

confidence interval 0.04–0.32). There was no evidence of an association between professional grade and rating of response. Those specializing in emergency medicine and, to a lesser extent, primary care gave significantly more negative responses than those specializing in general medicine (model 2: adjusted mean difference in ratings (emergency medicine *vs* general medicine) 0.78, 95% confidence interval 0.42–1.13; adjusted mean difference in ratings (primary care *vs* general medicine) 0.30, 95% confidence interval 0.05–0.55). This was not true of surgery.

These results suggest that there are differences in how the medical registrar is perceived, dependant on gender and speciality. Interestingly those specialities referring on a regular basis to the medical registrar were more negative. There was no significant overall effect of age or stage of training, reassuringly suggesting that seniority does not lead to disillusionment or disappointment in the current batch of medics.

This is a limited study with inherent bias because of the sampling method – those with a greater vested interest in the role will have been more likely to respond. There was under-representation of surgical specialities and of those >45 years old, and missing data for speciality. However, both this and the other small study presented to the Royal College of Physicians suggest a worrying trend towards an increasingly negative perception of the workload and overall role of the medical registrar. It will be important to look further into these issues (Table 4).

The Royal College of Physicians is collecting data on the workload of registrars, acknowledging that medical on call is essential to acute service provision. An overwhelming workload that threatens recruitment is not acceptable. A redistribution of resources may be necessary (P Cadigan, 2011, unpublished data). Specific areas of study include the time spent on various clinical activities, interactions with members of other teams (with respect to time,

clinical utility and educational value), the role of the medical registrar in handover, and the perception of the role by other doctors, health-care professionals and patients (Grant and Goddard, 2012). The results of this work will make interesting reading. In the mean time, what can you do to prepare yourself for the role as it currently exists?

The medical take

Your day job as a speciality registrar will bring its own challenges: clinics, multidisciplinary team meetings, referrals and the acquisition of specialist skills such as endoscopy or bronchoscopy. However, for most new medical registrars the medical take is the area of greatest apprehension.

The role of the medical registrar is fundamentally different to that of a senior house officer. Senior house officers do most of the work required for each patient – taking thorough histories, completing full examinations, selecting appropriate investigations and initiating acute management.

Table 2. Demographic details and descriptive statistics of respondents

Characteristic		%
Sex (n=613)	Male	40.0
	Female	60.0
Age (n=613)	<29 years	56.4
	30–44 years	39.2
	≥45 years	4.4
Professional grade (n=613)	1 = medical student	10.0
	2 = house officer (FY1)	7.3
	3 = SHO (FY2, ST1, ST2)	40.1
	4 = speciality registrar (ST3–7)	29.2
	5 = consultant	13.4
Speciality (n=384*)	Medicine	57.0
	Anaesthetics/intensive care	10.9
	Emergency	7.8
	Primary care	17.7
	Surgery	6.5
Rating (n=677)	1	19.8
	2	34.6
	3	38.6
	4	5.3
	5	1.8

* missing data partly a result of medical student, FY1 and FY2 respondents not identifying a speciality. FY = foundation year; SHO = senior house officer; ST = speciality trainee.

Table 3. Crude and adjusted associations between characteristics of respondents and their responses rated 1–5

Characteristic	Crude analysis		Adjusted analysis: model 1* (n=613)			Adjusted analysis: model 2* (n=384)		
	Mean	95% CI	MD	95% CI	P value	MD	95% CI	P value
Professional grade (n=613)	1 = medical student	2.3	2.1–2.5	–	–	–	–	–
	2 = house officer (FY1)	2.1	1.9–2.3	-0.23	-0.57–0.11	0.187	–	–
	3 = SHO (FY2, ST1, ST2)	2.2	2.1–2.3	-0.12	-0.37–0.13	0.349	–	–
	4 = SpR (ST3–7)	2.4	2.3–2.6	-0.01	-0.27–0.29	0.966	–	–
	5 = consultant	2.5	2.3–2.7	-0.01	-0.33–0.35	0.955	–	–
Speciality (n=384)	Medicine	2.2	2.0–2.3	–	–	–	–	–
	Anaesthetics/intensive care	2.5	2.2–2.8	–	–	–	0.29	-0.02–0.60 0.062
	Emergency	2.9	2.6–3.2	–	–	–	0.78	0.42–1.13 <0.001
	Primary care	2.5	2.2–2.7	–	–	–	0.30	0.05–0.55 0.018
	Surgery	2.4	2.0–2.8	–	–	–	0.29	-0.09–0.67 0.130
Sex (n=613)	Male	2.2	2.1–2.3	–	–	–	–	–
	Female	2.4	2.3–2.5	0.18	0.04–0.32	0.014	0.15	-0.04–0.34 0.114
Age (n=613)	<29 years	2.2	2.1–2.3	–	–	–	–	–
	30–44 years	2.4	2.3–2.6	0.18	-0.01–0.36	0.066	0.29	0.10–0.48 0.002
	≥45 years	2.6	2.3–2.9	0.36	-0.03–0.75	0.069	0.23	-0.20–0.66 0.289

