Time off

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Resolving the problems of staffing for the proposed 48 hour week needs radical thinking

Managers are keen to develop the 24/7 philosophy in the NHS, realising that many facilities, overburdened during the 9–5 day, are empty or at least underused for the majority of the time. Operating theatres, secretarial offices, and outpatient clinics tend to be deserted at night and weekends, and many departments such as radiology and technical laboratories offer restricted out-of-hours service.

We are bidden to adopt flexible working patterns to use accommodation better, for example evening clinics and weekend operating lists. There is a mood to provide fuller support services out-of-hours.

However, it is simultaneously the case that the European Union and government are concerned about the culture of overwork, which is a curiously British phenomenon. The idea of the 48 hour week seems a pretty distant prospect to most clinicians. Indeed the new prospective consultants' contract version of this is that doctors will work *at least* a 48 hour NHS week before engaging in private practice. This is hardly in the spirit of the concept to avoid overstretched and tired doctors trying to offer a full service. The analogy of plane pilots is apt. Airlines do not allow moonlighting when the normal working week has clocked up the appropriate number of flying hours. This is on the grounds of safety for passengers: surely patients deserve as much consideration. Anyone involved in acute medical specialties will be familiar with excessively long hours, and the drawbacks of disrupted personal lives and fatigue which results.

How to resolve this problem is not so easy without a large increase in the number of doctors. It would take years to train the additional staff, though there is a large pool of able applicants who in the past have been denied medical school places as a matter of government policy. Importing doctors has been a cheap option in the past, but it is no longer politically correct to take them from under-doctored countries like those in South Asia. Interestingly the countries which have a surplus of medical graduates in the European Union do not seem to be a rich source of labour. This may itself say something about relative remuneration and conditions in countries such as France, Spain, Italy, and Germany.

How to reorganise activity patterns to make the working week shorter while preserving continuity of care is problematic. Shift and partial shift systems have serious drawbacks when consultants are expected to have continuous responsibility for everyone over whose bed their name appears. In the past the whole time working week has been based on the concept of 40 routine hours plus emergency out-of-hours cover. This means that a huge number of doctors would be needed to satisfy a 48 hour week requirement. Sixteen doctors would just about cover it as long as none of them were ill, took study leave, or went on holiday.

There are 168 hours in a week including five week days and a two day weekend. Doctors expect to work most conventional hours plus some evenings and weekends. It is indeed possible for doctors to work a 168 hour week. It happened to me as a house physician when the opposite number of a 1:2 rota was prostrated by flu for a fortnight and a locum could not be found (or was not sought very hard!). The only way we could make the rota work when she was properly in harness was a system of alternate weeks being on 24 hour duty Tuesdays plus Thursdays or Mondays, Wednesdays, Fridays, Saturdays, and Sundays. We were able to take two or three half days each week so that the average working week was 93 hours rather than the 103 hours most 1:2 rotas involve.

When there are three doctors in a common rota the working week falls to 83 hours, with four doctors to 72 hours, with five to 66 hours, etc. The law of diminishing returns operates when people try to base their lives on a 9–5 day and a five day routine working week. A fudge factor is voluntary overwork, which tends to become an increasing feature as rotas become notionally less arduous. Doctors go to educational meetings in evenings, at weekends, and sometimes for days at a time for national and international conferences. When they go away they are never out of the learning environment even when notionally socialising with colleagues. There are sometimes out-of-hours administrative and managerial meetings. Many doctors choose to have an extensive domiciliary visiting and private practice: the main driver for this is financial, which looks very strange to the rest of the world whose basic income is much less.

There are often research, refereeing, and publishing commitments that have to be discharged out-of-hours.

It is in the nature of those who enter medical training and hospital practice, in particular, that they tend to be competitive and dedicated. They would generally prefer exhaustion to boredom. There is a definite cult of presenteeism which means that people are reluctant to go home even when they are not productive or even positively in the way. It is hard for doctors to realise that overwork leads not to better results but to greater inefficiency and mistakes. A job that is a struggle on Friday afternoon after a weekend on emergency take is often quick and simple on a Monday morning after a refreshing weekend off.

Can we really reorganise to adapt to a maximum 48 hour working week? This would require discipline and direction to persuade people to change their habits. One system that might work would be to divide the week into sections such as 0900 to 1300 hours, 1300 to 1700, and 1700 to 2100 hours. Overnight no routine duties would be undertaken between the hours of 2100 and 0900.

The consultant would be required to work at least one four hour routine morning or afternoon clinical session each day from Monday to Friday to give a 20 hour core week. The other 148 hours of the week would be divided up for emergency duties between clinicians. For instance, if there were eight or 10 consultants in emergency rotas each would work an additional 15 to 18 hours to give a total basic working week a 35 to 38 hours.

This would leave another 10 to 13 hours to be filled with extra routine sessions during week days, or in evenings and at weekends if more appropriate. Any weekend routine NHS work would be by rotation so that no-one was required to work every Saturday morning, for instance.

If all these sessions were for the NHS or for academic or educational purposes then a full time contract would be appropriate. If they were taken for private practice then a reduction of NHS contract by two to 3 × 4 hour sessions would be appropriate. To make this work no other clinical work would be permitted over 48 hours. This system would allow proper continuity of NHS care and preserve the freedom of consultants to engage in other activities such as private practice if they wish. It would need to be a legal requirement that doctors did not engage in formal medical or paramedical activities outside the 48 hour week.

It could certainly work. Some years ago a surgeon in a 17 man rota at a Danish university hospital told me that he was required to leave the clinical areas altogether after his 32 hour statutory

week! He staved off boredom with academic work.

This 48 hour week would address the problem of senior consultants, in that they would be able to function fully as equal members of the team, in a reasonable working week rather than

having reduced clinical commitments as is being currently proposed. Indeed, why should doctors be more interested in teaching, administrative, and managerial work rather than patients just because they are over 55?

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IMAGES IN MEDICINE.....

Missing ring pull

Ring pulls from aluminium cans can be swallowed or inhaled accidentally when the tab breaks off into the can and when the contents are drunk quickly.

In this case, the tab was swallowed and was thought to be stuck in the oesophagus because of local discomfort. Plain radiographs were of no help and so endoscopy was performed and the tab retrieved from the stomach using a basket.

Unfortunately *x* rays at energies used for standard chest and abdominal films do not show the tab as might be expected because of the low density of aluminium. It is essential therefore that in cases where there may be doubts as to whether this was actually swallowed—for example in babies, that the doctors are not lulled into a false sense of security by not seeing the tab on an *x* ray film.

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