letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and sent by email to: Clinicalmedicine@rcplondon.ac.uk

Junior doctors' working hours: 48 hours in 2009. Meeting the challenge

Implementation of the European Working Time Directive (EWTD) in 2009 is a requirement under health and safety legislation. Roy Pounder has argued in a recent editorial that medical care is already compromised with a 56-hour working week and that a further reduction to 48 hours is unsustainable in terms of patient safety and junior doctor training (*Clin Med* April 2008 pp 126–7). We would contend that this is an unnecessarily pessimistic view and is not based on the evidence from units that already have a 48-hour working week in place. It may be tempting to speculate that some European countries do not take the EWTD as seriously as the UK. It is, however, the law and although there may be changes to the detail of the directive relating to the exclusion of on-call from home from the 48-hour tariff, we must accept that any such alterations are unlikely to be agreed before 2009. If we are to develop and test our systems for training after 2009 then we must be proactive now.

Who cares for patients?

It is unfortunate that a senior member of the medical profession apparently fails to recognise that modern patient care is provided by multidisciplinary teams (MDTs), not doctors alone. Many units recognised in 2004 that the most efficient use of resources, when hours of work for junior doctors were reduced to 56, was to implement a team structure for out-of-hours care. The Hospital at Night (HaN) model was developed in order to minimise out-of-hours work for junior doctors while maintaining patient safety and daytime training opportunities. The success of HaN has been demonstrated in both the Baseline Report[1] and the Benefits Realisation publications.[2] As a model, using a MDT to triage and manage patient care across a number of specialties, HaN has been shown to improve patient safety and has been extended in some trusts into a 24/7 model where elective and emergency work are split with critical care and HaN teams working together. Care at night is delivered by many different healthcare professionals not only by physicians. Innovative trusts have built multiprofessional, MDTs engaging junior doctors from across the spectrum of specialties and utilising nurses with advanced practitioner skills to create the appropriate skill mix for safe patient care. We recognise that this is not an easy or rapid process but the evidence suggests that with senior leadership, management support and good local data on patients' needs, a team can be created that will improve patient care and outcomes while supporting medical education and meeting EWTD requirements. Nurse leadership of these teams is increasingly common with the advantage that the more permanent staff group have knowledge of the hospital and its ethos and culture. They also have the training to lead a MDT.

Continuity of care

The issue of loss of continuity of care needs to be addressed. It seems that many doctors assume that continuity of care is only possible if the same (junior) doctor sees a patient every day. The assumption that this is an important facet of patient care and one that patient's value has to be challenged. Tired doctors are unsafe – there is an incontestable body of evidence to support this, some provided by Pounder and colleagues.[3] The concept that continuity of care is provided by individual junior resident doctors is dead, and should have been buried long ago. Patients want safe care and there are excellent mechanisms for ensuring that details of each and every patient are handed over regularly. National Workforce Projects have funded several schemes looking specifically at improving handover. Simply introducing a HaN team increases the likelihood of doctors and nurses engaging in joint handover to the benefit of patient care and continuity. If consultants are not expected to see patients daily then the argument about continuity of care is less about what is good for patients than preserving an out of date style of working. It is relevant, however, to consider how junior doctors are to gain experience and training in the development of disease over a period of time. As no one now expects juniors to work every day and every other night as in the 1980s, this exposure can only be provided if the patterns of work are sensitive to the needs of the trainee. Very intense shift patterns with too many runs of nights and too few daytime shifts are likely to compromise not only training but also patient safety and the health of trainees. There are examples of hospitals where all trainee physicians are already working a 48-hour week with overall no more than one week in eight being nights. While a pilot site was cited as an example of where a 48-hour week was initially unsuccessfully implemented this early report should be balanced with evidence from more successful, published pilots.[4] Many of the pilots will be reporting their final outcomes from July 2008 but there are interim updates on the National Workforce Projects website available to everyone for scrutiny.

Can we train in 48 hours a week?

The concerns about training in a 48-hour week need to be addressed. The new curricula are all about achieving competences, not serving time and with more effective monitoring of trainee activity from log books it will be clear if targets in training are not being met because of the reduced hours. Trusts must move towards a service that is not reliant on junior doctors to the extent that those doctors cannot access sufficient daytime training. The HaN model was devised precisely to protect against that and we would encourage colleagues to consider this as an option with proven success in planning for 2009. Training opportunities during normal and extended working hours must be maximised.[5]

© Royal College of Physicians, 2008. All rights reserved.

Inevitably the majority of training takes place when consultants are present during the day. Consultants must have teaching and training time identified in their job plans and must reflect the needs of trainees. It is perhaps an anomaly that a weekly ward round is still considered by some to be sufficient for patient care and training. The EWTD cannot be met simply by altering junior doctors' rotas if training is not to be compromised; the role of the consultant as trainer needs to be defined in relation to the patterns of work for trainees not simply in relation to the academic curriculum.

