

Shift work for specialist registrars in acute medicine: more questions than solutions

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ABSTRACT – Trainees' hours are under review once again, due to the changes incurred by the latest pay deal and the likely enforcement of the European Working Time Directive. Until now, specialist registrars (SpRs) training in general internal medicine (GIM) have been accustomed to residential on-call rotas or partial shift schemes as a means of covering emergency work. Some NHS trusts have suggested that GIM SpRs should now work full shifts to meet the restrictions of European Working Time Directive. This article outlines the views of the Royal College of Physicians' Trainees Committee on the potential impact of full shift work for GIM SpRs on medical services. Impaired continuity of inpatient care and reduced staffing levels for outpatient services were felt to be the most serious possible consequences. Some short-term solutions are suggested, but in the long term, increased numbers of both consultants and SpRs will be vital to maintain and improve standards in acute medicine.

The implementation of the latest junior doctors' pay deal has been welcomed by many as appropriate remuneration for the unsociable hours worked by trainees. It also represents a positive step towards the 48-hour week proposed by the European Working Time Directive¹, with which all European Union countries must comply by 2012. A further stipulation of the European Working Time Directive is that junior doctors must receive a minimum of 11 hours rest in every 24-hour period by August 2004. Limiting the unsocial hours worked by any health professional should benefit patients and staff alike, since staff are likely to be less fatigued and demoralised, resulting in improved standards of care.

The work intensity of most UK specialist registrars (SpRs) involved in residential on-call rotas for general internal medicine (GIM) justifies the New Deal's highest payment level (band 3). This is largely because most SpRs receive less than 5 hours of continuous rest in each 24-hour on-call period at least 75% of the time. SpRs have become relatively 'expensive commodities', particularly since NHS trusts are now required to meet the difference between band 2A and band 3 payments from their own budgets.

Converting such GIM SpRs to full shift work, ie weeks of 'nights on-call', has been seen by some NHS trusts as a means of making their juniors' hours comply with both the New Deal and the European Working Time Directive. It is perhaps ironic that the hospitals with the greatest number of SpRs involved in acute medicine, where individual SpRs are arguably the least pressed, are those most likely to be under financial pressure to introduce full shift work.

Impact on patient care

Increasing the hours of rest and reducing the number of hours worked continuously by SpRs is likely to be of greatest benefit to patients admitted during unsocial hours. However, the results of Dr Hugh Mather's SpR questionnaire² suggest that many trainees are concerned that both emergency admissions and existing inpatients may suffer from losses in continuity of SpR-led care. Although such fears have been refuted by members of the BMA's Junior Doctors' Committee³, representatives of both the Royal College of Surgeons' Trainees and the British Orthopaedic Trainees' Group (personal communication) have supported this view.

With respect to acute admissions, many feared that SpRs might develop a 'clocking-off' attitude, since they had witnessed this among senior house officers (SHOs) on full shifts. Suboptimal patient handover between teams was frequently cited as a problem. Of concern were consistent comments by SpRs that once 24-hour responsibility for a patient was removed, doctors seemed less interested in following up their patients' progress, although this opportunity is often removed by the ward-based care system. Many felt that this reduced continuity would ultimately lead to a less informed generation of doctors.

At present, many SpRs feel that they are the only team members who are truly aware of their existing ward-patients' problems, owing to the haphazard attendance of SHOs working full shifts. If all the medical team worked full shifts, care of inpatients would probably suffer through lack of continuity. SpRs who already work full-shift rotas have commented anecdotally that, on average, patients stay longer in hospital, because of the reduced availability of senior team members to alter patients'

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management and to determine discharge dates. Other potential 'system gaps' are likely to include the unavailability of SpRs to see ward referrals and to give specialist advice to junior colleagues. Such advice is increasingly needed in hospitals in which inpatient care is ward based and juniors' experience is restricted by their ward's speciality interest.

The introduction of full shift work for SpRs is likely to result in longer waiting times for outpatient clinics and elective procedures, in the absence of parallel increases in the numbers of consultants, SpRs themselves and, possibly, nurse specialists.