* Model 1: sex, age category and professional grade, model 2: sex, age category and speciality. CI = confidence interval; FY = foundation year; MD = mean difference; SHO = senior house officer; SpR = speciality registrar; ST = speciality trainee.

In many district general hospitals a 12-hour on-take period can include the assessment of up to fifty patients.

When you start ST3 you may be tempted to remain in the role you are familiar with and want to re-clerk every patient before making any decisions about their care. This is not possible, and is not an effective use of your time. Instead, you need to focus on rapid decision making. The challenge is to use the skills in pattern recognition that you have developed over years of experience to direct patients to the most appropriate investigations and treatment (Groopman, 2007). You are now valued for your knowledge, your judgement and your ability to organize and advise others.

Many of the questions you will be asked will have no right answer and will require you to weigh up risks and benefits of a given course of action and individualize decisions to the patient in front of you. You will have to rely on assessments made by and information provided by others, and will therefore have to develop the ability to rapidly assess the competence of those you are working with. This is a fundamental change in your role that you need to anticipate in order to plan how you can most effectively direct your time and attention during your shift (Table 5). A recent article in this journal provides excellent advice on preparing for and managing a medical take (de Woolf, 2011).

Leadership: dictatorship or democracy?

You will already have observed and, consciously or unconsciously, judged many medical registrars in their role. You will have formed opinions not only on their clinical competence but also their leadership style and ability.

There is a wealth of literature analysing the relative effectiveness of different styles of leadership. In the corporate world such theories are well known and highly valued, and techniques for adapting and enhancing an individual's leadership skills are built into training programmes. In medicine such skills are often paid lip-service only before consultant grade roles, with an assumption that good doctors make good leaders and managers. It is important to develop an insight into your own leadership style and consider how you are viewed by others. A degree of emotional intelligence will ensure that you make the most of your strengths and maximize the influence you exert. Do you naturally adopt an autocratic, democratic or laissez-faire leadership style, as classically described in Lewin et al (1939)? How do you negotiate with and influence others?

In reality effective leadership is not simply based on a rigid set of attributes or behaviours. You will need a wide range of abilities and approaches that you can draw upon, and select in response to the individual situation. At a cardiac arrest call an

autocratic style can be effective and ensure there is rapid implementation of the treatment algorithm. When deciding which juniors will cover the wards and who will clerk you may favour a democratic or laissez-faire approach. And when looking for a bed on the intensive care unit you will need to draw on all your persuasive and negotiating skills to advocate for your patient.

Can't we all just get along?

An essential part of your role will be to liaise with other specialities, both those making referrals for acute medicine input and those whose expertise your patients require. This is often a source of friction as it is easy to feel unfairly burdened by the requests of others. This is especially true when you perceive the requests to be unjustified. Here are some points to remember as you count to ten and stop yourself exploding at the orthopaedic FY2 who has called you to ask how to manage his patient's chest pain.

Be flattered by the fact that they need you

Although it may not always feel like it we are all working towards high quality patient care. If another team asks for your input take it as an opportunity to make an impact on that patient's experience.

Remember that you are an expert

You may feel that your knowledge of chest pain is no better than any other doctor who trained in the last decade, but this is not necessarily the case. You have been through recent exams, attended training days and read guidelines that are up to date, and have recent practical experience in management. Do not be surprised if you find yourself advising consultant surgeons and experienced GPs on things you consider straightforward. Just remember that there are skills they have that you don't, and if you requested their help in removing your patient's gall bladder or following up their chronic kidney disease you would expect them to be obliging.

Limit your involvement

Many requests will be for advice, not for you to take over care of the patient. You should ensure that, when appropriate, this is how you respond. Being clear about what information you require, giving advice about further investigations or treatment

Table 4. Unanswered questions about the role of the medical registrar

Are perceptions of an unmanageable workload accurate?
Is there evidence of a negative impact on recruitment to acute medical specialities as a result of a negative perception of the role of medical registrar?
How does the organization of the medical take influence job satisfaction?
Is the selection process into acute medical specialities robust in identifying those with the required skills?
Does the training programme for current ST1s and ST2s adequately prepare them for the transition, in particular the leadership and management aspects of the role?

