Cross cover for physicians: an additional burden

ABSTRACT – *Objective:* To examine the extra burden placed on consultant physicians when providing cross cover for colleagues who are absent on annual or study leave.

■ *Methods:* A questionnaire was sent to 455 consultant physicians with an interest in gastroenterology, practising in the UK in October 1996.

■ *Results:* The response rate was 77%, with 350 completed forms returned. Ninety percent of respondents participate in the acute intake; they provide 85% of cross cover for their colleagues. Only 2% of this burden is carried by the appointment of locums.

■ *Conclusion:* Provision of satisfactory cover for inpatients under the care of absent colleagues can place serious demands on consultants at a time when their specialty commitments are also high. Future manpower planning must take these added burdens into consideration.

The last few years have witnessed rising demands on the time of consultants participating in the general medical intake[1]. Recent reductions in trainees' hours of work, and their requirements for protected time and postgraduate education, mean that a greater proportion of patient care is being undertaken by consultants, who must be flexible in the organisation of their schedule in order to meet their clinical and other responsibilities[2].

During the last 16 years, the numbers of patients admitted on the acute medical intake have almost doubled[3,4]. It is now becoming the norm for consultants to perform 'post-intake' ward rounds[2]. The workload from the acute intake may increase considerably when a colleague is away on annual or study leave, particularly when the absent colleague shares the same specialist interest. Gastroenterologists, for example, may have to face a doubling of their inpatient endoscopy workload[5]. For these reasons, the Royal College of Physicians Specialty Committee on Gastroenterology initiated a survey of cover arrangements for consultant physicians specialising in gastroenterology in the UK.

Methods

We identified consultant physicians (or equivalent academic physicians) specialising in gastroenterology in the UK from the 1996 membership lists of the British Society of Gastroenterology and the Royal College of Physicians specialist register. Questionnaires were sent to 455 doctors in October 1996. Where necessary, one reminder letter was sent in November 1996. All doctors were asked for details about: the nature and location of their posts; whether or not they participated in the acute general medical intake; their emergency intake rotas; and the arrangements they made for cover of their acute medical inpatients whilst on annual or study leave. They were also asked whether they conducted post-intake rounds when they are covering intakes for colleagues, and whether they did regular ward rounds of patients who are already under the care of absent colleagues. Finally, they were asked to calculate the total number of patients admitted on intakes, and the number of intakes for whom each consultant would be nominally responsible during a colleague's absence.

Cross cover arrangements were analysed as follows: doctors were asked what arrangements normally prevail for dealing with their emergency intake duties when they are on annual or study leave. They were asked to apportion the contributions of cross cover from physician gastroenterology colleagues, other colleagues, junior doctors and outside locum cover, or to state whether other arrangements applied (eg 'physician of the week')[6]. The burden of cross cover for each individual totalled one, and fractions were added together when cross cover was provided from more than one source. For example, a colleague receiving locum cover for 30% of the time and cross cover from a physician/gastroenterology colleague for 70% of the time, was scored as locum cover 0.3, and physician/gastroenterologist cover 0.7.

Results

Of 455 forms dispatched, 350 were completed and returned, giving a 77% response rate. Ninety percent of respondents are involved in the acute medical intake. Of the respondents, 223 are from a DGH (97% doing takes), 85 from a teaching hospital (84% doing takes), 23 are hepatologists (45% doing takes), and 17 are academic physicians (93% doing takes).

Most of the responsibility for cross cover is taken by physician colleagues (85%), with 47% of cover provided by colleagues sharing an interest in gastroenterology. Furthermore, the great majority of respondents (97%) cover for colleagues on annual or study leave. This is not simply nominal cover, as 71% are expected to perform post-intake rounds on behalf of absent colleagues. Only 5% of the cross cover burden is carried by junior medical staff (senior registrars, registrars, lecturers or staff grade physicians with nominal consultant cover only). Outside locums provide only 2% of the cross cover burden. Other arrangements apply for about 7% of respondents; these include a 'physician of the week' system or adjustment of the intaking rota to ensure that a consultant is never on take during his or her absence.

DEBORAH K KNIGHT-DAVIS RGN, *Research Assistant*
MARILYN G FOUWEATHER RGN, *Research Assistant*
EMMANUEL D SRIVASTAVA MD MRCP, *Consultant Physician*
MILES C ALLISON MD FRCP, *Consultant Physician*

Gastroenterology Unit, Royal Gwent Hospital, Newport

Arrangements also have to be made to provide cover for the patients already under the care of colleagues who are on leave: 28% of respondents stated that they performed regular ward rounds of their absent colleagues' 'old' patients; 58% did not regularly see these patients, but provided nominal cover and expected their junior staff to draw their attention to 'problem' patients. Respondents were asked to state the maximum number of patients for whom they might be nominally responsible during the absence of a colleague. The median number of patients was 38 and the maximum was 100. A full breakdown of the numbers of physicians taking part in the acute medical intake at each hospital, intake rotas and intake sizes is given in Tables 1, 2 and 3 respectively.

