The evolution of restricted hours of duty for resident medical officers in New Zealand: a personal view

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ABSTRACT – The New Zealand Health Service had to start adapting to significant restrictions in junior medical staff's hours of work in the mid-1980s. Some consequences of this presage those that will occur in the UK and Europe with the implementation of the European Working Time Directive (EWTD). These naturally include continuity of patient care, changing responsibility and hours of senior medical and administrative staff, some aspects of medical professionalism and training issues. Life does, however, go on.

KEY WORDS: hours of work, New Zealand, Resident Doctors Association, resident medical officers (RMOs)

Recent contacts with the Royal College of Physicians (through its International Office) have brought to attention the growing concerns of physicians in the UK over how the European Working Time Directive (EWTD) will impact on conditions of employment of junior medical staff and consequently on the staffing of hospitals. During a recent visit to New Zealand, a country with public hospitals and a health service very similar to that in the UK, Professor Roy Pounder, the College's Associate Director for the Far East and Australasia, realised that this country went through a similar process some years ago. He felt that some observations from the antipodes would be helpful.

A number of cultural developments in medical practice have occurred in New Zealand before their inception in the UK; these include the institution of a publicly funded National Health Service, a more recent and less successful experiment with financially independent 'public' hospitals competing with each other for contracts, and the limitation of hours of work of junior medical staff. The last development, of course, is predicated primarily on the safety of work of tired doctors and possibly on an increased intensity of work when 'on duty'. It probably also reflects a growing Western societal value for a 'work–life balance'.

Human Rights, hours of work and the New Zealand Resident Doctors Association

Just before I arrived in New Zealand in 1986, junior medical staff had won an important ruling from the Human Rights Commission, limiting their hours of work and requiring residence on-call to be recognised as 'working time', even if some sleep during it proved possible. These events coincided with the formation of the New Zealand Resident Doctors Association (NZRDA), a powerful and at times aggressive body advocating for junior medical staff and their employment conditions. New Zealand was thus possibly one of the first countries to have to cope with changes to junior staff rosters and training, which many other parts of the world have had to tackle since.

The overall rules put in place by the New Zealand Higher Salaries Commission in 1985 have remained largely unchanged, although there has been a perception of increasing rigidity in application and institution of rules, such as advanced notice requirements for out-of-hours work. The original rule states: 'The parties have a commitment to work back to a maximum of 60 hours per week. RMOs [resident medical officers] shall not be required to work more than 72 hours in any consecutive seven days not more than 16 hours in any day'. The immediate consequence was the necessity to replace out-of-hours cover by those also working during the day with shift work. Accepted ancillary rules now include:[1]

- some carefully monitored exceptions to the 16-hour rule
- no more than two shifts of longer than 10 hours in 7 days
- minimum duty periods being 8 hours with no split shifts in the same day
- a minimum of 8-hours break between shifts
- 2 full days rest after five consecutive night shifts
- no more than 12 consecutive days of duty before a 48-hour break
- at least every second weekend free
- emergency department and intensive care rosters individually approved with the NZRDA.

The NZRDA wishes to continue to 'improve' this situation, 12-day stretches and 7 continuous nights being particularly unpopular. Splitting these into shorter stretches does necessitate a larger pool of RMOs and consequent further imbalance in the workforce. However, New Zealand has not so far experienced a problem with an overload of fully trained specialists with no senior posts to go to. This is due in part to migration and also to continuing expansion of the number of senior posts. There is still contention around being on-call out of hospital, particularly for smaller surgical subspecialties, eg cardiothoracic surgery and neurosurgery, which is an issue for consultants [senior medical officers (SMOs)], too. The ramifications of this include planning for a limit to the number of such operational departments in the country (D Powell, personal communication).[2]

Comparison with Europe and the UK

It is difficult for me to speak from personal experience for all New Zealand or indeed perceive what similar evolution has taken place in the UK and therefore what new challenges the EWTD will impose. Deborah Powell, General Secretary of the NZRDA, is well aware of the EWTD and believes this goes beyond the rules applying in New Zealand. She feels that New Zealand has taken a pragmatic approach, specific to one employment situation, which allows some degree of flexibility in negotiation of hours and rostering, although there have certainly been major problems for administrators adhering to the agreed rules. The work pattern of SMOs has also changed considerably, partly as a consequence of the new rosters. Deborah Powell shudders at the rigidity of the EWTD and appreciates the difficulties it will cause for drawing up legal but effective RMO cover.

Personal impressions and concerns

What do such changes in RMO rostering mean "at the coal face"? Continuity of day-to-day care of inpatients now rests largely with the consultant, and the likelihood of any of the team's junior staff present at the ward round having personally admitted the patient is lower than in the past. Consultants, it must be said, have also adopted the fashion for complete handover of responsibility and weekly shifts are now popular, although this can increase the asynchrony with RMO rosters. The rapid turnover of patients on a medical or subspecialty ward has reduced the value of long-term continuity for patients as well. Good quality handover procedures have become vital at junior and senior levels (in many cases combined and led by SMOs) and provision for overlapping shifts has been made. The lack of familiarity of on-call SMOs with particular RMOs covering out-of-hours work generates safety concerns where issues of communication, confidence and knowledge of ability are important. (Is medicine now one of the few professions where supervisors have little direct role in appointing and employing those who report to them but have to carry responsibility for their actions?). So far, no major general need has been created for SMOs to stand in as residents, although some cover has been required during crises and thresholds for returning to hospital out-of-hours have dropped when personally known juniors or more expert subspecialty trainees have been less available.

Perhaps most concerning is a growing 'clock-watching' approach – something perhaps inevitable when time responsibilities are much more tightly defined – although this is not universal. Managers are sometimes reduced to hair-tearing when trying to cover unexpected gaps in RMO rosters. RMO services are critical to clinical performance and individuals frequently demand (and receive) very generous payment for covering such gaps.

These trends do reflect or encourage some changes in medical culture that will concern many. RMOs are now clearly employed by and responsible to hospital management. The need to impress senior medical staff with dedication as well as proficiency has lessened and the need to accept a collective and collegial responsibility to provide comprehensive cover for an institution has all but gone. Medicine would not, however, be the profession it is without attracting many who, at least on occasion, will go beyond contractual conditions to help out a patient or colleague. My senior colleagues recently found it worthy of note that a UK locum registrar stayed on for an extra couple of hours to help the night registrar with some of the patients in the emergency department awaiting admission.

Finally, there are training issues. In daily practice, RMOs rarely now do complete assessments that allow them to present a well-documented case to a consultant, except briefly over the telephone late at night. Somehow, many do manage to acquire this skill, a high degree of proficiency being needed to pass the Part I FRACP clinical examination. Restricted hours inevitably reduce experience and the loss of some degree of continuity also prejudices learning, especially in medical specialties. Review of minimum duration of specialist training requirements will undoubtedly be required, although the UK may need this rather less given the traditional frequent prolongation of 'youth', sometimes, if memory serves, to the doctor's mid-40s.

Postscript

New Zealand may be a little ahead of the UK in implementing the changes described above but other stresses and strains suffered by physicians in both countries have been similar. However, morale in New Zealand seems to have held up remarkably well by comparison.[3] Perhaps there is something to be said for a high value on leisure time, especially when there is easy access to bush, beach and barbecue, along with a perfectly adequate availability of cultural and sporting activity.

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