Trainees' Forum

Contributions are welcome from trainees on any aspects of their training

Senior Registrar On-Call Duties

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Much has been written concerning Higher Psychiatric Training, in respect of both the training and research opportunities which should be provided for senior registrars, and the degree of responsibility which should be expected of them. However, one area over which there is some dissension, and which appears in practice largely to be left to the discretion of the individual hospital, is the matter of on-call duties.

Since most senior registrars will inevitably reach consultant status, it would seem appropriate that their on-call duties should prepare them for the responsibilities of the consultant on-call rota. However, in some cases it would appear that the view held is that both junior and senior trainees should be classed together so far as on-call duties are concerned. This is surely a refutation of the purpose of higher training. More pernicious, since outwardly it seems a reasonable proposition, is the view that, since senior registrars are intermediate in status between consultants and junior trainees, they should be prepared to act up or down as the situation demands. Few would object to the occasional first on-call duties which might crop up in times of crisis, but in practice this view leads to a small (but far from insignificant) group of senior registrars performing regular on-call duties on both junior and senior rotas.

Despite the strong feelings aroused by this topic in consultant and trainee alike, there exists no central record of what duties senior registrars are asked to perform in reality. Initially, I was moved to attempt to fill this gap in a spirit of enlightened self-interest, and I then only envisaged sampling one or two Regions. However, the interest shown by those senior registrars who were first contacted prompted me to extend the survey to cover the whole of England and Wales.

Method

The survey was carried out in May and June, 1980. A list of all senior registrar posts in England and Wales was obtained from the Joint Committee on Higher Psychiatric Training. Honorary Senior Registrar posts, i.e., involving a substantial proportion of time spent in research or other academic work, were excluded, as were posts designated for forensic psychiatry, child psychiatry, psychotherapy or psychogeriatrics in such posts, since on-call duties are often atypical.

A simple postal questionnaire was therefore sent to all senior registrars in general psychiatry in England and Wales. The recipient was asked to indicate whether his on-call duties comprised; (1) first on-call; (2) second on-call; (3) consultant rota; (4) no regular duties, or a combination of these. First on-call is taken to be that rota which supplies the hospital duty doctor. Second on-call is defined as a rota separate and distinct from both the first on-call and the consultant rotas.

Results

One hundred and twenty-three hospitals were contacted and replies were obtained from all of them. Eight hospitals proved no longer to have, or never to have had, a senior registrar post, and the data are therefore culled from 115 posts; 69 of these were at large psychiatric hospitals and 46 in general hospital units.

A total of 26 senior registrars (22.6%) undertake first on-call duties, the proportion being virtually the same at psychiatric hospitals and general hospital units. This may be broken down into 15 (13%) who are on a first on-call rota only, and 11 (9.6%) who undertake regular duties on both first and second on-call rotas. The remaining 89 may be divided into three groups: 33 (28.7%) are on a separate second on-call rota, 40 (34.8%) participate in the consultant on-call rota, and 16 (13.9%) have no regular duty commitments.

When the results are broken down by Region, we find that the distribution in most Regions is not far from the average, though the small numbers involved make comparison difficult. However, four Regions (Northern, Yorkshire, North West Thames and South West Thames) have over 30% of senior registrars with first on-call duties, and in four other Regions (Trent, East Anglia, North Western and Wales) no senior registrars are required to perform first on-call duties. Whether these differences reflect Regional policy is impossible to deduce on the basis of the information available.

Discussion

On-call duties for trainees in psychiatry have always been somewhat different from those in other specialties, where a multi-tier system usually operates. Perhaps as a relic of large, poorly staffed asylums, it is the usual practice for senior house officers and registrars to participate in a common, first on-call rota. Since such a rota is of its very nature rarely more arduous than 1 in 5, there are usually very few complaints.

