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LETTERS

WEEKEND STAFFING AND MORTALITY

Use consultants only for critically ill patients at weekends

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Using Dr Foster's publicly available relative risk data, my hospital also shows an association with increased mortality at weekends by age, length of stay, and certain comorbidities.[1] It is unclear without multivariate regression analysis that senior input is an independent predictor.

No doubt there will still be a clamour for consultants to be on site 24/7 as a result of this conclusion. The analysis categorised a senior doctor as ST3 (specialist trainee year 3) or above, even though ST3 is the most junior grade of registrar and traditionally only consultants or associate specialists are regarded as senior. As such, any rearrangements that stem from this analysis should concentrate on increasing members of staff ST3 or above rather than consultants alone.

In my experience, consultants drafted in at weekends are often asked to make discharge decisions on well patients, outlaid to non-medical wards, or asked to perform the unfocused "post take ward round" rather than see critically ill patients to whom a senior decision may make the difference between life and death, as Dr Foster's report intimates.

If more consultants are to be required in hospital outside of traditional working hours, please allow us to see genuinely sick patients (and hence teach the junior medical staff) and not be there just to tick boxes about meeting "seen by a consultant within x hours" targets.

Competing interests: None declared.

1 Goddard AF, Lees P. Higher senior staffing levels at weekends and reduced mortality. *BMJ* 2012;344:e67. (10 January.)

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