Junior Doctors Committee
Supporting colleagues on the acute medical take
July 2014
Summary
The crisis in acute medicine has led to suggestions that higher medical trainees in specialties that do not engage in the medical take (non-GIM) lose this opt-out in order to improve the working environment. We believe that deployment of non-GIM higher specialty medical trainees to the medical acute take may be acceptable if safeguards for both trainee and patient can be assured by agreement on an individual trainee basis.

Background
The medical take is, broadly, the hospital admissions under the care of the medical team over a defined period of time. The medical take is normally managed by the medical registrar. This role is intrinsic to higher training programmes for those in training to be consultants in many (but not all) medical specialties. Medical registrars have leadership and supervisory roles as far as the take is concerned but they are often, additionally, the senior medical decision-maker in the hospital, the sole repository of certain advanced medical skills, and those expected to lead on managing the most unwell patients. Traditionally a testing but rewarding role, the challenges have grown substantially in recent years owing to rising patient attendances, four hour targets in Emergency Departments, changing skill levels in the medical and ED teams, and more frequent requests for support from other specialty teams. During a period of running the acute take, the norm (rather than the exception) is a series of shifts of 12 or more hours of intense and sustained activity to meet patient need, with little or no opportunity for rest, over 3-7 consecutive 24 hour periods. The demands of the service also leave little time for training the medical registrar, junior trainees or the non-medical team.

More junior trainees recognise these pressures and perhaps as a result, recruitment into medical specialties that take part in General Internal Medicine (GIM) is now difficult. The developing workforce crisis is exacerbating these problems (see Appendix A for data). Rotas are becoming more unsociable, the training environment less favourable and the pressure on the medical registrar simply unsustainable. Therefore, the search for solutions is timely.

These issues have been addressed directly in reports from the Royal College of Physicians (RCP)1-3. Key recommendations include increased curricula and time allocations to GIM, participation by non-GIM trainees in acute medical services and, ultimately, dual certification for all trainees in GIM. A longer period of general training in programmes that are shorter overall has been controversially suggested by the Shape of Training Review4 Some employers are now proposing the deployment of trainees who have entered higher training from Core Medical Training (CMT), or equivalent, but whose curricula requirements do not afford them time to train in GIM and, as such, take part in the medical registrar role.
BMA Policy (see also Appendix B)

1. The current workload of the medical registrar is, in many cases, believed to be unmanageable. This results from the interplay of the intense demands of the NHS acute service in its current configuration and the small number of doctors available to help with the work. This negatively impacts upon the medical team’s training.

2. It is possible, and desirable for patients, for an individual doctor to develop good general and good specialist skills and knowledge. This may require prolonged periods in the training grades (over and above that required to train a pure “specialist” or “generalist”) and should be funded and regulated properly.

Overarching Principles

1. Patient Safety. Approaches that ameliorate the intense medical registrar workload and difficult rota patterns should improve patient safety and service quality. However, those taking on the medical registrar role must demonstrate that they possess the key capabilities and should never be deployed unsupported or untrained.

2. Doctor Wellbeing. The whole profession should strive to support one another across traditional specialty boundaries. The continuing privilege of certain specialties to opt out of the acute take may need review out of consideration for our colleagues. The involvement of non-GIM trainees should not unreasonably compromise the patterns of work they might have expected on appointment.

3. Training Quality. Any solutions for the redeployment of non-GIM trainees should enhance training quality for all involved (compared to the status quo) and not place any trainee’s progression at risk. No academic work should be compromised by such solutions.

4. Continuity of Specialist Services. Non-GIM trainees take part in their specialty on-call rota, clinics, procedure lists and other specialty services to meet patient need. Within existing hours limits, any redeployment of trainees away from their normal specialist service commitments risks destabilising those services. Recruitment in areas engaging with redeployment to the acute take must not be compromised as to do so would merely exacerbate the problems that this solution is intended to solve.
Junior Doctors Committee View

Interventions to improve the training environment across the acute take are broadly to be welcomed. We believe that the redeployment of non-GIM trainees to the acute take is one such approach that could improve training, deliver a higher quality of working life for many trainees, and a better service to patients. As such, it should not be dismissed without further development.

Although “pull” solutions would be preferable, they are impracticable until the numbers of trainees willing to act as the medical registrar are increased. Employers and trainers must recognise that participation by non-GIM trainees in GIM work not appearing in the original person specification of their programme would represent a significant concession by those trainees to support their colleagues and patients. Many trainees already perceive that their training is considered an optional extra by hospital employers who only value the service they provide – a factor which partly explains the recruitment crises in acute and emergency medicine. Given that most training programmes remain effectively time limited, trainees in such adverse environments who remain expected to progress in their training at the same rate as those in the most favourable workplace suffer considerable additional stresses. Furthermore, it is imperative that the quality and depth of non-GIM specialty training valued by patients and delivered at the front door is preserved. We believe that the following recommendations, consistent with our four guiding principles, are most likely to render redeployment acceptable to trainees.

Recommendations

For employers:

1. Any progress towards deployment of non-GIM trainees to the acute take must start with individual employers exploring all other means to ameliorate the pressures of the acute take. This should include evaluating whether consultants in Acute Medicine need to be more involved.

