest opportunity to improve matters. However, the NHS remains inflexible and making the medical registrar post attractive to those in earlier stages of training is the biggest challenge.

KEYWORDS: medical registrar, training, workload, work-life balance

In 2013, the Royal College of Physicians (RCP) produced the report *The medical registrar: empowering the unsung heroes of patient care* as part of the Future Hospital Commission.[1] This report was compiled following interviews with over 200 medical registrars across the UK and identified the key problems facing them, as well as producing numerous practical solutions. Three tumultuous years in the NHS later, have working conditions and future prospects for the medical registrar changed?

In the report, four main areas of concern were identified:

1 pressure of workload
2 problems in teamwork within and between teams
3 quality of training
4 flexibility of working lives.

Given the recent (and ongoing at the time of writing) dispute between junior doctors and the government over a new contract, it is timely to look at each of these four areas. As an aside, should the government read this (unlikely I know), pay was never raised as an issue by the registrars interviewed for the report.

Workload

Workload for all hospital staff has risen relentlessly over the past 10 years.[2] Not only has the number of hospital admissions increased, the patients being admitted are more complex, there are fewer beds available and hospitals have faced unprecedented financial challenges with the imposition of austerity. To meet this challenge, the NHS has looked to increase its workforce but the inability of our national workforce planning to meet this change in demand is shown by the failure to appoint 42% of consultant physician appointments in 2015.[3]

Consultant numbers have increased in this period but the opposite is true for medical registrars (Fig 1). The reasons for this are complex. There has been a small planned reduction by Health Education England because of financial constraints and this has hit some specialties more than others. There has been an increase in medical registrars working less than full time, which probably reflects the changing demography of the medical registrar grade. Finally, and perhaps most importantly, there has been a failure to recruit around 8% of posts (depending on specialty).[4,5] This is both a symptom and a cause of workload pressure.

Workload is a function of the work to be done and the workforce and tools available to do it. The workload to be done seems unlikely to fall for the foreseeable future, despite the plans of the current wave of 'sustainability and transformation plans'. The number of hours that junior doctors will work also seems unlikely to increase.[6] New technologies to assist working for all doctors in the NHS, such as electronic patient records, mobile technology, near patient testing etc, have all failed to significantly slow the incoming tide of work. Therefore, if we want to reduce the workload for medical registrars, we have to either increase their numbers or get other people to do some of the work.

The latter was one of the key solutions proposed in the 2013 report. The 'roles and responsibilities' description has been implemented in some hospitals but more noticeable has been the development of allied health professional roles to assist the running of medical wards. The number of physician associates being trained in the UK has increased almost exponentially in the past 2 years as has the number of advanced nurse practitioners.[7] Anecdotally, these have both improved working lives in hospitals where there has been an increase in support staff but this is hard to quantify on a national scale.

For most medical registrars, there is a clear distinction between the workload created by their on-call and acute medical take roles and the workload produced as a specialty registrar. Medical registrars report that the acute medical workload impinges heavily on their specialty training.

The intensity of workload is important as is the vital need to take adequate rest. The negative effects of lack of rest on

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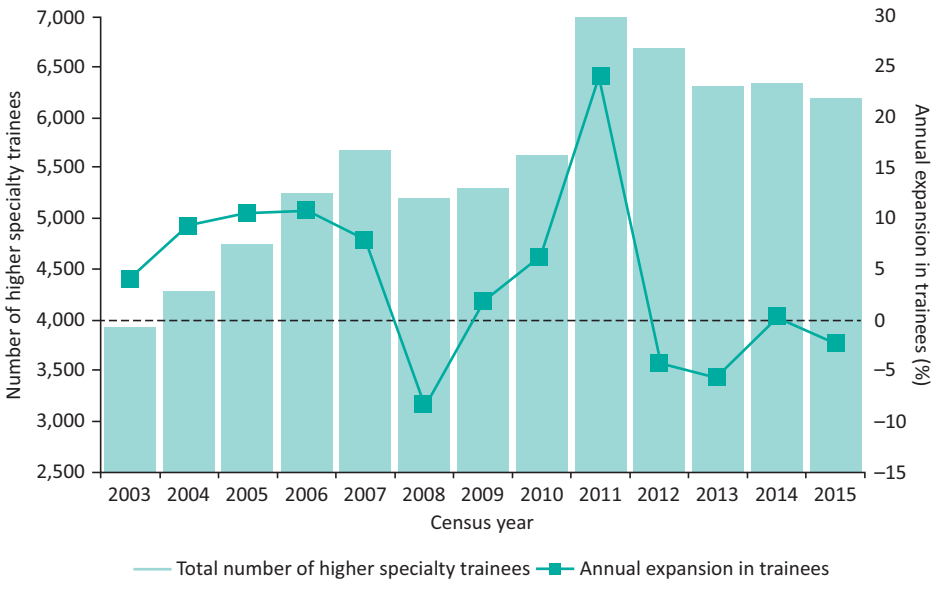

