Is it time to relieve junior doctors from “relief rotations”?

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ABSTRACT

Relief junior doctors provide cover for absent colleagues on leave. One of the main advantages of the relief system is the availability of covered leave for junior doctors. However, it also has several drawbacks, including the lack of time-accreditation by Training Colleges. This viewpoint identifies some of the problems with the current relief system in New Zealand and suggests potential solutions to improve the experiences for junior doctors, patients and employers.

Types of relief

The New Zealand Resident Doctors’ Association (NZRDA) contract stipulates that RJDs ought to make up approximately 1 in 7 house officers and 1 in 5.5 registrars (ie, approximately 14–18% of junior doctors). These reliever ratios pertain to RJDs covering for colleagues on leave (eg, annual, sick, bereavement, educational or parental leave). It is expected that additional RJDs will be employed to provide adequate cover for junior doctors absent for other reasons than being on leave (eg, on rostered days off (RDO) and night shifts). The proportion of RJD, therefore, is usually higher than the quoted reliever ratios. Although somewhat less prescriptive, the Specialty Trainees of New Zealand (STONZ) contract has similar relief system stipulations to the NZRDA contract.

A third type of relief is referred to as “short-notice relief” (SNR). Any junior doctor (whether relief or not) may be rostered by their employer to cover SNR, the primary goal of which is to cover last-minute after-hours gaps. The SNR period can be up to seven consecutive days, and typically commences on a Saturday. Caps on the number of after-hours shifts varies among the different contracts. Similarly, prioritising the services covered by the SNR junior doctor varies because it depends upon service needs and any other available cover. If an SNR junior doctor is required to

Relief junior doctors (RJDs) are post-graduate year 2 or higher (PG-Y2+) house officers and registrars who provide cover for absent colleagues. A PG-Y2+ junior doctor is generally expected to be rostered to at least one 3–4-month relief rotation per year. This “relief system,” although not unique (eg, it also features in Australia), seems to be more ubiquitous/prevalent in the New Zealand healthcare workforce. Although it useful for plugging deficiencies in junior doctor rosters, RJDs often have a sub-optimal and fragmented clinical experience. This arrangement can severely undermine the educational value of the rotation due to compromises in the continuity of care, curriculum and supervision. To at least partially compensate for the inconvenience, RJDs are paid two pay-categories above the usual (ie, non-RJD) pay-category. The exact nature of the work required of the RJDs varies. During work-hours (ie, 0800–1600), RJDs may be allocated to certain specialties for the entirety of their rotation (eg, cardiology relief), or work as general relievers. After-hours, RJDs fill gaps in the on-call rosters based upon need and each RJD’s level of expertise. By contract, employers are required to inform RJDs of their rosters at least two weeks in advance. This is particularly relevant for on-call duties, as allocation for work-hours duties may change on the day if an RJD is required to be re-deployed to cover last-minute day gaps.

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work an after-hours shift, they are paid at an additional hourly rate for the duration of their shift. Over-night shifts (2300–0800) incur a higher rate, and the employer generally has a deadline of 1600 of notifying the SNR junior doctor of their need to cover the night shift; evening shifts (1600–2300) have a deadline of 1400.\textsuperscript{3,4}

### Current status

Currently, it is estimated that approximately 25–35\% of PG-Y2+ junior doctors are given a relief rotation at any one period (Personal communication, Resident Doctors Support Team, Canterbury District Health Board). This is significantly higher than would otherwise be expected. The causes of this increase have not been formally examined, but the recent implementation of the NZRDA's contract (split night rostering and introduction of schedule 10 RDO) has likely contributed.

### Advantages

Covered leave for junior doctors is one main advantage of a robust relief system. Working together with their employers, junior doctors can take time-off for holiday, study, courses, conferences, paternity and child-care and sick leave (especially on short-notice). To compensate for the inconvenience of relief rotations (eg, varied daily schedule and sub-optimal continuity of care), RJDs are financially compensated at higher rates than non-RJDs.

The relief system may be an avenue for junior doctors to work flexibly or on a part-time basis. Moreover, the pool of RJDs provides a “buffer” should any non-relief vacancies arise. Finally, relief rotations may also provide RJDs a wider view of the various departments within a hospital, especially those junior doctors on short-term contracts and those from overseas.

### Disadvantages

Perhaps the main drawback of relief rotations is the lack of time-accreditation by several Training Colleges, as relief rotations are often viewed to offer less supervision and educational value. For example, the Royal Australasian College of Physicians only allows up to a maximum of six months of “other” rotations, which may include relief.\textsuperscript{5} The College of Intensive Care Medicine only accredits relief rotations (as part of the trainee’s non-core experience) if at least four weeks are spent in a single medical sub-speciality.\textsuperscript{6} Similarly, candidates applying for surgical training with the Royal Australasian College of Surgeons can only accredit relief periods (often >4 consecutive weeks, although the exact duration varies) if spent in a single surgical specialty.\textsuperscript{7}

At the current rate of one guaranteed relief rotation per year (and occasionally two), this often results in prolongation of training/eligibility to sit College examinations. However, as relief rotations tend to entail fewer learning, teaching and clinical supervision opportunities,\textsuperscript{1} it is not surprising that the Training Colleges impose such strict accreditation criteria.