2. A resourced, board-level working group should be convened to explore and agree the initial employer approaches. This should include representatives from registrar grade GIM and non-GIM trainees who will be affected by any changes. This group should be clear that the deployment of non-GIM trainees must be motivated by training quality, patient care and doctor quality of life considerations. Any suggestion that cost saving is a priority would necessitate total trainee and trainer disengagement from the process.

3. As a minimum, employers will need to demonstrate engagement with RCP recommendations.

4. Employers should accept liability for any additional indemnity payments required of trainees for acting beyond their non-GIM role.

5. Employers may wish to investigate other ways to incentivise participation, without favouring any one trainee group.
For trainers

6. When considering redeployment, the first consideration should always be the impact on the trainee's individual training requirements.

7. Any redeployment of trainees must be made based on the merits of the educational case and kept continuously under regular, robust and trainee-focused review.

8. As a minimum, non-GIM trainees should never be allocated to a role or post that is, at other times, not filled by a training GIM registrar.

9. Redeployment should only take place in the first 12-18 months of higher specialty training (ST3-4) when it is least likely to place non-GIM training at risk. Later, the pressure to complete specialty curricula without extended training time should make redeployment much more difficult to justify. In an era where curricula are growing to reflect patient need, allocating time “out of specialty” to GIM work will be difficult to justify educationally.

10. Non-GIM trainee time spent on the acute take would need to be only a proportion of that of a GIM trainee, reflecting their different (and individualised) educational priorities.

11. On an individual trainee basis, the Educational Supervisor (ES) would need to agree a clear plan for protecting the non-GIM components of training.

12. Where the ES was not in a position to elucidate areas for development within GIM (because of a lack of GIM experience) a separate ES for the GIM work would need to be involved.

13. This GIM ES will also have a key role in ensuring patient safety. Although non-GIM trainees entering higher specialty training directly from CMT have notionally been prepared to work as a new medical registrar, in practice they may lack suitable preparation, including functional competencies with advanced invasive procedures.

14. Where a lack of experience or capability in GIM is identified, in the interests of patient safety this must be addressed before the trainee can be deployed to the medical take. This may take the form of additional training for the individual, or by ensuring that the medical team has the complete skill mix by deploying GIM and non-GIM registrars together.

15. Where trainees have not proceeded directly to higher training from CMT (for example having had a period out of programme, or a career break), there will be a much greater burden on the GIM ES to demonstrate that redeployment will be safe.

16. Once agreed with the non-GIM trainee, the conclusions of these in-depth discussions will be recorded in the training portfolio Personal Development Plan. This will provide a degree of protection to the trainee at the ARCP if non-GIM competencies have not been met.
For postgraduate deans, LETBs and deaneries

17. It is essential that any planned redeployment is approved on an individual basis by the postgraduate dean.

18. Processes for appeal against redeployment will need to be developed at the level of the deanery function as a further check against local coercion of non-GIM trainees.

19. LETBs/Deaneries known to be implementing redeployment of non-GIM trainees may find recruitment to their areas becomes more difficult. There should thus be liaison between deanery functions to ensure that the implementation of redeployment is uniform across the country, as well as to support sharing of best practice.

20. When good practice has emerged, it will be essential to codify the processes in the Gold Guide.

Please direct queries to info.jdc@bma.org.uk

References


## Appendix A: Acute Medical Specialties

**Recruitment Figures June 2013**

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<th>Specialty</th>
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Source: JRCPTB
Appendix B: Policy Appendix

1. ANNUAL REPRESENTATIVE MEETING

Medical Workforce
That this Meeting views with great concern the recent Royal College of Physicians report that found that 37% of trainee physicians describe the workload of the medical registrar as unmanageable, and calls upon the BMA to:—
   i) lobby for implementation of recommendation 23 of the Francis Report to develop standards for minimum staffing levels;
   ii) work with relevant bodies to develop evidence-based tools for appropriate minimum medical staffing levels for different services;
   iii) lobby deaneries, LETBs and other relevant bodies to ensure that training is protected in the face of high workloads. (2013)

Medical Education & Training
That this Meeting believes generalist & specialist knowledge and skills can & should co-exist in the same doctor, and we:—
   i) believe the solution to the problems of the acute take is not to create a new cadre of generalist-only doctors, but to better equip doctors in speciality training with more generalist training;
   ii) call on the Shape of Training review to avoid recommending a separation of generalist & specialist training;
   iii) call on the Royal Colleges to consider extending training programmes to allow more generalist experience to be gained in the setting of a regulated, funded training programme rather than outside training. (2013)

2. JUNIORS CONFERENCE

This conference:
   i) recognises the pressure medical registrars are under in the NHS as described in the Royal College of Physicians’ report ‘The Medical Registrar’;
   ii) believes that such pressure on a relatively small number of individuals is detrimental to their health, training and potentially to patients;
   iii) believes that a greater number of medical specialties should be participating in the acute medical take where curricula permit, with more medical trainees dual accrediting in both their chosen sub-speciality and general medicine;
   iv) acknowledges that such a move would need to be done in a managed, prospective way to guarantee patient safety;
   v) believes that acute medicine must be better supported and resourced as a standalone medical specialty and measures to boost recruitment should be brought forward by HEE. (2014)