

INTERNATIONAL RESIDENT WORK HOURS CONFERENCE, AUCKLAND, NEW ZEALAND

Alert & Awake for Everyone's Sake

Dr. Philippa Gander

Director, Sleep/Wake Research Centre, Massey University, New Zealand

"There will be resistance to change. When people come up to me to say, 'I worked this and that number of hours and I was just fine,' I respond to them, 'you are an 'n' of 1. I have an 'n' of 1366, and 64% is a pretty good response rate.' Residents are the sleepest group I've ever come across! You can't just cut back on hours. This will only transfer more work to others. It's important to take a much more integrated look, a much more systems-based approach to redesign how the work gets done and by whom. In future research, we want to focus on the team – RNs and MDs."



Dr. Charles Czeisler

Chair, Division of Sleep Medicine at Brigham and Women's Hospital Boston, MA

"Let me give a case presentation: 39-year-old PGY 5 in anesthesia, driving home at 3 PM after a seven-hour shift fell asleep and caused an accident. As a PGY 1, he had worked more than 30 consecutive hours and was also in an accident. How would this case be handled if it was in court? He would be evaluated as having had a history of falling sleep at the wheel and working long hours. In the preceding 2-3 weeks he had taken home call in the ICU, and worked 2 weeks in a row, six hours of sleep each night with 3-4 pages a night. We got his cell and page records from the hospital. His sleep was clearly disrupted."

"Once we get this MD degree, we forget the commonsense things. Physicians need education in sleep medicine. This is a shared responsibility – it is institutional and it is personal. Why would we consider it reprehensible for someone to get behind the wheel of a car drunk, but not sleep deprived?"



Sleep researchers, resident and attending physicians, hospital administrators, and union staff from New Zealand, Australia, Canada, the U.K., and the U.S. gathered in Auckland, New Zealand in late 2005 to tackle the internationally recognized problem of long work hours. "Alert and Awake for Everyone's Sake," was hosted by the New Zealand Resident Doctors Association, a national union that represents all of the country's 2,500 physicians in training.

New Zealand Resident Medical Officers, as they are called, have had strong contract language limiting their work hours since the mid-1980s. Consecutive on-call shifts greater than 16 hours are prohibited, cumulative week totals are capped at 72 hours and residents are guaranteed two full weekends off a month. And yet, the union reports that some 15% of New Zealand residents – surgeons in particular – still work 24+ hour shifts on occasion.

"We learned that we all have a problem with residents working excessive hours whether it's New Zealand, Australia, Canada, the United Kingdom or here in the States," said CIR President Barbie Gattton who represented CIR at the conference. "But it was also clear to us that we definitely have it the worst. People couldn't believe that we are routinely scheduled to be in the hospital for 24-30 hours."

The international sleep researchers presenting at the November 9-11 2005 conference were all in agreement that those long hours take a serious toll on patients and those who care for them.

"Sharing Across Borders"

"We would like to welcome all delegates, who represent a broad, international spectrum from the United Kingdom, United States, Canada, Australia and New Zealand. This is an exciting opportunity to explore critical issues facing the medical profession on a global scale. The health sector faces the challenge of handling the results of fatigue which compromise the health and safety of both doctors and their patients."



Dr. Deborah Powell
General Secretary
New Zealand Resident Doctors Association



Dr. Philippa Gander, Director of the Sleep/Wake Research Centre at Massey University in New Zealand, and former NASA physiologist, reported on the results of a just released national survey ("Work Patterns of New Zealand Resident Medical Officers: Implications for Doctors and Patients and Strategies for Improvement," Nov. 5, 2005). The four-page survey was completed by 64% of the country's full time residents in training. The results caused Dr. Gander to conclude "this is the sleepest group of people I've ever come across."

According to Dr. Gander, the survey revealed that 15% of Resident

Medical Officers were required to be available for work for at least 24 hours continuously on at least one occasion; 42% had fallen asleep at the wheel while driving home from work; and fully two-thirds could recall making a fatigue-related clinical error at some time in their careers.

There will be resistance to change, summed up by Dr. Gander, but the evidence speaks for itself. "When people come up to me to say, 'I worked this and that number of hours and I was just fine,' I respond to them, 'you are an 'n' of 1. I have an 'n' of 1366, and 64% is a pretty good response rate."