When one considers the problem of the senior registrar, matters are somewhat different. Certainly, other specialties do not require their senior registrars to perform first on-call duties. Although it is obviously difficult to make com-

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parisons, it would seem clear that the responsibilities of higher trainees should be rather different from those of junior trainees. The majority (77.4%) of hospitals in this survey recognize this, and their senior registrars either have a second on-call rota midway between the junior and consultant rotas, participate in the consultant rota, or in some cases have no regular duties at all. This last would seem the least useful solution in terms of training unless the senior registrar is given the opportunity of covering on the rota of consultants during their periods of leave. If the senior registrar is to participate regularly in the consultant rota, a probationary period would be sensible, during which a consultant would be available for advice. Separate second on-call rotas are in general only feasible if a hospital has more than one senior registrar, or if other experienced staff such as medical assistants are available to participate in the rota.

Second on-call duties tend to vary widely in their scope, from giving advice over the telephone, to providing psychiatric cover for casualty departments and general hospitals. Sometimes, the second on-call is involved in a community crisis service. Although many first on-call rotas are self-sufficient in the event of illness or non-appearance of the duty doctor, some hospitals require the second on-call to step into the breach on such occasions.

The sector in which dissatisfaction is most apparent is, not surprisingly, that where senior registrars are still performing first on-call duties. However, it is only fair to note that a very small proportion said they were happy to perform such duties. These fall into two groups—those who prefer the higher proportion of Class A UMTs attached to first on-call duties, and those who work in small, often specialized units, which can be covered from the duty doctor's home.

Unless it is their own wish, senior registrars should not be expected to perform regular first on-call duties. Both psychiatric hospitals and general hospital units are sufficiently well staffed now for an adequate first on-call rota to operate without the participation of senior registrars. Higher trainees should not be used as extra pairs of first on-call hands. The psychiatric services suffer from this practice since a not inconsiderable proportion of consultants will not have had an adequate training in their on-call responsibilities.

Matters *are* improving, albeit slowly. Three questionnaires were returned with a note that duties had changed for first on-call to second on-call within the preceding few months, and indeed the figures in this paper may already be a little out of date. This is a sensitive issue, and individual hospitals may feel that their right to organize their own on-call arrangements should not be infringed. But unless higher trainees push for an improvement in their on-call duties there will still be a number of hospitals which cling to the time-honoured on-call arrangements—'because it is traditional here'. Unless senior registrars in such a situation make their feelings known, it will be assumed that they too are happy with the status quo.

Parliamentary News

(April to July, 1981)

Legislation

Section 144 of the Supreme Court Bill, now in the final stages of its passage, makes substantial changes in the arrangements relating to Lord Chancellor's Visitors by amending Sections 108 and 109 of the Mental Health Act, 1959. The existing offices of Medical and Legal Visitors are abolished (except that the position of the present holders is safeguarded), and instead there will be panels of Visitors, Medical, Legal and General. The Court of Protection will establish standing rules as to the circumstances in which patients should be visited, but the visit will be made by a General Visitor unless the judge (i.e. the Master of the Court of Protection) considers it essential that it should be made by a Medical or Legal Visitor.

Mental Health Services and Miscellaneous

In reply to two questions by Mr C. Irving, three research projects on the *primary care* contribution were mentioned, one being carried out at the Institute of Psychiatry, as well as the general practice research unit at the Institute.

The number of *patients in mental illness hospitals* is now about 76,000 compared with about 112,000 twelve years ago; it is thought that there may be up to 5,000 patients capable of living in a different setting.

If a *mental hospital is closed* and the premises and site sold, the proceeds are to be used to develop other mental health services.

Lists were published on 4 June of local authorities that had or had not provided various forms of day or residential care.

On 7 July Sir George Young, replying to a question from his own side of the House, again spoke of the official policy of *support for schizophrenic patients* living in the community, and praised the work of the National Schizophrenia Fellowship.

The Minister, on another date, refused to accept the length of waiting lists as a criterion of need for expanded

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