



Temps de travail

Gilles Capellier

Pôle Urgences-SAMU-SMUR-Réanimation Médicale

CHRU Besançon 25030

Temps de travail

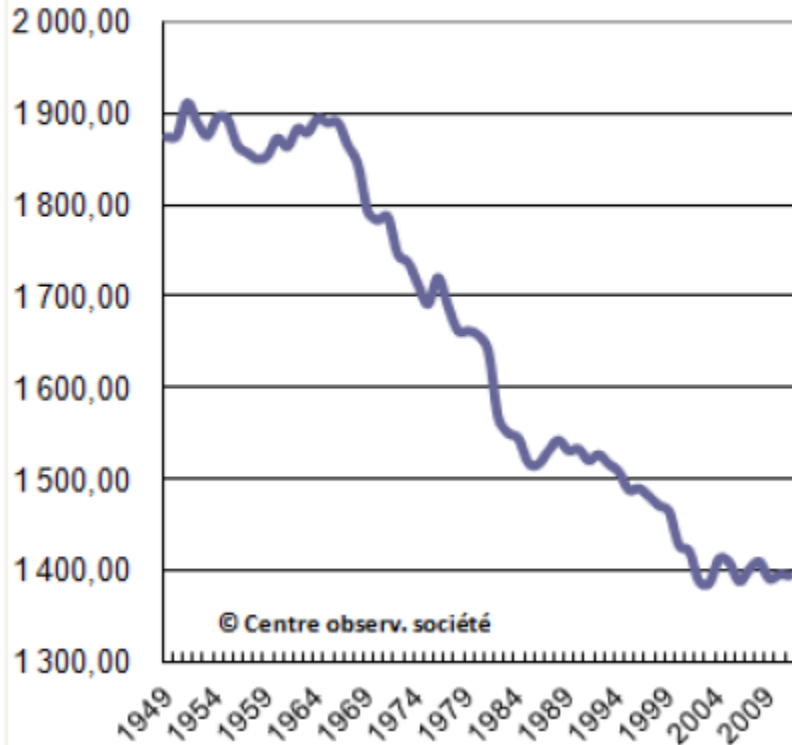
- Combien d'heures avez-vous travaillé en clinique en moyenne par semaine?
- Combien d'heures avez-vous travaillé pour vos besoins de formation par semaine?
- Etes vous satisfait de vos conditions de travail?
- Etes vous heureux au travail (0-10) ?
- Appliquez vous la recommandation du repos de sécurité après une garde?
- Considérez vous votre formation (temps dédié) suffisante?

Temps de travail

- Avez-vous bien dormi cette nuit?
- Etes vous reposé?
- Combien d'heures avez-vous dormi cette nuit?
- Combien d'heures avez-vous dormi en moyenne cette semaine
- Avez-vous fait une garde sur la dernière semaine?
- Avez-vous pu dormir pendant la garde?
- Avez-vous utilisé des moyens pour rester éveillé?
- Avez-vous piqué du nez pendant la garde?
- Combien d'heures avez-vous dormi après la garde ?

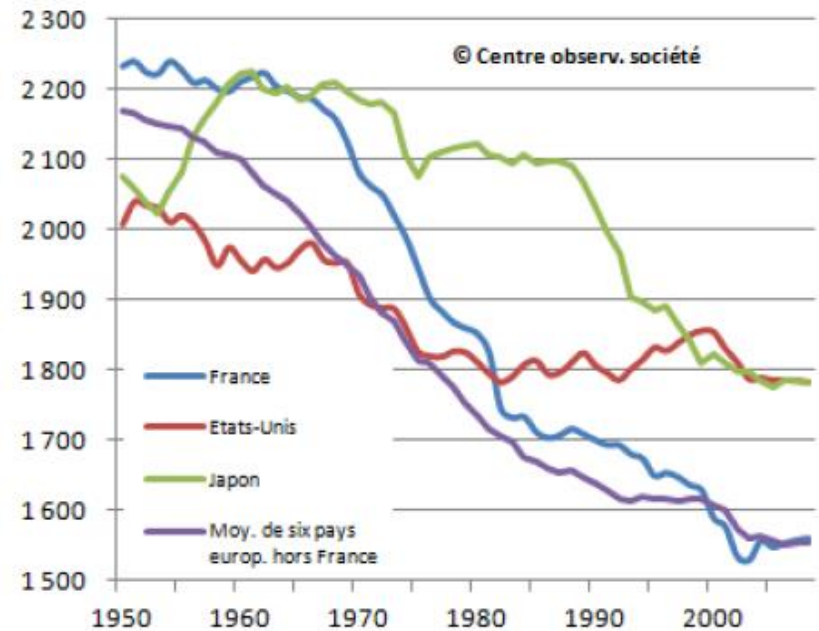
Durée annuelle du travail des salariés

Source : Insee, comptes nationaux. En heures.



