RESPONSIBILITY OF CONSULTANT ON-CALL

1. Purpose

At present, the ideal standards for consultant labour ward and emergency gynaecological cover cannot be achieved. While permanent solutions are being sought, the Royal College of Obstetricians and Gynaecologists is making recommendations for the interim period, to ensure that patients receive high-quality and safe care and to provide appropriate support for trainees. In this document, the term ‘trainee’ includes locums, staff grades and others in non-consultant posts.

2. Introduction

The consultant's role starts with demonstrating leadership: teaching and supporting trainees, midwives and nurses at all times. It encompasses providing a service for those patients who require senior medical assistance while at the same time undertaking simpler procedures when there is a need to do so.

The consultant should therefore be present on the labour ward or in the outpatient clinic or theatre when they have a fixed session there. Their role, as set out above, is a continuing one, not a series of individual tutorials or seminars (as helpful as these may occasionally be.)

Obstetrics and gynaecology is an apprenticeship-based specialty and the consultant must be present to ensure that the trainee is taught and supervised properly; ultimately, the consultant is responsible for their trainees. There comes a time when trainees needs to learn to work alone but this should never be at the expense of their confidence or, importantly, the safety of patients. The consultant must be nearby at all times until the trainee has been assessed as fit for independent practice.

Ideally, in the future, there will be 24-hour consultant presence in the majority of obstetric and acute gynaecology units as work patterns evolve. Until then, the on-call consultant must be available, on the telephone for advice and able to come in when their presence is needed. It should be remembered that ‘needed’ applies to the trainees’ needs, not the consultant’s needs. Trainees must always feel able to discuss things with the consultant and should be encouraged to ask the consultant to come in if needed. The consultant will occasionally have to make a judgement as to what is right but the conscientious consultant will always ask the trainee what they would prefer: advice or presence.

In particular, the presence of the consultant is required when things go wrong. Asking the consultant on call to come in because someone has just had an unexpected poor birth outcome will be invaluable for the mother and her family, as well as the staff. The same applies to out-of-hours emergency gynaecological surgery.
3. RCOG standards

The RCOG sets standards to improve the care of women in all aspects of the specialty. The College recommends that the care of women who have acute obstetric complications and emergency gynaecological conditions should be accorded the highest priority. The College, in partnership with its sister colleges and the professional societies, has set standards across women’s health.1–3

Table 1 illustrates labour ward standards. Please note that these standards include prospective cover.

Ideally, and in the future, there will be 24-hour consultant presence in the majority of obstetric and acute gynaecology units as work patterns evolve. This would improve the care of women and the training of junior staff.

4. Interim solutions

Doctors at every level have a duty to call for help if they feel that a clinical situation outside the list requires the direct input of a consultant. A trainee’s request for a consultant to attend should be stated in clear, precise terms, so that there can be no misinterpretation. The request should be documented in the notes. Senior midwifery, nursing staff or other medical staff should contact the consultant or senior trainee directly if it is considered that the clinical situation requires senior medical input (known as ‘jump call’).

Consultants and senior trainees should respond positively to requests for assistance from staff covering the labour ward and gynaecological emergencies. Consultants should be aware that there are some situations where they must attend in person. Patient safety is the priority.

4.1 Attendance in person

In the following situations, the consultant should attend in person, whatever the level of the trainee:2

- eclampsia
- maternal collapse (such as massive abruption, septic shock)
- caesarean section for major placenta praevia
- postpartum haemorrhage of more than 1.5 litres where the haemorrhage is continuing and a massive obstetric haemorrhage protocol has been instigated
- return to theatre - laparotomy
- when requested.

### Table 1. Labour ward standards

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition (births/year)</th>
<th>Consultant presence (year of adoption)</th>
<th>Specialty trainees (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>60-hour</td>
<td>98-hour</td>
</tr>
<tr>
<td>A</td>
<td>&lt; 2500</td>
<td>Units to review staffing continually to ensure adequate based on local needs</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>2500–4000</td>
<td>2009</td>
<td>–</td>
</tr>
<tr>
<td>C1</td>
<td>4000–5000</td>
<td>2008</td>
<td>2009</td>
</tr>
<tr>
<td>C2</td>
<td>5000–6000</td>
<td>Immediate</td>
<td>2008</td>
</tr>
<tr>
<td>C3</td>
<td>&gt; 6000</td>
<td>Immediate</td>
<td>Immediate</td>
</tr>
</tbody>
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4.2 Attendance in person or immediately available

For the procedures listed below, the consultant should attend in person or should be immediately available if the trainee on duty has not been assessed and signed-off, by OSATS where these are available, as competent for the procedure in question:

- obstetrics:
  - vaginal breech delivery
  - trial of instrumental delivery in theatre\(^4\)
  - twin delivery
  - caesarean section at full dilatation
  - caesarean section in women with body mass index greater than 40\(^5\)
  - caesarean section for transverse lie
  - caesarean section at less than 32 weeks of gestation

- gynaecology:
  - diagnostic laparoscopy
  - laparoscopic management of ectopic pregnancy
  - any laparotomy.

4.3 Consultant's decision to attend

When a senior trainee (ST6/7) is on call with a more junior doctor or when the labour ward and emergency gynaecology clinics are being covered directly by a senior trainee, it is the consultant's decision whether to attend.

4.4 Doctors in non-training grades

Doctors in the non-training grades should have their capabilities and experience assessed by their individual units and a clear decision should be made as to the level at which they should be working. The doctor should then have the same cover as a trainee with equivalent experience.

5. Handover

There must be a mechanism for formal handover between consultants following a period of on-call.

6. Compensatory rest for night work

It is acknowledged that implementation of the above recommendations (particularly when covering a junior trainee) will result in more night work for consultants on-call. It is therefore recommended that consultants should have no fixed clinical duties the following morning/day, depending on the intensity of the workload. It is also appreciated that meeting the above conditions may reduce the availability of consultant staff to carry out elective work, which in some units may lead to further pressure on waiting lists. However, the College believes that acute emergency care of women must take priority.
References


This Good Practice guidance was produced by Dr Rennie Urquhart FRCOG, Mr Julian Woolfson OBE FRCOG and Dr Tahir Mahmood FRCOG on behalf of the Professional and Clinical Standards Committee.

It was peer reviewed by the Professional and Clinical Standards Committee and clinical directors of obstetrics and gynaecology before being finally approved by the RCOG Standards Board.

The RCOG will maintain a watching brief on the need to review this guidance.