Coping with pressures in acute medicine—the second RCP consultant questionnaire survey

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ABSTRACT — The second questionnaire survey of consultant physicians involved in acute unselected takes in 1999 achieved a 76% response rate, and the results have been compared with those from the first survey of 1997. The proportion of consultants whose trainees worked partial shifts had increased from 42% to 61%, although these patterns of duty were adjudged to have detrimental effects on the quality and continuity of care, and on junior staff education and training. The benefits of ward-based systems were counterbalanced by their disadvantages, but introductions of admission wards and assessment units were considered a resounding success. The number of hospitals with ‘physician of the week’ schemes had increased from 12 to 23, but opinion of their value was sharply divided. The provision and competence of all grades of locums was identified as an increasing problem. Seventy per cent of respondents stated that they would never participate in ‘hands-on’ emergency care, although 86% thought that future consultants might have to do so. Seventy-nine per cent reported increases in the pressures of their posts and in their working hours, and the tensions between general and specialist duties were highlighted. Most consultants considered that the only long-term solution to the staffing crisis was a marked expansion in the numbers of all grades of medical staff.

It is becoming increasingly difficult to maintain safe levels of care in acute medicine for a number of reasons, notably the inexorable rise in emergency admissions and the reduced hours of doctors in training. In response to these pressures, innovative work patterns have been developed, including admissions wards, shift duty rota1, ward-based schemes and ‘physician of the week’ systems2. The first consultant questionnaire survey of the Royal College of Physicians (RCP), undertaken in August 1997, provided feedback on these and other aspects of acute services.1 A second survey was undertaken in August 1999, and achieved a 76% response rate, with 1,803 physicians involved in acute unselected takes providing detailed information on several topical issues. The full report contains a wealth of data, has been circulated to all respondents, and is now available on the College website, to which the interested reader is referred. This short review focuses on the differences between the results of the two surveys and on new data from the second survey.

Logistics overview

The proportion of consultants reporting 30 or more admissions per 24 hours increased from 25% in the 1997 survey to 40% in 1999. The most common take rota was still 1 day in 5, but the proportion of respondents reporting an arduous 1 in 4 rota showed a satisfactory decline from 22% to 14%. The numbers of trainees on acute teams had increased over the two years. For example, the number of consultants with a team of 1 specialist registrar, 2 senior house officers and 1 house physician (a total of 5 trainees) rose from 168 to 272, whereas that of consultants with 1 specialist registrar, 1 senior house officer and 1 house physician (3 trainees) fell from 296 to 196. These changes occurred despite an embargo on the creation of new posts, and were probably achieved by the integration of general and elderly care medicine, and by the incorporation of trainees in specialties such as dermatology and neurology into acute teams. The use of non-career grade doctors on the acute team had more than doubled, from 84 to 197. Nevertheless, 23% of acute teams did not have a specialist registrar, and 104 still comprised only 1 senior house officer and 1 house physician.

Partial shift rota

The proportion of consultants whose hospitals had introduced shift rotas for trainees had risen sharply from 42% to 61%, despite the negative feedback from the 1997 survey, and (presumably) because of pressure from Regional Task Forces. The 1999 survey has given a more detailed evaluation of these rotas, with assessments of their impact on continuity of care, junior staff education and training, and – most significantly – on quality of care. All were decidedly unfavourable, with mean ratings of 2.6–3.9 out of 10, although the mean for the overall success of the rota was more equivocal at 4.9. Free text comments indicated that shift rotas were viewed primarily as a means of complying with requirements on trainees’ hours of work; but although some trainees were indeed less tired, the detrimental effects on quality of care, junior staff education, team structure and job satisfaction considerably outweighed any benefits. The forthcoming reduction in trainee hours to 48 per week will force most

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hospitals to adopt shift rotas, but it should be acknowledged that this will lower standards of care and is at odds with the current drive towards quality.