Table 5. Core components of the role of the medical registrar

Discussing and accepting referrals from emergency medicine, GPs and other inpatient teams
Organization of the take: allocation and prioritization of cases to juniors
Rapid decision making regarding investigations and intervention
Direct review of the most acutely unwell patients, often those in the resuscitation bay of the emergency department
Decision making on most appropriate location for ongoing care and ceilings of care
Leader of resuscitation and peri-arrest calls
Expert resource for the entire hospital

trials, and setting parameters for further discussions will make the interaction much more constructive. It is also important to clarify what you expect to be documented in the notes. Your advice of 'medical registrar suggests that central burning chest pain in the context of normal electrocardiogram, bloods, chest X-ray and observations most likely upper gastrointestinal, therefore trial of proton pump inhibitor and review seems most appropriate' may somehow be misinterpreted as 'medical registrar says discharge', implying a level of responsibility for the patient's pathway which you may not feel appropriate. It is wise to clarify what anyone seeking phone advice is planning to document.

Build future relationships

While you may like the idea of being feared and think this may be a good tactic for preventing future referrals, this is unlikely to be a successful long-term strategy. In particular in respect to accident and emergency, these doctors will be referring to you frequently for months. Being clear about your expectations, explaining the reasons behind your decisions and suggesting alternatives to the default position of 'refer medics' will provide valuable feedback and training for FY2s working in accident and emergency and ensure that they never again refer you a patient with a rectal bleed, just because the patient happened to be on warfarin.

Accept the realities of current medical practice

We live in an increasingly scrutinized and litigious world with Care Quality Commission reviews and newspaper headlines casting dark shadows over many hospitals. Individuals no longer feel confident relying on knowledge they gained at medical school and are often actively encouraged not to step outside their area of expertise. We increasingly treat older patients with active interventional approaches, leading to a frail and elderly population residing on surgical and orthopaedic wards managed by junior doctors with limited senior support.

We may lament the deskilling of surgeons in terms of their ability to treat common medical complications but we should be questioning the model of health care provided within the NHS and the training provided within speciality programmes, not the individuals striving to provide high

quality care within their sphere of competence. In orthopaedics a multidisciplinary model has been enthusiastically adopted, using the specialist skills of physicians specializing in medicine for care of older people to improve outcomes for older patients undergoing hip replacement as recommended in the National Confidential Enquiry into Patient Outcome and Death (2010) report. Perhaps this is an insight into working practices of the future, although concerns have been raised about resource implications (Herd, 2011).

Physician heal thyself

'Rule your feelings, lest your feelings rule you' wrote Publilius Syrus in the first century, a warning that seems particularly apt for the transition to becoming a medical registrar. Stress is accepted as a large part of the life of a doctor, but at what point does the potentially beneficial effect on performance of heightened awareness and engagement become pathological, impacting on the ability to do your job, and spilling over into your personal life?

Doctors are notoriously bad at asking for help and instead pursuing less adaptive coping strategies such as alcohol misuse (British Medical Association, 1995), so it is worth considering some tactics that may be helpful in dealing with the stress of the role, in addition to preparing in advance (*Table 6*).

Embrace the fear

Accept that initially you will be under increased pressure, and that this will improve as you gain experience and confidence. Be aware of the signs and symptoms of stress in yourself and be alert to what expectations you are placing on yourself, and whether these are realistic.

Table 6. Preparing for the transition

Create and take opportunities to 'act up' in a supported environment

Reflect on and analyse how other people execute the role

Know your own leadership style, strengths and weaknesses

Accept that things will not always go smoothly and the aim of your first few shifts should be survival

Know the structure and availability of support from seniors and other acute care providers, e.g. intensive treatment unit

Take a break

It is easy to go through a 13-hour shift without stopping for lunch, drinks or even a 'natural break' since there is always something you could be doing, and someone who wants your attention. This is short sighted as humans are more efficient and effective if they have regular breaks. You must make time to stop, sit down and have lunch. It is also important to model such behaviour to juniors, if only to minimize the chances of them becoming exhausted, taking sick leave and leaving you under-staffed.

Re-adjust your work-life balance

You may have to resign yourself to a period of imbalance when you step up into a new role, but remember that this is not indefinite. Managing the expectations of colleagues and family so you do not create additional pressure for yourself is essential.

Prepare for night shifts

You will already have worked many nights as a senior house officer and developed strategies to ensure you are able to deliver high quality care despite sleep deprivation. However, your role as the night registrar will involve many more judgement calls, so it is even more important that you look after yourself. The Royal College of Physicians's publication 'Working the night shift: preparation, survival and recovery' (Pounder and Horrocks, 1996) is a useful evidence-based refresher on how best to develop a routine to minimize your sleep debt and function at your best in the twilight hours.