Fig 1. Higher specialty trainee numbers and annual expansion in the UK (2003–15). Reproduced with permission from the Royal College of Physicians.[3]

performance are very well documented and other industries, such as transport and industry, have specific safeguards in place to ensure rest is taken.[8] The move away from on-call rotas to shift rotas in the last decade has resulted in the removal of on-call rooms and other facilities to allow protected rest. This needs to change to allow adequate rest for those working the night shift. At the risk of upsetting *Daily Mail* readers, doctors must sleep on the job. We have allowed a culture to develop that sees rest as failure when in fact it is failure to rest that risks patient safety. This is as true in nursing as it is for doctors.

Other solutions to improve workload proposed in 2013 included:

- having a named consultant physician to be a 'champion of the medical registrar' supported by a manager to assess workload
- the RCP assessing what a safe level of staffing is with respect to the medical registrar
- the Department of Health reassessing the effectiveness of the 4-hour target
- hospitals ensuring management of the perioperative patient is considered when assessing the medical registrar workload.

Progress has been made on each of these to some degree.

The creation of 'Guardians of Safe Working' by Jeremy Hunt[9] gives an opportunity for a consultant physician to have dedicated time to assess workload. Having said this, though, the lack of clarity about whom and how this role will function is of concern. They must be seen to be impartial to trainees and accountable to them as the trainees' main route of whistleblowing on poor working conditions. The RCP plans to produce clear guidance on how these individuals can work most effectively.

The RCP has established a working party to look at safe staffing levels in the acute setting. This will include the medical registrar grade and, although the evidence base is relatively slim, we hope the report will be heavyweight in its impact and practical usefulness to all members of the medical team.

The recent relaxation of financial penalties for 4-hour breaches[10] may help the medical registrar a bit, if only because more funding in trusts will allow more staff to be employed. However, the target remains in place as a measure of trust performance.

The Royal College of Anaesthetists has set up a 'perioperative medicine' group.[11] The relative excess of anaesthetic trainees to future consultant demand has a positive benefit in that there will be increased availability of anaesthetists on the ward. Hopefully this will reduce the dependency on the medical registrar by surgical teams.

Teamwork

It is not just medical registrars that report a loss of the team on medical wards, with many consultants bemoaning the death of the medical firm.[12] Nostalgic reflection, though, does often overlook the problems of the past and it is as useful to look at what makes teams work well in the modern world as well as what made teams work in the past.

Medical registrars, more than any other grade of hospital doctor, swing between being a team member and a team leader. Clear roles and responsibilities for different team members, as outlined above, are therefore important. Good communication and feedback within and between teams is also crucial, especially where shift working and high intensity of work are present. Together, these lead to a common purpose for all in the team. Feedback is often cited as the single form of communication lacking for many trainees. It allows learning, development and, more importantly, contributes to a sense of being valued.

While hard to quantify, it is the failure to feel valued by their peers and consultants that is at the root of most trainees' concerns about teamwork. This was expressed at a recent meeting for trainees held at the RCP where several trainees said 'no one says thank you anymore'. Arguably, this failure of the system to value trainees was the root cause of the ongoing dispute over the junior doctors' contract.

One solution proposed to help develop the role of medical registrars in hospital teams, improve their sense of being valued and develop their leadership skills is that of the 'chief registrar'.[13] Analogous to the senior resident in many US

hospitals, the chief registrar has dedicated time (40–50% of contracted hours) for developing the working lives of their trainee colleagues. This idea has been supported by many hospitals and a chief registrar programme has been started under the auspices of the Future Hospital Programme at the RCP. There are currently 23 chief registrars in hospitals in the UK. This leaves at least 150 hospitals without one (which is disappointing) but once the results from the first wave of the programme have been disseminated, this will hopefully give other hospitals little excuse not to develop the role in their site.

The success of a team is usually related to the leadership of that team and the role of consultants is crucial to this. Poor consultant leadership results in a lack of support and valuing felt by the medical registrar and an increase in problems for that registrar to have to manage. Some of the reasons for this are understandable: increase in intensity of workload for consultants as for other hospital staff; erosion of time for supporting professional activities because of increased hospital activity; shift handovers and working time restrictions limiting one-to-one time with registrars; and a loss of morale by consultants themselves.