Charles Czeisler, MD, PhD, Chair of the Division of Sleep Medicine at

"Our Issues are Universal"



"It's refreshing to hear consultants [attendings] saying the same things that we say. We assume that they don't want change, but they do. Our issues – in all countries – are universal. House Officers in the U.S. have it worse than us, but it's not perfect here either. It's taken us 20 years to be mostly in compliance [with call shift maximums of 16 consecutive hours]. But 15% of us are still doing 24-hour call, and that's a problem. But we will change."

Dr. Deralie Flower
4th year, Ob-GYN
President
NZ Resident Doctors Association

"We are a High-Risk Group"

"There is comfort in knowing everyone else has the same problems and everyone – all countries – are trying to find solutions, for example, Dr. Czeisler's car crash study. We all know the anecdotes, but I've never actually seen the data before. Now I understand the science of why it happens. In Australia, we have a campaign about drunk driving and driving when you're too tired, but it doesn't target doctors. We are a high-risk group because of the long hours we work and the fact that we have to drive from site to site and rotation to rotation. There is a role for the employer to take the initiative with taxi vouchers or staff buses. The Hospital should provide these things because we are too tired to assess our own fatigue."



Dr. Nada Hamad
2nd year, Internal Medicine
President, Resident Medical Officers Assoc.
New South Wales, Australia

"Now We Have Some Ideas"

"I'm going back home to Canada with a few ideas for pilot projects. The speakers made me think again about the problem of long hours and addressing it in new ways. For us the traditional schedule is 1 in 3 or 1 in 4. Shift work is nowhere in our collective agreement. There are no consecutive hours limitations – no way to intervene. Now we have some ideas for how to address this. We could, for example, go to the hospital administration and propose Dr. Czeisler's 16-hour, 4 day shifts [interventional schedule identified in NEJM article as reducing intern errors in a medical ICU setting]. If you go to the Administration, identify a problem and then identify a solution it's much better. Now we have something to propose and the evidence to back it up."



Dr. Martin Bernier
3rd year, Internal Medicine
President
Federation of Medical Residents in Quebec

are organized, with one union for each province. Hours are then set through the provincial collective bargaining agreements. In New Zealand, hours are governed by the residents' national contract and by national occupational health and safety language. In Australia, the Australian Medical Association has also developed a comprehensive 'code of practice' for hours of work, but it does not specify an hours limit nor is it enforceable. In the United Kingdom, where residents are also all unionized, the EU's Working Time Directive does have the force of law. In the U.S. the accrediting body overseeing graduate medical education has set hours limits but they are very long (on-call shifts of 24 plus 6 are permissible and commonplace) and not effectively enforced.

Asked what most impressed him about the international hours conference, CIR Executive Vice President Simon Ahtaridis, MD, who attended along with Dr. Gattton and CIR national staff Mark Levy and Sandy Shea, said he was "struck by the degree of organization house officers in other countries have compared to here in the U.S."

"We are far behind them in being able to develop evidence-based guidelines for resident work hours that are safe for patients and ourselves," said Dr. Ahtaridis. "Having all housestaff unionized really allows for a much greater impact on policy. They are able to engage in serious dialogue with high level government officials, hospital administrators and senior physicians, who are all working on identifying problems and solutions."

"Unionization = Greater Impact on Policy"

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Dr. Simon Ahtaridis
3rd year, Internal Medicine
Executive Vice President
Committee of Interns and Residents/
SEIU, USA

Dr. John P. Collins

Dean of Education, Royal Australasian College of Surgeons

"I have a passion to do something about hours and training. I can assure you not everyone wants the system [of training physicians] to stay the same. It nearly destroyed me, my wife, and my marriage. According to the Australian Medical Association (AMA)'s "Risk Form" – a survey geared to identifying residents who are working unsafe hours, 45% of the 178 surgical trainees fell into the high risk category, that is, who were working more than 100 hours per week. Our goals – and why we care about resident work hours – are high quality patient care, improved training and improved house officer well-being."



Dr. Elisabeth Paice

Dean Director, London Deanery United Kingdom

"Teams are the answer to so much of what's wrong. It's the idea that you sit down with a multidisciplinary group to discuss what is to happen with each patient. That is more valuable than one person's non-reflective just 'being around.' The old style team – residents in the hospital for hours on end – is gone. In the airline industry, for example, the team forms as they walk into the cockpit. We are professionals because of our training, our skills and we can move into a situation and work as a team. In other industries, people learn how to do this. We have to let go of some things in the past that were great. We do have to do things differently. What are physicians doing after hours? For example, on Saturday and Sunday there may be no phlebotomist in the hospital, so the second resident on call gets called in to do phlebotomy. We need to get real – there's no advantage to a house officer's training here!"