La baisse du temps de travail dans le monde

Source : Insee d'après Groningen Growth Development Center. Heures par an.



Quelle est la « vraie » durée du travail ?

La durée du travail rémunéré des salariés n'est qu'une estimation du temps réellement travaillé. Elle sous-estime nettement la réalité du poids du travail dans la vie quotidienne. Il faudrait compter les heures travaillées en plus mais « oubliées », non déclarées de façon plus ou moins tacite par le salarié, notamment dans le secteur privé. Une partie des cadres supérieurs salariés – sous certaines conditions - comptabilisent leur temps de travail en « jours » et non en heures (avec un maximum de 10 h par jour). Il y a aussi les heures de travail des non-salariés, supérieures de 10 à 15 heures en moyenne hebdomadaire à ceux des salariés, mais qui disposent en contrepartie de beaucoup plus d'autonomie en termes d'organisation et d'indépendance dans le travail. Enfin, il faudrait comptabiliser une part des tâches domestiques, principalement réalisées par les femmes, qui constituent une forme de travail non rémunéré et sans contrat, plus ou moins contraint, souvent dans une zone grise entre le travail et le loisir. Tout dépend au fond de la définition donnée au mot « travail ».

EVOLUTION DE LA DURÉE LÉGALE DU TRAVAIL EN France

XVIIIème siècle : on travaille du lever au coucher du soleil, tant qu'on y voit.

1841 : interdiction du travail pour les enfants de moins de 8 ans
interdiction du travail de nuit pour les enfants de moins de 13 ans
journée de travail limitée à 8 heures pour les 8-12 ans, à 12 heures pour les 12-16 ans

1848 : 12h/ jour

1900 : semaine de 70h, avec au plus 11h/jour (loi Millerand)

1906 : semaine de 60h

1919 : semaine de 48h (« 8h de travail, 8h de sommeil, 8h de loisirs », revendication du 1^{er} mai 1886 à Chicago), Décret d'application en 1926 !

1936 : semaine de 40h et deux semaines de congés payés (Accords de Matignon)

1941 : semaine de 48h (Charte du travail du gouvernement de Vichy)

1946 : semaine de 40h

1982 : semaine de 39 h

1997 : semaine de 35 h (« Travailler moins pour travailler tous »)
Accords d'annualisation des salaires: possibilité de 48h/semaine sans heures supplémentaires.
Elargissement des plages d'accueil au public (flexibilité)
Aujourd'hui : 5 semaines CP, RTT

Temps de travail et Société

- **4 grandes catastrophes civiles liées en partie à la fatigue:**
 - 1984 Bhopal
 - 1986 Explosion de la navette spatiale Challenger
 - 1986 Accident de la centrale nucléaire de Tchernobyl
 - 1989 Naufrage du pétrolier Exxon Valdez
- **Libby Zion's death in USA**
 - D A Asch, RM Parker, NEJM 1988;318:771-775
 - Interactions médicamenteuses
 - Décès de la malade et enquête conclue à fatigue de l'interne (parmi probablement d'autres causes)
 - Modification du temps de travail et de la durée des gardes

The Well-Being of Physicians

April 15, 2003 THE AMERICAN JOURNAL OF MEDICINE® Volume 114

Table 2. An Interpretation of How Organizations Can Promote Physician Well-Being

- I. **Promote Physician Autonomy:** Increase physicians' ability to influence their work environment and participate in decisions that effect practice. **Provide flexibility and increased physician control over schedule.**
- II. **Provide Adequate Support Services:** Supply **adequate physician coverage to allow time off.** Provide adequate and coordinated nursing, secretarial, administrative, social work, and laboratory support in a effort to promote efficient patient care.
- III. **Cultivate a Collegial Work Environment:** Create a work environment that fosters healthy relationships among employees. Examples: retreats, team building exercises, working toward common goals, holiday parties, etc.
- IV. **Be Value Oriented:** Promote the core values of the medical profession. Incorporate these values into the institutional mission. Involve physicians in helping organizations promote and achieve this mission.
- V. **Minimize Work-Home Interference:** Facilitate flexible and readily accessible child care. Allow flexibility in scheduling and provide ready coverage for important life events (births, funerals, illness, family emergencies).
- VI. **Promote Work-Life Balance:** Provide adequate vacation time and limits on overtime expectations. Develop organization sponsored seminars and retreats on job-life balance. Develop mentoring program and periodic sabbaticals.