This is a challenge but it is one that consultants must meet head on and overcome. If the firm is a family, we should be unsurprised if it collapses because of absent or poor parenting. Consultants need to be positive and excited about medicine, show interest in their trainees, fully engage in their training, give them feedback regularly, take them for coffee (or invite them round for a meal), and say thank you. This can seem hard when faced with a ward full of new sick patients or a safari ward round to six different wards with a pile of administration to do and an over-booked clinic in the afternoon. However, the result is a happier team that works together, a happier ward round and, most importantly, better patient care.

Training

The conflict between service and training has been an ever present theme when discussing quality of training with medical registrars. The demand to service the acute take is seen by many as reducing training opportunities in their specialty. This is especially true for specialty trainees requiring procedural experience.

Working hours are mostly, but not solely, to blame. The hours contracted to work by medical registrars per week has fallen from 72 in the 1990s to 56 in the 2000s to 44 in 2016.[6] Length of training and, for physician trainees, the time spent in non-physician specialties before core medical training have both fallen over the past two decades.[14] Overall, the total number of hours spent by a physician in training has halved in this period. This reduction has been as a result of changes to the junior doctor contract and, of course, by working time regulations. Brexit has offered an opportunity to tweak some of the more restrictive regulations but there is unlikely to be an increase in hours worked.

Such reduction in training hours is not an issue if the quality of training improves. However, the evidence from trainee surveys suggests the opposite is true.

Core medical training has suffered from the same quality issues and perceived adverse influence of the acute take. A survey of core medical trainees in 2012 showed that 44% felt their training had not prepared them to be a medical registrar.[15] As a result of such surveys, a set of quality criteria for core medical training was introduced in 2014.[16] This focused on the areas of training that trainees were most dissatisfied with and put the onus on training providers to meet minimum quality criteria, such as attendance in outpatient clinics. These criteria have been challenging to introduce but have been successful.

Quality criteria for medical registrar training are currently in development by the Joint Royal Colleges of Physicians Training Board and trainee representatives. These will be focused on the four areas described in the 2013 report as well as focusing on specific training issues.

Work-life balance

The medical registrar workforce has changed over the past 20 years. The current generation have different hopes and aspirations to those that their consultant colleagues had.[5] Work-life balance has shifted to prioritise life over work and thus the ability to have a job that allows this dissuades many from becoming a medical registrar. The only measure reported by medical registrars to have improved when the working time regulations came into force was work-life balance, with over 55% saying it was better following the 48-hour week.[14]

The failure to understand the importance of this balance is another reason that it has been difficult to reach agreement with a new junior doctors' contract. The push from employers has been to create a contract that allows increased weekend working without increased costs.[17] However, this obviously means that there are no financial incentives to do 'work time' at anti-social hours and the subsequent loss of 'life time'. The lack of any other incentives together with the other issues above has resulted in a very disaffected workforce. Imposition of a contract aggravates this further. Many experts in occupational health and wellbeing are clear that a failure to understand the holistic needs of a workforce and address those needs results in a less productive, less healthy and less safe service. This is an area that is relatively devoid of evidence in the medical workforce. At the risk of sounding like a typical researcher – more research is needed.

The importance of 'life time' is perhaps best exemplified by the demographics of different specialties at the medical registrar level (Fig 2). It is an over generalisation to say that female medical registrars have different career aspirations compared with their male colleagues but there are differences. Female medical registrars are more likely to want to work less than full time and more likely to be willing to work in 'junior consultant posts'. They are less willing to move deaneries and this suggests that family and home life is more of a priority than career for many female medical registrars. Specialties that impact less on 'life time' have a predominantly female registrar workforce.

Given the generational and demographic shifts in the medical registrar grade, it would be foolishness to not ensure the medical registrar job changes to reflect this. Jobs need to be more flexible and accommodate less than full-time working, child care, easy access to the internet, etc. Employers that do not should be unsurprised when they cannot recruit.

