STATEMENT ON NIGHT SHIFT ROSTERING OF EMERGENCY PHYSICIANS

1. PURPOSE

This document outlines the position of the Australasian College for Emergency Medicine (ACEM) on night shift rostering of specialist emergency physicians in Australia and New Zealand.

2. SCOPE

This document applies to all Australasian emergency departments (EDs).

This policy should be read in conjunction with ACEM's G23 *Guidelines on Constructing and Retaining a Senior Emergency Medicine Workforce*.

3. CONTEXT

Emergency departments in Australasia operate three core shifts: day, evening and night. The length and exact timing of each may vary between hospitals and regions; however, the night shift usually starts by 11pm, and finishes by 9am.

Under current staffing arrangements in the majority of EDs, FACEMs are present on the day shift and evening shift. This coincides with the majority of patient presentations; 86% of ED presentations in Australia occurred between 8am and midnight during 2014-2015.[1] [1]

During a night shift, ACEM recommends that at least one FACEM is rostered on-call (for presentations of approximately 15,000 annually). Depending on the patient presentation numbers for the ED, ACEM makes further recommendations for the number of non-FACEM senior decision makers that should be present in the ED overnight.[2] [2]

4. ACEM POSITION

ACEM does not support the introduction of night shift rosters for specialist emergency physicians within the current health system.

4.1 Patient Quality of Care

ACEM's priority is ensuring that the highest standards of medical care for patients are maintained in emergency departments across Australia and New Zealand.

[1] Relevant data for New Zealand was unavailable at the time of publication.
[2] The ACEM G23 *Guidelines on Constructing and Retaining a Senior Emergency Medicine Workforce* describe non-FACEM senior decision makers as physicians who have the appropriate clinical care skills to manage a critically ill patient unsupervised, or until a specialist emergency physician (FACEM) becomes available and can assist. This can encompass training (i.e. ACEM trainees) and non-training roles (e.g. Career Medical Officer).

The majority of an ED's workload being managed on night shift, are patients who have presented during the evening, but are yet to be seen. This is a result of ED overcrowding due to hospital access block. Access block (where admitted patients cannot leave the ED due to a lack of in-patient bed availability) has been shown to have significant effects on patient care, including increased patient harm and mortality, as well as longer hospital stays. [3] It continues to be the biggest problem facing Australasian EDs, with recent research showing approximately one third of EDs workload is still represented by access blocked patients. [4] This indicates that hospital systems would be increasingly improved and more efficient, if overall hospital flow and bed capacity and management was improved, rather than simply expanding the size of the ED specialist workforce. [3]

Whilst the availability of senior clinical decision making is valuable, under the current staffing model consisting of a skilled junior medial workforce available on-the-floor during night shift, and appropriate consultant availability on-call to, there is little evidence to show that patient care is adversely affected. If EM consultants staffed the emergency department continuously, while the rest of the hospital continues to operate on current staffing arrangements, there is insufficient evidence to show that this would lead to better outcomes for patients who require inpatient services.

There remains a number of hospital EDs across Australasia with limited or no FACEM involvement at all, with less than 5% of ACEM accredited EDs (n = 7) meeting ACEM's *Guidelines on Constructing and Retaining a Senior Emergency Medicine Workforce* in 2015. [2] A further major issue is the current maldistribution of the specialist workforce between metropolitan and rural and regional locations. Less than 40% and 60% of rural and regional hospitals in Australian and New Zealand respectively, have FACEM presence, compared to metropolitan hospitals, of which 100% have FACEMs on staff. [5] Within this context, the addition of specialist night shift rostering has the potential to only exacerbate these inequity issues.

The case for night shift rostering of FACEMs is not justified, until:

- Appropriate day and evening shift staffing across the hospital, is provided to ensure appropriate patient flow, and therefore overflow of evening shift work does not occur; and
- The inequity of specialist EM physician access between metropolitan and rural and regional areas is addressed.

4.2 Resource constraints

ACEM is unaware of any modelling conducted to determine the number of emergency physicians required, and the amount of funding needed, for EDs across Australasia to implement FACEM night shift rostering. With an existing maldistribution of the workforce across Australasia, and substantially smaller numbers of FACEMs in rural and regional areas, this would likely mean that some hospitals, would not to be able to provide 24/7, on-the-floor cover.