John-Henry Pffifferling
 medical anthropologist
 1200 médecins

These physicians offered a list of lessons they wished they had learned at earlier points in their careers, such as:

- how to find balance in their lives
- how to say "No!"

A Gender-Based Analysis of Work Patterns, Fatigue, and Work/Life Balance Among Physicians in Postgraduate Training

Philippa Gander, PhD, Celia Briar, PhD, Alexander Garden, MB, ChB, PhD, Heather Purnell, MSc (Hons), and Alistair Woodward, MBBS, PhD

Australie et NZ

Acad Med. 2010;85:1526-1536.
doi: 10.1097/ACM.0b013e3181eabd06

These data from a New Zealand national survey show that limiting work to 72 hours per week has not prevented many junior doctors in hospital-based clinical

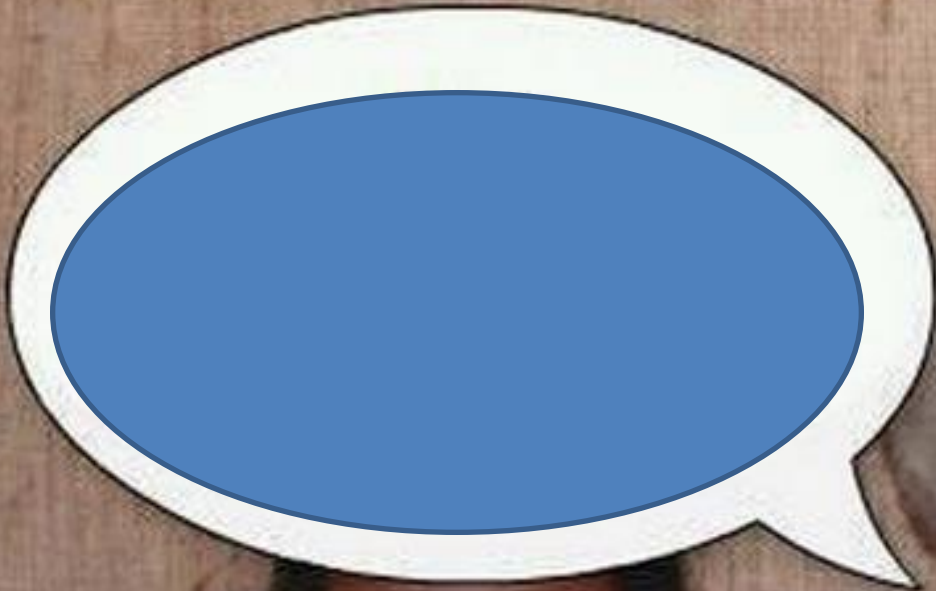
The logistic regression analyses confirmed that multiple aspects of work

Independent risk factors for reporting problems with social life, home life, personal relationships, and other commitments included longer total duty hours, increasing amounts of night duty, and schedule changes.

changing among physicians in postgraduate training,^{15,17,19,20} a change that has major implications for postgraduate medical education and for workforce planning.

and schedule changes. The total fatigue risk score was a stronger predictor of problems in life outside work than was any single aspect of the work pattern.

**Conflit de
génération ?**



Sommeil

- Signes de fatigue: (après carence d'une nuit)
 - Perte de conscience, de concentration (lapses in attention)
 - Augmentation du temps de réaction (détection d'une situation à risque)
 - Altération de l'attention visuelle
 - Ralentissement de la mémorisation
 - Altération de l'humeur
- Conséquences du manque de sommeil
 - Erreur médicales
 - Evite de faire des tâches complexes
 - Accident de travail
 - Accident de trajet
- Modalités d'interventions pour limiter les effets
- Répercussions: manque de sommeil chronique, perte du rythme nycthéméral, phase de réveil (sleep inertia)
- Apparition variable selon les individus: dès 16 heures d'éveil !
- Comparaison à une prise d'alcool, 24 heures sans sommeil = 1G/L !