It's not all doom and gloom

While there has been progress since the report, this has not been as large as many would have hoped and this may have left

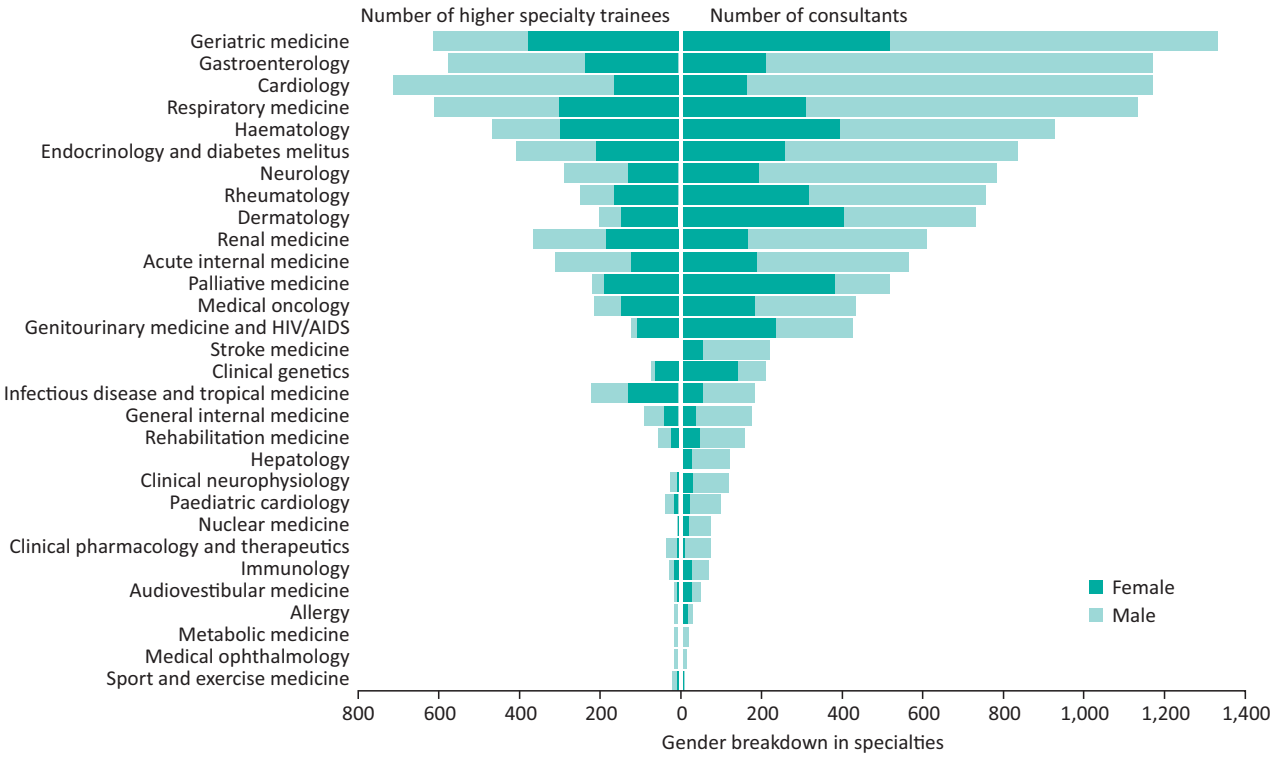

Fig 2. Gender breakdown of the consultant and higher specialty trainee workforces in the UK. Reproduced with permission from the Royal College of Physicians.[3]

the reader feeling despondent. Indeed, given the worsening pressure on the NHS and the contract dispute, it can be argued that medical registrars are in as bad a position now as before the report was published. The junior doctors' contract dispute has created a gulf between the government and the profession wider than ever before. The NHS is under the greatest financial and demand pressures for a generation. Surely, there is no hope?

Paradoxically, the paucity of consultants to fill vacancies in most of the major specialties is good news for medical registrars. The choice of jobs in different parts of the country, except perhaps London, is large and it is a buyer's market. This is likely to be the case for many years and so may help lift spirits in the middle of a night shift in the emergency department or on the surgical ward.

Medicine remains a brilliant job and the RCP is committed to providing the resources to allow doctors of all grades to be supported and make the most of their careers. The next phase after the 2013 report has been to collect the evidence to show what can be done to improve the working lives of all doctors, including the medical registrar. This work, under the tagline 'keeping medicine brilliant' is being published in a series of practical resources over 2016–17. While we hope that policymakers and employers will work hard to improve the lot of trainees, it seems likely that most of the work will have to be done by the profession itself. The RCP will do its utmost to rise to this challenge and challenge all parts of the profession to improve the lives of the medical registrar.

The issue of morale of the workforce is now centre stage. When the 2013 report was written, a deaf ear was turned to the alarm call by many. The industrial action in 2016 means that the plight of the medical registrar and their morale can no longer be ignored. Let us not waste this opportunity. ■

Conflicts of interest

The author has no conflicts of interest to declare.

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