No studies to date have examined the effects of relief rotators on patient care, safety or outcomes.\textsuperscript{4} RJDs anecdotally find less satisfaction in relief rotations due to the lack of patient-care continuity, familiarity with departmental guidelines, overall team cohesion and structure/routine in day-to-day work. RJDs’ general lack of satisfaction with relief rotations may even lead to increased absenteeism, which negates the purpose of the relief role. The fact that RJDs are paid more by their employers further exacerbates the loss of human-power and the opportunity cost. Therefore, relief rotations may prove sub-optimal not only for the RJDs, but also for their patients and clinical teams.\textsuperscript{9}

### Going forward

A functional relief system ought to achieve three goals:

1. allow junior doctors to take leave (whether planned, or on short-notice) without significantly compromising the work-flow/patient safety
2. enable employers to effectively respond to the ebbs and flows of workforce demands without undue financial waste
3. be designed in such a way that does not compromise patient care or the educational value for RJDs.
RJD-free rostering

Several departments, particularly ones on shift-rosters (eg, ICU), have forgone the relief system. Their junior doctors are required to apply for planned leave prior to an advertised deadline. If planned leave is needed following the deadline, junior doctors are expected to swap shifts among themselves to provide sufficient cover such that no shifts are left vacant. For unplanned/short-notice leave, the vacant shifts are advertised to a list of interested junior doctors to pick up for an additional pay (financial cost to the department). Failing that, consultants would cover the vacancy.

Embedded relief

Embedded relief involves the employment of a surplus of junior doctors in each department (the number will depend upon each department's clinical demands).\(^3\)\(^,\)\(^4\) For employers, this absolves them of (or significantly reduces) the need to specifically hire RJDs, while retaining the same human-power (or more of it) to safely organise rosters and leave requests. For junior doctors, this ensures the totality of their clinical time is counted towards their training without unnecessary delays.

Here's a hypothetical example to illustrate this innovative approach:

The Department of Neurology at Hospital X currently employs 4.5 full-time-equivalent (FTE) junior doctors (3 registrars, 1 in-patient house officer and 0.5 out-patient house officer). To cover for absences, the Department gets approximately 1.3 FTE RJDs. These are made up of one relief registrar (shared with the Nephrology, and Infectious Diseases departments), two relief house officers (shared with the Haematology and Oncology departments) and a third relief house officer (shared with the Nephrology and Respiratory departments). Therefore, while the Neurology Department has a total of 5.8 FTE junior doctors, the RJDs are fragmented among several other departments. This not only translates to possibly fragmented care divided among several departments. It also means that the time spent by those RJDs is unlikely to yield meaningful clinical experience in any one department or be counted towards their training.

To counterbalance some of the problems identified above (while retaining the advantage of having some roster redundancy), the embedded relief system would entail allocating the Department 6.0 FTE junior doctors (in the form of 4 registrars and 2 house officers). Each of the four registrars would, for example, participate acute stroke care, in-patients, consults and relief/ad hoc clinics. This way the “burden” of relief is shared (eg, a month at a time during a four-month rotation) while each junior doctor receives meaningful clinical experience, and the Department is still able to meet patient-care demands.

The embedded relief system is not without its drawbacks. It is conceivable that, over time, the departmental workload could expand such that “redundant” junior doctors are no longer treated as such. This would make it more difficult for junior doctors to take leave. Junior doctors could also be paid less for doing similar/more work (ie, not remunerated at two pay-categories above the usual).

Conclusions

Having some redundancy in the rostering of junior doctors allows sufficient laxity to allow for planned and unplanned leave to be covered. However, it is not without costs to employers (potential financial losses) and junior doctors (limited educational value and probably job satisfaction). Currently, RJDs are only allowed to accredit a limited time-period (if any) to count towards their training. Although some departments have forgone the relief system, the present system could do with some improvements.

We, therefore, suggest modifying the current relief system. This may appeal to both employers and junior doctors alike. The system could take the form of a hybrid that incorporates both embedded as well as dedicated RJDs. Embedded RJDs would cover most of the departmental human-power needs and gain valuable educational experience accredited by their Training College (ie, by restricting the time and scope/specialty of relief work). At the same time, having dedicated RJDs would keep a degree of flexibility for covering leave and/or last-minute needs for re-deployment. To make dedicated RJDs more appealing to junior doctors, they may be offered a range
of sub-specialty exposure and/or the use of the expertise of overseas junior doctors who are only intending to stay in New Zealand short term. We expect this proposed hybrid system to be useful for rostering junior doctors in both large and small hospitals (although it may be easier in smaller hospitals with fewer junior doctors/rosters).

What is clear is that there is a need for an on-going dialogue among the various stakeholders (namely, junior doctors, trade unions, employers and Training Colleges) in order to improve the current status of relief rotations. In this hybrid system, more relief rotations would count towards training, night shift/RDO rosters could be restructured, the coordination of relief rotations could fit with training requirements, allocations could be matched to RJDs’ areas of interest, and departments could have a consistent, workable and equitable framework for everyone, including junior doctors, who we may yet save from (most!) relief rotations.
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Nil.

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