The role of the consultant physician needs to be addressed by the leaders of the profession; is it not time that the most sick patients were seen by trained medical staff with sufficient skills and experience to improve outcomes? Consultants are more evident in acute care than in the past and we would suggest that standards are raised when a greater proportion of acute care is delivered by trained doctors. We cannot go on leaving all direct care after 5 pm and before 8 am to less than fully trained doctors.

New ways of working?

Hospital at Night is a proven tool, not only for EWTD compliance but also for improving service and training. There are other changes in ways of working that are having, and will continue to have a positive impact on patient care. The reorganisation of services, development of clinical care networks or hub-and-spoke models will be necessary for some specialties and has already been successful in, for example, vascular work. The role of other healthcare professionals such as anaesthetic practitioners needs to be scrutinised so that the impact is not to reduce training experiences for doctors but enhance them and improve the service. There are several working parties investigating specific specialties where cross cover is impossible such as obstetrics and gynaecology, paediatrics and anaesthesia, where examples of best practice in relation to EWTD are being identified.

What should you do?

Pounder suggested that physicians should take a great interest in solutions and rotas proposed for juniors from 2009. We would propose that physicians show leadership and use the emerging evidence base to meet the challenge of the EWTD rather than waiting for others to propose solutions. All of us are responsible for, at the least, maintaining patient safety and protecting training. We need to meet the EWTD challenge with the changes necessary across the workforce not just in the training grades.

The greatest barrier to achieving the EWTD compliance is professional rigidity. Some of our traditional ways of working need to be challenged as they are simply not fit for modern patient care. We adopt clinical innovations that have a clear evidence base and need to do the same to protect the public from tired doctors, improve out-of-hours care and training.

WENDY REID
Clinical Lead, Hospital at Night; Chair, Clinical Advisors EWTD

JOHN COAKLEY
Medical Director and Consultant in Intensive Care Medicine,

Homerton University Hospital NHS Foundation Trust, London

References

1 Hospital at Night. *Hospital at Night baseline report 2006.* London: Hospital at Night, 2006.
2 Hospital at Night. *Benefits realisation and business case.* London: Hospital at Night, 2007. www.healthcareworkforce.nhs.uk/working_time_directive/hospital_at_night/benefits_realisation_%26_business_case.html
3 Murray A, Pounder R, Mather H, Black C. Junior doctors' shifts and sleep deprivation. *BMJ* 2005;330:1404
4 NHS National Workforce Projects www.healthcareworkforce.nhs.uk/wtd
5 Paice E, Reid W. Can training and service survive the European Working Time Directive? *Med Educ* 2004:38:336–9.

Junior doctors' working hours (2)

The call upon doctors to take more interest in the European Working Time Directive (EWTD) and possible solutions is long overdue and very welcome (*Clin Med* April 2008 pp 126–7). The lessons from 2004 show that if nothing else early planning is crucial to the successful implementation and sustainability of new working practices. Early planning allows time to develop more innovative solutions, identify additional local resource and ensure thorough local consultation. Trusts waiting until summer 2009 to start thinking about EWTD are more likely to opt for the easier, quick-fix solutions of rota redesign with little or no increase in resource, leading to the adverse impact upon service delivery and training that Pounder warns us about. It is unclear, however, as to which approach was taken by the trust cited within the cautionary tale and would be unfair to take this one example as representative of 48-hour rotas. Within NHS North West approximately 50% of the current medical rotas are already fully EWTD compliant experiencing much more positive outcomes and we are planning 100% compliance across all specialties and grades by August 2008. I would also recommend the joint British Medical Association, National Patient Safety Agency and NHS guidance on *Safe handover: safe patients* to address concerns relating to continuity of care.[1]

While many organisations accept that an increase in resource is likely to be required to deliver sustainable 48-hour solutions, this can be delivered in many different ways. Cell sizes, for example, can be increased through cross-cover, Hospital at Night and service reconfiguration before we start considering additional recruitment. Even if additional recruitment is deemed essential there is then the following question as to which grade requires expansion? While the utopian answer to this may be consultants and middle grade junior medical staff, the reality is that NHS resources are unable to support this without significant impact upon resource availability. If one has to chose, surely the most sensible option is expansion at the most senior level? Not only would this move further towards the NHS's vision of a consultant-delivered service but it would also provide employment opportunities for current specialist/specialty registrars who it is feared would otherwise not have consultant posts to progress to. Places such as the Royal Free Hospital, London, have already implemented similar models in paediatrics and the Royal College of Surgeons are accepting this as a sensible way forward in the future.[2,3]

Finally, it should also be noted that although EWTD is always portrayed as the villain in the story around junior doctors'

© Royal College of Physicians, 2008. All rights reserved.