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Letters to the editor

OVERVIEW

Please submit letters for the editor's consideration within three weeks of receipt of *Clinical Medicine*. Letters should ideally be limited to 350 words, and sent by email to: clinicalmedicine@rcplondon.ac.uk

Valuing the workforce who value their patients

Editor – when I read your article in the last issue of *Future Hospital Journal*, I thought that at last someone had recognised why recently qualified doctors so often these days find their first appointment disillusioning.[1] As you recognise, these admirable young men and women do their best to fulfil their idealised role, and it is not the long hours, heavy responsibilities and relatively low pay that they resent, but the fact that no one appears to care for them as they did for us when we were residents; making sure we did not miss our meals by turning up late (food is a good substitute for sleep), sympathising when – with the best will in the world – we got things wrong (according to our seniors), teaching us the knowhow that complements the knowledge that was all brought to our work (we learned this from the nurses) and providing us with the opportunities we needed to discuss our lonely anxieties with our fellow residents (often one of the self-appointed tasks of the now defunct ward cleaners and orderlies).

Administrators who have never been in our situation themselves have taken away the residents' dining rooms, replaced loyal ward cleaners with itinerant gangs, abolished the facilities for snacking that we used to have and gave us a kind of second wind in the small hours and generally treated us not as midshipmen but as conscripted seamen. We were taught to value others as we do ourselves; we learn by bitter experience that it is difficult to value others if we are not valued ourselves by those in authority who sometimes appear to believe that we owe loyalty to them and their preoccupation with making ends meet more than to our patients with their importunities. ■

JOHN A DAVIS
Retired professor, Cambridge, UK

Reference

1 Nicol E. Valuing the workforce who value their patients. *Future Hospital Journal* 2017;4:3–4.

Consultant job planning for a 7-day service

Editor – Being a gastroenterology trainee, I read with great interest Dr Lewis' article on 'Consultant job planning for a 7-day service' and how consultant cover was provided on a 7 day basis from 08:00–21:15.[1] I was surprised to see no inclusion of a consultant gastroenterologist on call overnight, particularly with National Institute for Health and Care Excellence guidance stating that urgent endoscopy is required in unstable patients who present with an upper gastrointestinal bleed.[2] With the number of consultants on this rota, one would feel that it would be just for a 1:10 out-of-hours gastrointestinal bleed cover, which should count for at least 1 PA. This is not just a gastroenterology problem, cardiology have obvious need for 24-hour cover and, given the changing nature of medicine, will we need more specialties to be on call overnight? Within *Clinical Medicine*, it has been highlighted that junior colleagues are less confident at performing procedures.[3] Junior colleagues soon become senior colleagues – will we reach a stage that we are required to ring the chest physician on call for an emergency chest drain or the haematologist on call for a sickle patient requiring an exchange transfusion? How will we compensate these consultants for this? The NHS is a 24-hour 7 day a week machine that is supported by consultants at all times; job planning needs to represent this. ■

Conflicts of interest

The author has no conflicts of interest to declare.

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1 Lewis M. Consultant job planning for a 7-day service. *Future Hospital Journal* 2017;4:33–6.
2 National Institute for Health and Care Excellence. *Acute upper gastrointestinal bleeding in over 16s: management*. NICE clinical guideline No 141. London: NICE, 2012.
3 Tasker F, Newbery N, Burr B, Goddard AF. Survey of core medical trainees in the United Kingdon 2013 – inconsistencies in training experience and competing with service demands. *Clin Med* 2014;14:149–56.

Response

Thank you for reading the article and forwarding your comments. On-call work for gastroenterologists (in terms of both specialist and general work) is mentioned in the text although I have not included the calculations for on-call payments. Currently, in our trust, general physicians are paid 1 PA to take part in an on-call rota 1:13 weekdays and 1:6.5 nights. In light of the fact that gastroenterologists also participate in endoscopy out of hours, we have a 75% commitment to the on-call rota (0.75 PAs) as well as taking part in a 1:8 endoscopy rota (paid 0.25 PAs).

Circumstances will vary at different trusts so this pattern of work (and remuneration) only reflects our trust's position and was not necessarily relevant to the wider NHS. I am, nevertheless, grateful to the reader for raising this important point. ■

Conflicts of interest

The author has no conflicts of interest to declare.