**Ward-based systems and admissions wards**

New data on ward-based systems are available from the 1999 survey. They had been adopted by a surprisingly high proportion of respondents – 54% – and received a mixed verdict, with a mean rating score of 6.6/10 for ‘overall success’. The many positive aspects, notably the reduction of ‘safari’ ward rounds and of large variations in workload, and the closer liaison with nursing staff, were counterbalanced by the loss of continuity of care, duplication of work and the daily arrival of new patients. Thus, no clear consensus emerged on this important issue. By contrast, admissions wards and assessment units received unambiguous support, with a mean score of 7.8/10, despite problems relating to insufficient bed numbers, lack of nursing support, and difficulties in transferring patients out of the units.

**‘Physician of the week’**

The number of consultants with experience of this scheme had increased from 67 (from 12 hospitals) to 156 (from 23 hospitals) between 1997 and 1999. The mean score for their success was an impressive 74/10. Some consultants said that this scheme was popular and had led to improved care, but others disputed this, and some found it unduly tiring. This system has produced considerable dissent in some hospitals where it has been introduced, and most physicians in other hospitals remain implacably opposed to it.

**Availability and competence of locums**

Difficulties in obtaining locums (particularly at senior house officer grade) were reported by 65% of respondents, and 53% had concerns over their competence. Ideally, trusts should not rely on locums but it is difficult to avoid their use, especially with the current embargo on new training posts. This is an increasingly important problem and needs careful monitoring over the next few years.

**General versus specialist duties**

The tensions between general and specialist consultant duties were highlighted in the survey. Thirty per cent of respondents indicated that at least one consultant (usually a cardiologist) had withdrawn from the acute rota at their hospital, and 24% indicated that they themselves were considering this option. Many consultants felt that their specialist work, regarded as their first priority, was increasingly jeopardised by the general medicine workload. The understandable desire of some older consultants to concentrate entirely on specialist duties needed to be balanced against the extra workload for other colleagues.

**Solutions to the impending staffing crisis**

The question of consultant participation in ‘hands-on’ emergency care is currently topical®. Seventy per cent of respondents stated that they would never undertake these duties, consistent with a previous survey® – but 86% thought that future consultants might have to do so. Among other possible solutions, 64% felt that restrictions on trainee numbers should be relaxed, and 59% supported the use of nurse practitioners to help with acute workload. The overwhelming need for a marked expansion of the consultant grade was emphasised by many consultants as the best way to address these problems.

**Other issues**

Other issues covered in the full report include policies on care of the elderly and on the care of patients with acute myocardial infarction, the pros and cons of fixed versus rotating weekday take duties, the introduction of split weekends for trainees, the impact of external teaching for specialist registrars on service provision, and views on the proposed ‘junior consultant’ grade.

**Conclusions**

The second questionnaire survey of the Royal College of Physicians has shown that consultants are working harder than ever to cope with their heavier acute workload. Eighty-four per cent of consultants reported an increase over the past three years in the pressures of their post, and 79% an increase in working hours. They continue to demonstrate an impressive resilience and capacity for change in addressing these problems, often at increased personal cost. Most physicians consider that the only long-term solution is a considerable expansion in the numbers of all grades of staff. The next few years will be increasingly difficult, and further surveys will be needed to monitor the rapidly evolving situation in acute general medicine.

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This report outlines current practice in rehabilitation medicine, indicating the skills needed by the rehabilitation specialist and stressing the crucial role of multidisciplinary teamwork – both among clinicians and other health care professionals. It sets out what is required for an effective rehabilitation service both in terms of organisation and resources, and addresses recommendations to commissioners of health care, medical educators, NHS managers and doctors themselves. It is hoped that this report will bring greater understanding of rehabilitation medicine and lead to a less remote and fragmented service for disabled people.

Foreword SUMMARY AND RECOMMENDATIONS Introduction Definitions and background Medical priorities in rehabilitation Contributions of rehabilitation medicine consultants to the rehabilitation process The specialty of rehabilitation medicine Commissioning issues Resources required for rehabilitation medicine References Appendices: The interface between rehabilitation medicine and geriatric medicine Outline of the curriculum in rehabilitation medicine List of useful organisations concerned with disability

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