Table 1. Number of consultant physicians sharing the acute medical intake with each respondent at various hospitals in the UK.

Number of intaking physicians	Number of respondents (%)
<4	5 (2)
4–8	154 (49)
9–12	98 (31)
13–16	36 (11)
>16	21 (7)
Not Stated	2 (1)

Table 2. Hospital intake rotas for each of the respondents.

Rota	No. of Respondents (%)
<1 : 4	7 (2)
1 : 4	32 (49)
1 : 5	41 (31)
1 : 6	40 (11)
1 : 7	21 (7)
1 : 8	68 (22)
1 : 9	15 (5)
1 : 10	40 (13)
1 : 11–15	35 (11)
>1 : 15	15 (5)
Not Stated	2 (1)

Table 3. Average numbers of patients admitted over 24 hours on the acute intakes of the respondents (median = 18 patients).

Size of Intake	Number of Respondents (%)
1–10	23 (7)
11–20	174 (56)
21–30	83 (27)
31–40	17 (5)
41–50	3 (1)
51–60	4 (1)
>60	2 (1)
Not Stated	5 (1)

Discussion

The fact that over three-quarters of physicians with an interest in gastroenterology responded to the questionnaire indicates the degree of interest and concern regarding cross cover. There may be a response bias towards intaking physicians in district general hospitals; we cannot, therefore, be sure that 90% of physicians with an interest in gastroenterology participate in the general medical intake. However, most of the physicians in this study now undertake post-intake ward rounds, not just for their own firm but for absent colleagues as well. This new development is occurring at the same time as a near doubling of the medical intake[3,4] and a rise in the specialist commitment[5]. Although there has been a steady rise in the numbers of physicians with an interest in gastroenterology, there must be concern that consultants are responsible for so many patients whilst their colleagues are away. In many units, these increased demands coincide with junior staff recruitment difficulties, and the requirement to relieve specialist registrars of some of their service commitment.

We were surprised that only a tiny fraction of the cross cover burden (2%) is provided by outside locums. Not a single example was found of permanent consultant locum cover coming from within the trust. The reasons for the decrease in outside locum cover are unclear, though many trusts have a policy of not funding locum cover. Some consultants prefer not to have locums because the quality of cover may not be assured and extra work may be created for their return (including patient complaints). It has also become unfashionable for senior registrars and specialist registrars to do consultant locums. The Calman reforms have made a clear distinction between 'trainees' and qualified specialists in general medicine and gastroenterology. This limits the scope for specialist registrars to take responsibility for post-intake ward rounds.

The practice of cross cover for a colleague's absence while continuing one's own clinical, teaching and administrative duties must be challenged. Doubling the number of inpatients with acute problems under the responsibility of one clinician is likely to reduce the quality of patient care. Consultants covering for absent colleagues might be advised to cancel some of their own elective commitments, such as outpatient clinics and routine endoscopy lists. Without a substantial increase in consultant numbers, this will lead to longer waiting times[1].

Possible solutions

More consultants

Some hospitals have difficulty in providing junior medical staff to support new consultant post-holders. There now seems to be a strong case for more 'double-headed' firms – one team of trainees for two consultants, who cover each other's absences.

Physician of the week

At the time of our survey only a small proportion of hospitals had adopted this system. In order to work effectively, it would appear that this arrangement requires that at least eight consultants be involved in the acute medical intake[6]. At least two physicians would have to have an interest in gastroenterology, because it would not be possible for a single-handed gastroenterologist to devote more time to general medicine at the expense of his or her specialist commitment during that week. There has been some concern that the 'physician of the week' system may compromise continuity of care, but those who have adopted the system have not encountered this problem in practice[6].

Increase in staff grade posts or locum cover

It is unlikely that this will be widely achievable because of the lack of suitably qualified physicians prepared to take up staff grade posts or do locums. Many consultant physician posts are unfilled in the UK, and there is a more pressing need to train more consultants rather than staff grade or locum physicians.

Specialist registrars covering consultants

Whilst this solution might conflict with the philosophy of the Calman training initiative, it is not unreasonable that a specialist registrar at an advanced stage of his or her training might undertake post-intake rounds on behalf of an absent consultant, inviting the covering consultant to see 'problem patients' only. Locum consultant cover could even be counted as part of the general medical component of the 'options' during the later years of specialist registrar training.

Other innovations

A few large hospitals have abandoned the admission ward, and now allocate their intake patients to specialist wards where they are taken over by a physician with an interest in the relevant specialty. This would be expected to improve the quality of care but may skew general medical training for junior doctors.

Acknowledgements

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Address for correspondence: Dr M C Allison, Gastroenterology Unit, Royal Gwent Hospital, Newport, South Wales NP9 2UB.

NATIONAL LOTTERY CHARITIES BOARD

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April–October 1998

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