If night shift rostering were to be introduced, there would need to be significant additional funding provided for emergency physician remuneration and associated additional administration costs. This would need to not only compensate physicians adequately for night shift work, but also to account for the extra physicians required to undertake and maintain such a roster. There has been no indication by Governments in Australia and New Zealand that additional funding will be provided. In this environment, ACEM is concerned that the default (and cheapest) model of weekly shift rotations would be employed, with subsequently poorer health and wellbeing outcomes for emergency physicians. [6]

ACEM acknowledges that as patient presentations to the ED approach and exceed 100,000 in the coming years, there may be a need for health services to consider FACEM night shift rostering. However – this could only ever be implemented safely, for both patients and physicians, if the following principles were adhered to:

- Appropriate number of FACEMs are present across all shifts (day, evening and night), and across all regions.
- Evidence based plans in relation to time spent off duty by specialists, post night shift, particularly in relation to circadian disruptions, also noting that recovery time would be additional to usual leave.

- Limits on the number of night shifts rostered as emergency physicians age.
- The additional cost required, encompassing remuneration and likely increases in sick and other leave.
- Organisational strategies to ensure the physical and mental well-being of FACEMs.
- Agreement from the local FACEM group that the night shift rostering system to be put in place is feasible.

4.3 Workforce wellbeing and sustainability

Emergency medicine is a rewarding but demanding and high pressure specialty, with emergency specialists being at the pinnacle of decision-making density in the hospital system. This level of intensity over a long career is difficult to sustain, and can result in an increased risk of physician burnout. Physician burnout – characterised by emotional and physical exhaustion, a reduced sense of personal accomplishment and feelings of ineffectiveness, and is negatively associated with the quality of patient care and patient safety (e.g. an increase in medical errors). [7]

Where night shift rostering of emergency physicians is routine, such as the United States, research has also shown that a majority of emergency physicians report night shift as having a moderate or major negative influence on job satisfaction. Fatigue, poor physical health, poor quality of sleep, mood disorders, and impacts on relationships have also been reported, with physician burn out the potential consequence. [8] Older emergency physicians have reported less ability to recover and higher levels of emotional exhaustion from working night shift. [6] Physicians reported that working fewer night shifts or eliminating the practice entirely would protect against early retirement. [6] Whilst in Australia, a recent audit by the Australian Medical Association (AMA) into safe working hours found that emergency medicine was the only specialty that failed to see a reduction in the number of doctors falling into a 'high risk' category of fatigue and performance impairment over a five-year period. [9]

ACEM remains concerned at the long-term effects night shift rostering will have on both the well-being of its workforce, as well as the long term sustainability of the specialty, within the current health system climate. Fatigue and performance impairment for specialist emergency physicians, across their career, would only be exacerbated if night shift rostering were to be introduced, particularly if the United States model of weekly shift rotations were to be adopted.

5. REFERENCES

1. AIHW 2015. Emergency department care 2014–15: Australian hospital statistics. Health services series no. 65. Cat. no. HSE 168. Canberra: AIHW.

2. ACEM. G23 Guidelines on Constructing and Retaining a Senior Emergency Medicine Workforce. West Melbourne: ACEM; 2015. 14p.

3. ACEM. S127 Statement on Access Block. West Melbourne: ACEM; 2014. 2p.

4. ACEM. 2016 Access block point prevalence survey. West Melbourne: ACEM; 2016. 4p.

5. ACEM. Directors of Emergency Medicine Hospital Data Survey Report of Findings. West Melbourne: ACEM; 2015.[3]

6. Goldberg R, Thomas H, Penner L. Issues of Concern to Emergency Physicians in Pre-Retirement Years: A Survey. The Journal of Emergency Medicine. 2011; 40(6): 706-713.

7. Arora M, Asha S, Chinnappa J, Diwan, AD. Review article: Burnout in Emergency Medicine Physicians. Emergency Medicine Australasia. 2013; 25(6): 491-495.

8. Smith-Coggins MD, Broderick KB, Marco MD. Night shifts in Emergency Medicine. The Journal of Emergency Medicine. 2014; 47(3): 372-378.

9. AMA. Managing the Risk of Fatigue in the Australian Medical Workforce: AMA Safe Hours Audit 2011. Barton: AMA; 2011.

6. DOCUMENT REVIEW

Timeframe for review: every five (5) years, or earlier if required.

6.1 Responsibilities

Document authorisation:	Council of Advocacy, Practice and Partnerships
Document implementation:	Standards Committee
Document maintenance:	Policy and Research Department

6.2 Revision History

Version	Date of Version	Pages revised / Brief Explanation of Revision
V1	Nov-16	Approved by CAPP

[3] Member log-in required.