Irish Medical Journal
Established 1867

Issue: Ir Med J; Vol 112; No. 7; P692

On Call Medical Rosters: New Approaches Should be Explored

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Most doctors find that their on-call duties are the most difficult, challenging, and disruptive component of their work. This is particularly the case for junior hospital doctors. They are the group that have to remain resident in the hospital when on-call.
The on-call stressors are the lack of sleep, the fatigue, the case-mix unpredictability, the reduced availability of senior staff direction, the sense of isolation, the psychological fear associated with inexperience, and the limited radiology and laboratory support. In simplistic terms our hospitals are 9-5 structures trying to provide a 24/7 service. The short-falls of the system rest disproportionately on the shoulders of the on-call medical staff. It should be accepted that rosters are the biggest difference that hospitals can make to a doctor's work experience. Whether the rota is satisfactory or punitive will determine the ability of a hospital or health service to attract and retain staff.

On-call commitments interfere with social life, personal development and hobbies. Outings with friends and sports arrangements have to be cancelled at short notice. There are the major disruptions to family life. Anniversaries, family gatherings, and children's birthdays are frequently missed1.
These intrusions into a doctor's personal life are particularly exasperating when it involves additional on-call duties to cover other colleagues. The frustration is compounded when the sacrifice doesn't appear to have been appreciated or when there are difficulties in getting paid for the additional hours that have been worked.

In both the UK and Irish health services, inflexible rostering has caused many doctors to reconsider whether they wish to remain in medicine. Roster-gaps are viewed very negatively by trainees. Many doctors have reported that they have been bullied into plugging these additional sessions. When they happen repeatedly or for long stretches, doctors develop a sense of injustice. For all of us, one of our biggest assets is our human capital, our ability to earn a living on reasonable terms. When the terms become negatively skewed, resentment and cynicism sets in.

Despite roster problems being a major battleground in most hospitals, it is surprising how little innovation has taken place. The same rigid roster arrangements are posted year on year followed by continual dissatisfaction among doctors. There is a persistent and recurrent lack of transparency. A trainee may start a 1:7 roster but quickly find that this is not the case. The absence of one or two doctors through maternity or illness reduces the workforce to 1:5 resulting in increased on-call duties. The pressing daytime commitments have to be discharged by a smaller cohort, resulting in being unable to attend mandatory training days. This adverse cocktail of excessive clinical work, insufficient training, and inadequate study time will, in many cases, lead to failure in postgraduate examinations. This negative spiral of events is at the root of the decision of many trainees to leave postgraduate hospital training programs. It should never be acceptable for management to expect doctors to cover for inadequate staffing and suboptimal workforce planning.

Good roster planning and scheduling is complex and time consuming. It requires both patience and attention to detail. A key principle is that doctors on a roster must be treated as individuals with lives, commitments, and priorities outside their work. Rosters should be designed intelligently and thoughtfully. They must be mindful of the risk of fatigue. They must avoid excess variability of shifts. Different types of shifts should be evenly distributed. They must ensure that the doctor gets his/her full leave allowance including annual leave and study leave. They

should have sufficient, built-in capacity in place for unexpected absences such as sick leave, maternity leave, accidents, and resignations.
Annual leave is frequently a contentious issue between doctors, colleagues and management. At the outset the amount of leave entitlement of each doctor on the roster should be calculated. Fair and clear ground rules should be in place. There is a need to identify the maximum and minimum number of staff who can be away at any one time. The pressure on leave requests around peak times-Christmas, Easter and school holidays need to be managed fairly. The leave arrangements should be spread evenly through the period covered by the roster.
The previous employment data held by the hospital should be used to predict the amount of sick leave and maternity leave likely to arise. This calculation should be added to the roster plan.
There must be an accurate calculation of the doctor's training and education entitlements. It is important that these requirements are not subsumed by the service provision.

Dr. Rob Galloway, an ED consultant at Brighton, has implemented a new roster process. He has devised an annualized (pro rata for those on 6 months rotations) self-rostering system that makes shifts fairer for the staff. Staff are assigned the annual number of hours that they must work with all leave already deducted. In addition to annual leave, study, bank holidays, and 3 hours weekly private study are incorporated into the roster. The doctors arrange and work their shifts and the time is removed from their annual total. The doctors can easily swap duties among themselves. Flexibility is a feature of the system. Doctors can bank shifts. It is possible to do additional sessions in advance of seeking time off for a conference or some other commitment. The template has increased job satisfaction. It facilitates those trainees seeking less than full time employment. Both recruitment and retention has improved in hospitals that have adopted this approach.

There is an increasing recognition that the medical profession has been bad at caring for itself. The frequently quoted expression by older colleagues 'we had to put up with difficult rosters when we were young' is unhelpful. Such attitudes accentuate the problem and make trainee retention more difficult. The past with its rigid and unimaginative concepts of out-of-hours working arrangements must be set aside. Trainees must be listened to and their preferred ways of working should be incorporated into new roster structures.

The key criteria for good rosters are- sufficient staff to populate the roster, sufficient capacity to cope with unexpected absences, better workforce planning and 'trainee-friendly' arrangements.
The employment of short-term locums to fill roster gaps is not satisfactory solution. The induction of the locum is frequently inadequate and the doctor is left struggling in unfamiliar clinical surroundings and IT systems. Matters are compounded when the communication lines between locum doctor and the senior staff have not been clearly set down. A locum like any other doctor needs to feel valued and appreciated.

All these challenges are faced every day by Irish hospitals. Iris Cranley, Medical H/R Manager, at Temple Street children's hospital has a long experience in the organization of doctor's rosters. She states that in a 6 months rotation the doctor is entitled to 3 weeks holiday leave and approximately 2 weeks study leave. Every attempt is made to facilitate the doctors while also providing a seamless service for the patients. Leave is not allocated for Christmas/New Year as the medical staff prefer to arrange this among themselves. The sick leave rate among the doctors is 2%, compared with 4.6% across all employees in the HSE nationally. She adds, however, that when sick leave does occur, getting medical cover at short notice is difficult. Sick leave rates are a key indicator of staff morale and wellbeing. The Bawa Gaba story about a young paediatrician being convicted of negligence manslaughter and struck off by the GMC had a major impact on trainees at Temple Street. The stress-sick leave rate increased with doctors expressing anxiety about being on-call. The hospital responded by putting a second registrar on duty at nights. This had an immediate, beneficial effect and it resolved the concerns. This is a positive example of a hospital listening and responding to the trainees concerns.

The on-call roster is a major issue in the provision of out-of-hours medical care. It covers the times when things are most likely to go wrong. It must be actively managed with the right balance of senior and trainee input. Increased thought and innovation are required in order to make it safer and more clinically effective for both patients and doctors.

References:

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