Pictorial Epworth Sleepiness Scale

Name: _____ Date: ___/___/___ Hospital No: _____ Date of Birth: ___/___/___

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Even if you have not done some of these things recently, try to work out how they would affect you. Use the following scale to choose the most appropriate number for each situation.

Situation <input checked="" type="checkbox"/> Please tick box	0 No chance of dozing	1 Slight chance	2 Moderate chance	3 Definitely would doze
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g. Theatre or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Figure 1 The pictorial Epworth Sleepiness Scale. Each scenario has a series of pictograms depicting increased likelihood of sleepiness; participants are asked to tick the image that best represents their level of daytime sleepiness. (During the trial a ninth question portraying a sleepy driver was also included.)

Fatigue: Contremesures

- Modification des horaires et du planning
 - Diminution du travail de nuit
 - Diminution du nombre d'heures de travail
 - Diminution des gardes
- Sieste
 - Entre 20 et 60 minutes
 - Amélioration de la vigilance, performance
 - Augmente « sleep inertia » (phase d'éveil): attention
 - Meilleure si période protégée par autre médecin
- Gestion de la phase d'éveil
 - Peut être invalidante et source d'erreurs
 - Caffeine 200mg, gomme à mâcher caféine
 - Exposition lumière vive, eau froide

Fatigue: Contremesures

Micro breaks

- Quelques mouvements, marche, étirements
- Épaules, cou, dos

• Stimulants

– Cafféine

- (forte dose toutes les 6heures ou doses régulières (1 tasse) toutes les heures
- Effets secondaires à forte dose: physiques et psychiques
- Tolérance

– Modafinil (Modiodal)

- Domaine militaire
- Amélioration des fonctions d'éveil prolongé: réactivité, mémorisation..
- Conséquences sur endormissement

• Lumière blanche ou faible lumière bleue

Temps de travail: des situations qui n'arrivent qu'aux autres!

- S'être endormi au volant à un feu de signalisation en sortant de garde
- Avoir eu un "presqu'accident"
- Avoir piqué du nez lors de la relève de garde
- Ne pas s'être réveillé à l'heure de la relève de garde
- Avoir travaillé plus de 12 heures de garde
- Ne pas prévoir un jour de garde
- Ne pas prévoir un jour de garde
- Rater des événements familiaux ou avec les amis
- Se disputer avec son conjoint, sa famille, ses amis, ses collègues au décours d'une semaine "chargée"
- Avoir eu envie de changer de métier
- Avoir le sentiment de ne pas pouvoir être malade

"Best doctors have few needs, make no mistakes and are never ill"

Prevalence and Factors of Intensive Care Unit Conflicts

The Conflicus Study

Élie Azoulay¹, Jean-François Timsit², Charles L. Sprung³, Marcio Soares⁴, Kateřina Rusinová⁵, Ariane Lafabrie¹,

Am J Respir Crit Care Med Vol 180, pp 853–860, 2009

Originally Published in Press as DOI: 10.1164/rccm.200810-1614OC on July 30, 2009

Conflicts : 71,6%
Sévère: 53%
Dangereux: 52%
des répondeurs

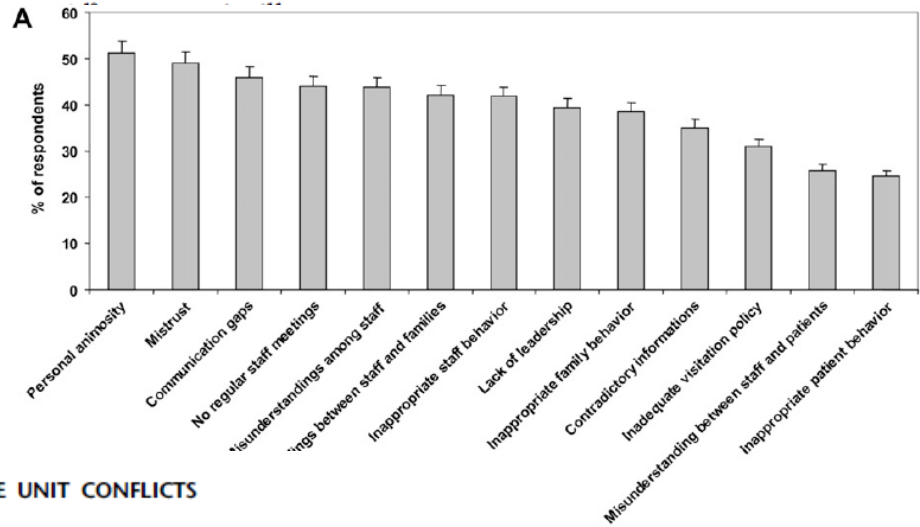


TABLE 4. FACTORS ASSOCIATED WITH INTENSIVE CARE UNIT CONFLICTS (MULTIVARIATE HIERARCHICAL ANALYSIS)