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Editor – we read with great interest the opinion piece concerning consultant job planning for a 7-day service authored by Dr Matthew Lewis in last issue of *Future Hospital Journal*.[1] We were each previously medical directors, with a combined experience totalling some 25 years, and found the examples of how to plan for 7-day services both clear and compelling. Lewis' conclusion that 'effective job planning allows finite resources to be used to the greatest effect' is one with which we entirely concur. Managing the way our workforce is deployed to ensure their skills are applied to best effect will ensure we are able to offer high-quality care to our patients in the most efficient way. This fundamental principle underlies the implementation of a number of the 15 recommendations of Lord Carter's report into unwarranted variations in the performance of NHS acute trusts in England.[2] Evidence of such variability has emerged previously in the report of the British Orthopaedic Association authored by TB.[3] This 'getting it right first time' (GIRFT) philosophy has led to real improvements in surgical outcomes within elective orthopaedics services and, for the first time, a fall in litigation claims – an important surrogate for quality. The GIRFT programme has now been funded to expand to more than 30 specialties. Each has a national lead, usually a clinician of national or international stature, and access to data that will ensure we know 'what good looks like' in terms of both outcomes and service delivery. Clinically conceived, clinically led and delivered by clinicians, hospital visits are already underway, at which the GIRFT leads engage face to face with the consultants and other clinical staff responsible for delivering each service 'on the ground'. This ensures they adopt best practices as defined by royal colleges and specialist societies, which have without exception expressed their support for the programme. Matching job plans for medical and non-medical clinical staff (eg allied health professionals, pharmacists) and those providing diagnostic services will be crucial to ensure best practice can actually be adopted and thereby meet the (7-day) needs of patients, the demands of actually providing the service and to maximise the beneficial impact of the NHS' physical (eg operating theatres, imaging equipment) and human resources. ■

Conflicts of interest

The authors have no conflicts of interest to declare.

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1 Lewis M. Consultant job planning for a 7 day service. *Future Hospital Journal* 2017;4:33–7.
2 Briggs T. *Getting it right first time. A national review of adult elective orthopaedic services in England.* London: British Orthopaedic Association, 2015.
3 Lord Carter of Coles. *Operational productivity and performance in English NHS acute trusts: unwarranted variations.* London: Department of Health, 2016.

Now, where are those matches at the end of this tunnel?

Editor – 20 years ago, pretty much to the day, Professor JR Bennett wrote 'will the last one out please turn off the lights in the emergency admissions ward'.[1] I fear Paul Jenkins' matches are far too little and much too late.[2] And, anyway, we are nowhere near the end of the tunnel.

Professor Bennett is the Cassandra of this tale. His editorial, 'The general physician – dinosaur or superman?', pretty much predicted all that has come to pass.

The catastrophe that is acute general medicine is a consequence of the syzygy of four separate, not altogether unconnected, events. I will describe the Norwich experience – Dr Jenkins hails from Norwich – although I know this has been replicated in teaching hospitals across England. It is worth pointing out that district general hospitals (DGHs) have weathered the storm far better as they do not have the luxury of multiple belligerent specialists to shoe-horn into creaking general internal medicine (GIM) rotas.

First came the closure of rehabilitation/convalescent hospitals. In Norwich, the canary in the coal mine was the sudden appearance of a flock of geriatric colleagues in the acute hospital offering to take over the care of elderly GIM patients. Slightly baffled, we specialist physicians seized the opportunity at face value. Only subsequently did we realise that the geriatricians had been rendered cageless as Norwich lost all of its community beds.

Secondly, the Royal College of Physicians promised a new specialty to deliver acute medicine. Acute medicine, as part of the Acute Care Common Stem, is a necessary service; just not in its current incarnation. The trust was persuaded that this new specialty would assume responsibility not only for acute admissions – the 'front door' – but ultimately for GIM in its entirety.

Thirdly, specialists seized the opportunity to make an unseemly dash to specialisation and super-specialisation. Professor Bennett has pointed out the Kafkaesque disincentive in which training for 'generalists' is a year longer than for 'specialists', the rewards for which are: a delay in achieving certificate of completion of training; being forced onto GIM rotas; having a reduced exposure to specialty patients; and to earn the public's opprobrium – despite having identical specialist training to the 'specialist'. Cardiology were first out of the blocks and were immediately followed by respiratory medicine. Gastroenterology's solution was to arrange regional rotations such that their specialty registrars did their GIM training in regional DGHs and their specialist gastroenterology training in Norwich; thus, the gastroenterologists were lost to GIM services in Norwich. The last doctors standing – nephrology and endocrinology – looked over our shoulders to find that everyone else had taken two steps back and we had been volunteered to manage the hippogriff. I advised at the time that this flight from GIM would mean running out of the doctors to deliver it within 10 years. We did.