Maintain some work-life balance

Look outside the window occasionally and remind yourself that there is a world outside the medical assessment unit. Plan to see friends and family in your time off, maintain hobbies and interests, and do things that make you happy. This may sound obvious, but physician burnout is all too common, and as a profession we are bad at following our own advice.

Get some exercise

Regular aerobic exercise has antidepressant and anxiolytic effects, increases resilience to stress and enhances self-esteem (Scully et al, 1998). It may be difficult to squeeze in some exercise without it becoming yet another drain on your time, but cycling or running to work may be a realistic option.

Have a laugh

If you ignore everything above you must follow this last piece of essential advice. The emotional demands of dealing with unwell patients and their families, superiors, juniors and managers, the frustrations at ‘the system’ and the myriad other tests your patience will endure every day can only be navigated with the ability to stop and laugh. A giggle shared with colleagues can be the release and remedy required to let you carry on.

The future in a consultant-delivered service

In most district general hospitals, the medical registrar is still king or queen of the hospital. They deliver acute medical care in the first 48–72 hours, a critical determinant of clinical outcomes (Royal College of Physicians, 2011). In an era of not only consultant-led but consultant-delivered care will this change?

According to an unpublished draft report commissioned by NHS London in 2009–10 the hospital mortality rate in London was 0.32% higher for patients admitted at the weekend than among patients admitted during the week. This has led to the suggestion that increasing cover by consultants at weekends could prevent more than 500 deaths a year in London alone, with similar results expected elsewhere. The proposed 7-day 12 hours/day consultant-led service would require many new appointments of acute physician consultants and is unlikely to be a reality in the very near future. But the impact of such a system on training and experience must be examined before any implementation.

On one hand greater feedback on decisions made during the take, and closer working between consultants and registrars in this environment could recreate valuable features of the old apprenticeship system. On the other hand, many consultants already view current registrars as inexperienced and ‘acopic’. With many decisions taken out of their hands by the presence of a consultant in the hospital this is only set to worsen.

It will also be important to further analyse this data before making vast changes to hospital working patterns. A further study replicated the finding that patients admitted at weekends had higher 30-day mortality but, importantly, showed that this was not independently predictive in a risk model that included illness severity (age and biochemical markers) and comorbidities (Mikulich et al, 2011). There is also no convincing data that the presence of more consultants alone impacts mortality. For the decisions consultants make to be enacted requires 7-day working of other services such as radiology and rapid response teams of occupational therapists, physiotherapists and social workers, and full teams of junior staff. Perhaps we need also to address out-of-ours community input, especially for nursing home residents and elderly patients, and not view the hospital as the only care provider amenable to change in the patients’ pathway.

Conclusions

‘Fulfilled’ and ‘happy’ were among the words least often selected by those answering the questionnaire on words they associate with the medical registrar. The perception of the role seems largely negative so why would you do it?

Becoming a medical registrar is what you have been waiting for – a culmination of years of education and training. It is a joy to use all the knowledge and experience you have gained, to push yourself to succeed and maximize your potential. There are few moments more satisfying than when a patient regains his/her pulse and blood pressure during an arrest, when a test comes back confirming the diagnosis you suspected that no-one else had thought about, or when a patient thanks you for your honesty and empathy.

Loving your work may be an impossible dream but remembering what you do and why you do it will help you get through the more frustrating days. Being a medical registrar requires patience, energy, self-belief, humour and resilience, but it brings rewards and satisfaction like nothing you have experienced before. Ensure you prepare yourself in advance and on the day you wake up as the medical registrar take a deep breath, paint on a smile and get stuck in. You’ll never look back. **BJHM**

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KEY POINTS

- The perception of the medical registrar, by those within medical specialities and others, is of an overworked and stressed, but essential, highly competent and experienced physician.
- The role of the medical registrar is fundamentally different to that of a senior house officer, requiring rapid decision making about treatment plans and appropriate levels of care for patients.
- An awareness of your leadership style and its strengths and weaknesses will help you organize and manage the juniors in your team, getting the most out of every team member.
- Interactions with other specialities should not be a tribal battleground. If you feel a referral is inappropriate explain why and propose alternative solutions. Build good working relationships and they will pay dividends later.
- The transition from ST2 to ST3 is often stressful. Being prepared for the likely challenges, having some self-awareness and being realistic about your abilities will help you manage the stress and feel the deep satisfaction of making a difference.