	Estimate	Odds Ratio*	95% CI	P Value	
Intercept	3.0604				
Respondent characteristics					
Male sex	0.1871	1.21	1.05–1.40	0.0101	
Older than 34 yr	−0.1603	0.85	0.74–0.98	0.0236	
At least one child	−0.1414	0.87	0.75–1.00	0.0507	
Works more than 40 h/wk	0.2561	1.29	1.11–1.50	0.0009	
Training in ethics	0.1638	1.18	1.02–1.34	0.0089	
Job title in ICU†					
Doctor	Reference	1	—	0.0005	
Nurse	−0.1858	0.83	0.69–1.00		
Physiotherapist	−0.1911	0.82	0.45–0.93		
Works more than 40 h/wk		0.2561	1.29	1.11–1.50	0.0009
Involved in pre-mortem and post-mortem care of at least one dying patient within the last wk	0.4248	1.53	1.33–1.76	<10 ^{−4}	
Symptom control in dying patients ensured jointly by nurses and physicians	−0.2488	0.78	0.59–1.03	0.0753	
Center characteristics					
Routine ICU unit-level meetings	−0.2725	0.76	0.57–1.02	0.0666	
More than 15 ICU beds	0.2522	1.29	0.97–1.70	0.0771	
Country characteristics					
Government health expenditure (as a percentage of total government expenditure)	−0.0240	0.98	0.96–1.00	0.0363	
Covariance parameters					
Country	Estimate	Standard Error			
ICU	0.2906	0.1199			
	0.7595	0.0962			

Fig
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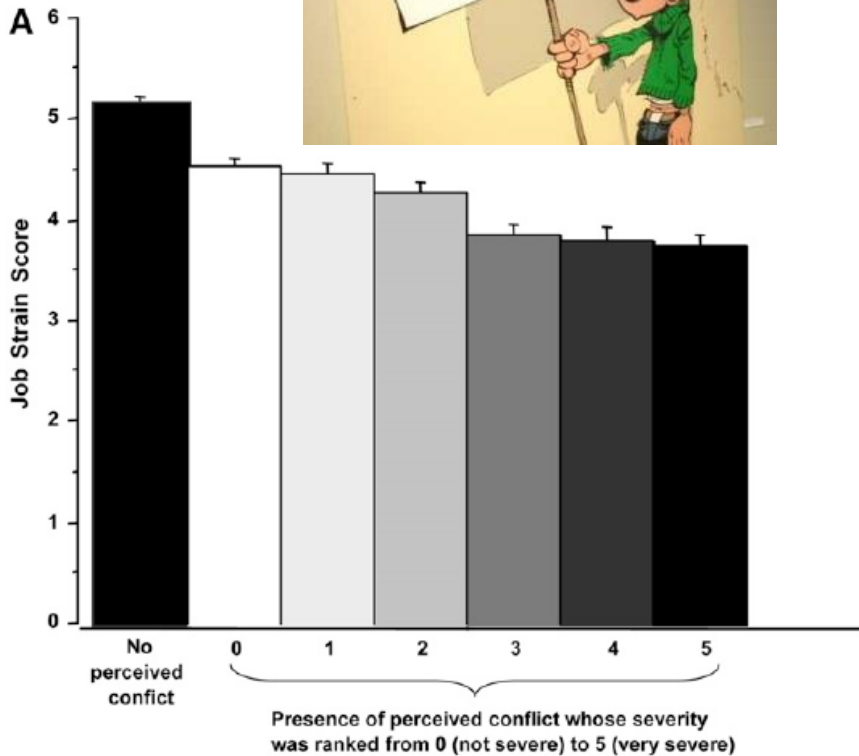
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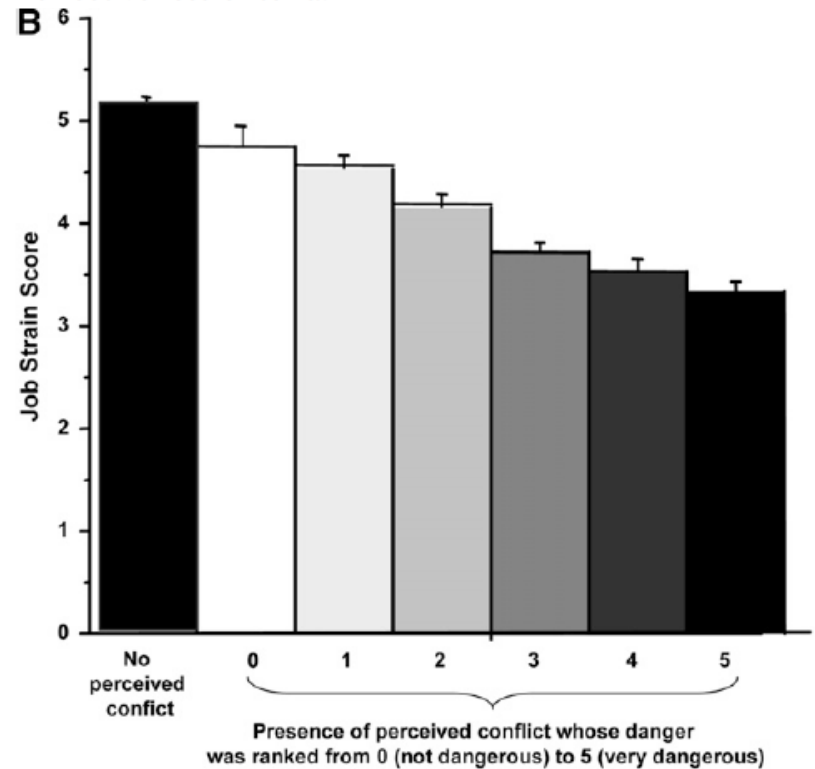
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practice. We suggest testing interventions designed to reduce conflicts, s... holding
unit-level... at each
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effectiveness criteria.

