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VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Don't undervalue non-clinical work

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Remember training? It takes 6-12 years after medical graduation and involves teaching, study, and serial exams. To become an effective consultant, learning through clinical practice isn't sufficient: it increasingly requires grounding in leadership, management, research, appraisal, and quality improvement.

These skills are taught by existing consultants, taking time away from direct patient care. Consultant readiness is also partly acquired when juniors occasionally act as decision maker or team leader, when consultants are working away from the wards.

I wonder whether one cause of poor morale in trainees is their close-up view of what working life is now like for the senior doctors they will become. Rising demand, worsening finances, targets, bed pressures, and workforce gaps put more strain on consultants, and burnout is a risk.

The expectation that consultants will always be present and review all patients is growing.[1] And, despite the United Kingdom's relatively low ratio of doctors to citizens,[2] we hear parliamentarians and commentators talk disparagingly of hospital doctors' declining "productivity."[3 4]

Job planning is becoming more draconian, with doctors expected to account for every hour instead of being respected as senior professionals who get the job done in the time it takes. Job plans sequentially allocate less time for non-clinical activities, including those that support the wider NHS.[5] A failure to reflect the actual time expended is dishonest. Emails alone take hours of non-clinical time.

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For doctors responsible for many inpatients, focusing solely on direct clinical care would mean being on the wards for 10 hours a day, reviewing all patients twice, and being available to update every visiting relative. The taxpaying public would understandably welcome more of this most visible role—without recognising other vital, unseen work.

On the hospital site we need trainers, educators, researchers, governance and quality leads, and medical managers to provide leadership. Off site we need training programme directors, as well as organisers and speakers for educational events. Doctors contribute to medical societies and colleges; they advise national bodies, guidelines, and audits; and they work with charities, patient groups, and the media. To maintain and update their skills and knowledge doctors need professional education and development. Appraisal and revalidation explicitly require this.[6]

Doing all of this probably also reduces the risk of burnout and helps keep doctors fresh in the final third of a demanding 40 year career. Morale affects care quality and, yes, productivity.[7]

A narrow focus on clinical presenteeism and productivity undervalues all of these other roles. With proposed changes to the consultant contract, which may remove clinical excellence awards for some of these extra contributions,[8] the current generation of trainees are less likely to look forward to being consultants.

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