Impact on SpRs' colleagues

It is likely that consultants will be held responsible for the short-fall in staffing incurred by their SpRs working full shifts. This may well reduce consultants' job satisfaction by restricting the time available for 'non-urgent' yet important and often rewarding tasks, such as research, teaching, administration and performing elective specialist procedures. In the absence of a firm guarantee of a national expansion in both SpR and consultant numbers, NHS trusts will need to meet immediate staffing shortfalls by introducing poorly structured and unregulated posts such as 'trust doctors'. Finally, the experiential learning of more junior team members could suffer as a result of their SpR's intermittent absences, particularly in terms of the learning of practical procedures, communication skills, deciding on appropriate inpatient investigations and developing discharge plans.

Impact on SpR training

Many UK trainees remain concerned that full shift work in acute medicine may have a detrimental effect on their specialist training. In particular, SpRs are likely to experience reductions in the number of specialist outpatient clinics and in their opportunities to learn specialist practical procedures. For example, if an SpR working a 1:12 on-call rota converts to a full shift of a week of nights on-call followed by a week off every 12 weeks, one week in six of their specialist training will be lost, without accounting for other 'long days' on-call, annual and study leave. Regular 'breaks' from ward work lasting two or three weeks might also affect the quality of SpR training in GIM itself, because of reduced continuity of care. SpRs who have worked with SHOs already working full shifts have commented that these SHOs find it difficult to learn patterns of chronic illnesses, and this is often compounded by 'ward-based', as opposed to consultant-based, patterns of care. Also, reducing the flexibility of the on-call system for SpRs may make it harder for them to secure study leave for specialist conferences, training days and courses. There are also likely to be fewer opportunities to teach students and to undertake clinical research.

Impact on quality of life

When the Trainees' Committee has discussed these issues, we have questioned whether the introduction of full shifts for SpRs might reduce the desirability of a career involving acute

medicine, leading to recruitment difficulties. This sentiment was shared by many of the SpRs who participated in the SpR questionnaire, who felt that shifts would diminish their quality of life. Reasons cited included less job satisfaction, fewer truly free weekends and greater difficulties for those with children and those whose partners were doctors. Furthermore, many had seen a lowering of morale amongst SHO colleagues who had converted to full shifts, due to increased work intensity accompanied by a poorer quality of their time once at home.

Possible solutions

Those controlling NHS funding need to be aware that SpRs' hours cannot be made to comply with the New Deal without some considerable thought as to how to manage the consequent reduction in the SpR workload. More doctors will be needed, but such changes are unlikely to occur in time to meet the financial deadlines currently imposed on many NHS trusts. In the short term, alternatives to full shift work for SpRs could be considered, such as partial shifts of 24 hours, with, perhaps, SHOs covering the SpRs' 5-hour rest period at least 75% of the time. Furthermore, whilst making radical changes to SpRs' working patterns in acute GIM nationally, we should audit the effects of these changes on standards of patient care using finite outcomes such as length of inpatient stay, and outpatient waiting-list time.

If full shifts are the only safe solution for SpRs managing acute medical admissions, it may be better to separate high-intensity GIM training completely from more specialist training. Alternatively, SpR training could be lengthened or protected subspecialty training introduced to allow SpRs to learn procedures that require continuity of practice, such as interventional cardiology and endoscopy.

Conclusions

The requirements of the New Deal and the European Working Time Directive are difficult to meet in the short term without modifying work patterns for SpRs training in acute GIM. Trusts will need to be aware of the potentially detrimental effects of these altered working patterns on service provision, so that short-term solutions to staffing problems can be arranged. In the longer term, more consultants and SpRs will be vital to maintain and improve standards in acute medicine.

References

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- 2 Mather HM. *The RCP specialist registrar shift survey*. Royal College of Physicians, June 2000. www.rcplondon.ac.uk/professional/spr/index.htm
- 3 Dr Trevor Pickersgill's speech to the BMA Junior Doctors' Annual Conference on Friday 8 June 2001. www.bma.org.uk/pressrel.nsf

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