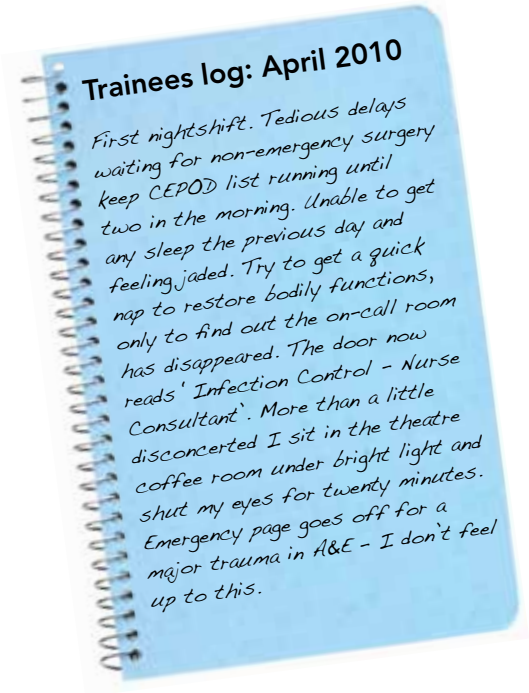
On Call Rooms

Mike MacMahon on behalf of the GAT committee



One of the many concerns expressed by members of GAT in this year's Annual on-call survey was the absence or potential loss of on-call room facilities. It is an everyday occurrence to hear members of staff question the trainee anaesthetist's right to an on-call room – "you work a shift, you shouldn't be sleeping" or "If you're being paid to be here, you should be doing something useful - like audit".

Unfortunately there is no legislation to protect rest facilities for those of us who work a full-shift pattern. What I hope to explore in this short article are some of the arguments as to why on-call rooms should be maintained. Instead of pushing to remove on-call rooms, a forward-thinking organisation would protect them and thereby protect their best asset - their staff.

What are the contractual rights of doctors in training in terms of access to on-call rooms?

A collaboration of NHS management, postgraduate deans and the British Medical Association (BMA) Junior Doctors Committee drew up the document HSC 2000/036(in 2000)[1] which fairly stringently set out the minimum requirements of on-call and catering facilities available as part of the 'new deal'. This applied to what was then 'on-call' (although doesn't explicitly define the term). Since the widespread adoption of full shift rotas within anaesthesia, much of these regulations are no longer applicable, and there is no contractual obligation to provide a room.

So what is the current situation for trainees?

The recent GAT survey showed that 26% of respondents (anaesthetic trainees working in the UK) had no access to an on-call room. A further 16% of trainees were aware of trust plans to remove their room[2]. Comments suggest that this is frequently done to make way for additional office space.

What about consultants, what are their rights?

At the moment, the majority of consultants work a partial shift system, and are therefore entitled to access to a room. However, if the trend towards having consultants as resident on-call continues then this may well change. It is unclear what the contractual obligations will be when this arrangement becomes a reality but I would anticipate that this is a point that needs to be clarified prior to signing any contract containing compulsory resident on-call and assistance from the BMA is strongly recommended.

Why should the trust give anaesthetists access to an on call room?

There are two separate arguments here:

1. Night-shift working confers a substantial disruption to the body's natural circadian rhythm. This disruption has been shown to have direct and cumulative effects on psycho-motor performance. The effects of fatigue are well documented within the transport and nuclear industries, with fatigue contributing to many high profile accidents[3]. This effect has also been demonstrated within medicine and anaesthesia, effecting both technical and non-technical skills[4,5]. Clinical error leading to patient harm should be minimised at all cost. By having the facility to have a short sleep, or 'anchor nap' as the BMA refer to it, the effects of fatigue can be effectively combated.

2. The cumulative effect of long-term night-shift work has detrimental effects on health. It is associated with increased risks of certain cancers[6] and cardiovascular mortality[7]. Workers in Denmark have even received government compensation for these effects[8]. Although there is, to my knowledge no evidence showing that an on-call room reduces these effects, it passes the test of logic that it should. Failure to protect the health of their employees in spite of increasing evidence of harm is ill-advised. A sensible NHS trust may take note of this information in the way that tobacco manufactures should have done for the well known deleterious effects of smoking in the 1980's.

What can a trainee do if their on-call room is under threat?

The New deal stipulates a minimum of 20 minutes rest in every six hours of clinical

duty. The BMA and the Royal College of Physicians believe this should be in a quiet room, away from clinical activity and with the facility for lying down / reclining (although there is no stipulation for this in EWTD). In the absence of these facilities, the case for a dedicated on call room is all the more powerful.

Possession is nine tenths of the law, and once the room has gone it's going to be very difficult to get it back. A solid case for maintaining the room should be made with a petition of affected parties. The support of the consultant body and the BMA as the trade union is essential. Email us at gat@aagbi.org to ask any specifics – we may be able to offer some useful advice from our collective experience and close links with the AAGBI council.

What else can GAT do to help?

The GAT committee feel strongly that adequate rest facilities are essential for both safety and welfare of trainee anaesthetists. As your representatives we will publish these views and collect data where you feel an injustice has occurred, but ultimately there is no vehicle for us to exert political pressure on individual trusts. We deliberated for some time whether this publication is the correct forum to publish data on which trusts had removed on call rooms; in the end it was felt too risky in terms of a potential libel case and because it may cause more harm than good. We welcome suggestions from members who have ideas as to what we as a representative body can do to improve this situation. Please also email us if you have been successful in reinstating and on-call room as your experiences will undoubtedly be useful to others in a similar situation.

The AAGBI has a working party currently looking into fatigue and the anaesthetist. These short publications are of high quality, use the best available evidence and carry significant weight in departmental affairs. Your comments will be forwarded onto the group, and may influence the direction it takes so perhaps this is the best forum to protect our rooms.

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2 The GAT annual on-call survey, NJ Love, Nov 2009, Personal communication; due for publication in anaesthesia news 2010.
3 AAGBI Working party on fatigue and anaesthesia, 2004. Available via: http://www.aagbi.org/publications/guidelines/docs/webversionfatigue04.doc
4 Howard SK, Rosekind MR et al, Fatigue in Anesthesia, Anesthesiology 2002,: 97; 1281 – 1294
5 Smith-Coggin, Roskind et al, Relationship of day versus night sleep to physician performance and mood. Ann Emerg Med 1994; 24: 928-34
6 Schernhammer ES, Laden F, Speizer FE, Willett WC, Hunter DJ, Kawachi I, et al. Night-Shift Work and Risk of Colorectal Cancer in the Nurses' Health Study. J Natl Cancer Inst. June 2003;95(11):825-8.
7 Kawachi I, Colditz GA, Stampfer MJ, Willett WC, Manson JE, Speizer FE, et al. Prospective Study of Shift Work and Risk of Coronary Heart Disease in Women. Circulation1995 December 1, 1995;92(11):3178-82.
8 Danish Night Shift Workers Get Compensation For Cancer. Accessed 17 Mar 2009 http://www.medicalnewstoday.com/printerfriendlynews.php?newsid=142454