



Key issues facing Resident Medical Officers (RMOs)

Deborah Powell

The key issues that have been identified for resident medical officers (RMOs) in the immediate to medium term, include those which are loosely described under the heading of *work-life balance*. For an RMO, this means balancing their private life, their professional life, their career options, and training processes. To put this issue in context, work-life balance is a key issue for New Zealanders generally.

RMOs are the younger members of the profession and, although not as young as they use to be, their average age is 33 years. However within the population generally, a desire to balance work and life outside of work is a key factor in employment relationships today. So much so that the current government through the Department of Labour has been surveying and seeking input on the issue (from a wide variety of parties and individuals) to provide some guidance and possibly strategic level assistance.

RMOs are simply reflecting that change in society. However, what work-life balance means for RMOs is likely to be different from that of individuals who do not work within the vertical training process that RMOs are party to.

On the issue of demographics, it is also worth noting (as stated above) that the average age of RMOs is now 33; and over 50% of RMOs are female. This clearly has implications for our membership with respect to a desire to have families and the implications that child-rearing has for people in the workforce. Interestingly, however, judging from recent RMO surveys, there is no gender distinction in a desire for work-life balance and (especially) access to part-time training. Of further note, and what may come as a surprise to some people, there is no distinction between specialty interest and a desire to have work-life balance; and (again) part-time training comprises a significant part of this issue.

For the sake of clarity, however, we need to identify that when the New Zealand Resident Doctors' Association (NZRDA) refers to part-time training we are referring to permanent part-time employment, not simply transitory ability to work part time for limited or specific events such as working part time while studying prior to an examination. NZRDA has clearly identified that there is a difference between these one-off events and a requirement for permanent options within the workforce.

Part-time work and training will become a significant feature within the deployment of RMOs in the near future. The demand for them are clear, and the ability of an employer to provide these conditions will enable RMOs to be retained in the system. The frequent knee-jerk reaction to this issue is the concern that we will have less available resources to deliver service—as RMOs reduce their hours to part-time employment.

However, we are currently losing RMOs from the system because they are unable to access part-time work. The ability to offer such forms of employment will at least retain these individuals in the system to some extent. Secondly, to complete training

requirements, people working part time (especially those in training programmes) will inevitably end up working as an RMO longer than they would as full-time employees. That will result in a balancing effect, as RMOs are in the system longer because of their part-time training and therefore there is no net loss overall.

The second area that will require consideration is that of training. The model upon which RMOs are trained is an apprenticeship-based model. Fundamental to that system is the team structure within which we work, which allows more senior medical practitioners to supervise audits and to assist the work of those more junior practitioners.

This system not only provides for apprenticeship-style training, it also ensures some comfort (as more junior members of the team take on added responsibility and skill) whilst ensuring that the patients get good safe practice. However, training is often perceived as a time-served system. We disagree that this concept of training as currently exist is going to continue or have validity.

We believe key issues for training practitioners lie in the principles of adult learning, supervision, and access to clinical material. Doing a procedure 100 times badly is not good training. Undertaking that procedure 10 times in a supervised environment followed by undertaking it without supervision but with assistance as necessary (see one, do one, teach one) is preferable.

Whilst the undertaking of work in an unsupervised fashion (with assistance at a distance) is certainly a feature of medical practitioners' learning in the advanced stages of the learning process, adult learning principles suggest it is an inappropriate mechanism of learning at a junior level, where direct supervision and assistance available at hand is more appropriate.

This clearly makes sense, not only from a training perspective—ie, those more junior needing direct training regarding what is taught, followed by the ability to undertake that work with someone immediately available should difficulties or questions arise, followed by independent practice but still with supervision available at a distance.

Somewhat ironically in New Zealand, however, we have seen a shift (over the last 5 years or so) in more senior RMOs working increasingly away from night shifts and more during daylight hours, and more junior members working the hours without direct supervision—ie, the night shift.

There is also a service delivery and patient care aspect to this particular work practice in that the non-daylight hours, and particularly night shifts, are the most risky time for something to go wrong, as there is limited staff available of limited seniority. Having more experienced, more able practitioners on during these times of the day would make sense from a patient safety perspective and yet again, we see the most junior members of the medical team performing isolated duty during most of these hours.

NZRDA, however, is not suggesting that those most senior (vocational registrants) should be performing night shifts in replacement of RMOs. However, to have the more senior members of the RMO team undertaking these hours of work, SMOs will have to change work practices and accept that the more junior members of the team requiring more direct supervision will be their priority—certainly in the evenings and weekends. This may well result in vocational registrants having to undertake some

periods of duty outside the ordinary hours of work—ie, into the evening and during weekends.

This is a natural tie-up between service and training in undertaking our training. And by providing training SMOs also provide a service. Ongoing acknowledgement of the integration of these issues is mandatory if we are to move forward within the employment relationship for both senior medical practitioners and resident doctors.

Increasing influences with occupational health and safety will also impact on our future work patterns. Currently there are limits on hours, limiting RMOs work to 16-hours a day, 72-hours a week, and 12-days without a 48-hour break. First introduced by the Higher Salaries Commission in 1985, limits are now being seriously questioned on the grounds of occupational health and safety. NZRDA believes that the long day system we currently operate is mandatory to maintain team structures and therefore best patient's outcomes. The alternative regular rotating shifts, the most common being 8-10 hour rotating shifts, result in significant information transfer risk, which in the context of medical care of the patients has a potential to increase adverse outcomes clinically for the patient. However, working 12 days without a break, working almost the equivalent of 3 working weeks in that 2-week period (ie, a minimum 112 hours in 12 consecutive days), and working 7 consecutive night shifts (of 10-hours minimum duration) are all areas that are unsustainable on the basis of health and safety.

For those that doubt such statements, a review of the literature is recommended. For instance, on the issue of 7-days of nights, the international symposium held in Europe concluded, and we quote;

‘The working of seven consecutive nights without good operational reason should now be considered the very opposite to good resource management’
(UK Police)

‘The worst possible shift schedule is to work between four and seven nights in a row’ (British Medical Association)

The issues relating to hours of work, continuity of care, and occupational health and safety are ones relatively familiar to NZRDA, given our limits on hours have been with us now for over 20 years. However, we suspect that the impact on SMOs conditions of employment (as a result of the implications of occupational health and safety demands) for a level of service delivery outside ordinary hours, and the requirement to supervise those more junior at such times, will impact increasingly on SMO patterns of work, and increasingly require SMOs to change their work practices whilst still maintaining team structures and all the benefits that these provide us.

Comments such as recently reported in a newspaper in New Zealand from a surgeon who completed a very long operation, returned home to have a shower and a shave, then went back to the hospital to continue operating on a new patient show that we are trained to withstand fatigue and work incredibly long hours.

This demonstrates a fundamental lack of insight by at least some members of the profession and a steadfast refusal to acknowledge basic human physiological features and outcomes that are well researched and well documented. Specifically in this instance, we cannot train to withstand the affects of fatigue. Physiologically, our performance diminishes with increasing fatigue to the point where, at 18-hours

awake, performance of a human being is equivalent to driving with a blood alcohol level that makes it illegal to drive. The medical machismo model (that this sort of comment demonstrates) must be put to rest once and for all.

Author information: Deborah Powell, Secretary, New Zealand Resident Doctors' Association, Auckland

Correspondence: Deborah Powell, New Zealand Resident Doctors' Association, PO Box 56431, Auckland. Fax: (09) 623 3996; email: secretary@nzdca.org.nz