**We suggest
“Decreasing the
number of working
hours!”**



Temps de travail: une certaine vision

Concerns about potential erosion of professionalism have grown in parallel with the duty hours restrictions. Many have suggested that residents may develop a “**shift-worker mentality**”—the “perception that **the clock governs the resident’s time of departure** from hospital, rather than patient needs.” Others have suggested that residents will **lose both their professional identity and patient ownership**—“the philosophy that one knows everything about one’s patients and does everything for them.”

Temps de travail et erreur (NEJM 2004)

- Durée du travail: >24h et gardes (plus de 30 heures consécutives)
- MICU et CCU
- Pas de modification résidents et seniors
- Internes: 1 an post thèse
- Analyse des erreurs par experts indépendants

Effect of Reducing Intern Work Hours on Serious Medical Errors in Intensive Care

Christopher P. Landrigan, M.D., M.P.H., Jeffrey A. Sloan, M.D., John W. Cronin, M.D., Rainu Kaushal, M.D., M.P.H., M.D., M.P.H., Joel T. Katz, M.D., Craig M. Lilly, M.D., Peter H. Stone, M.D., David W. Bates, M.D., and Charles A. Barger, M.D., for the Harvard Work Hours, Health, and Performance Study

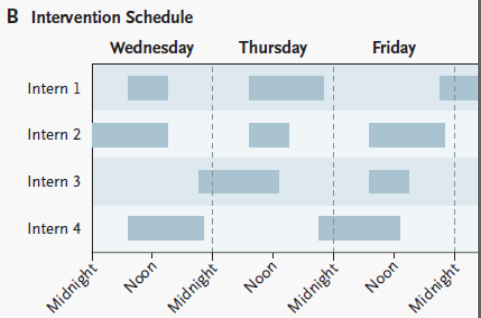
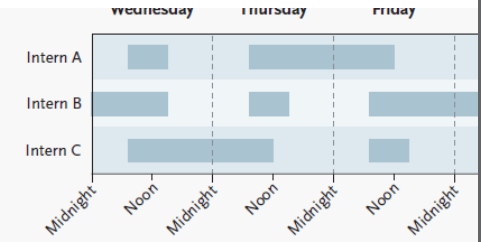


Figure 1. Representative Work Hours during a Single Week for Interns (Panel A) and the Intervention Schedule (Panel B).
 Scheduled work hours are indicated by the bars. Panel A shows a traditional three-day schedule (e.g., Wednesday for Intern A), followed by an extended shift (e.g., Thursday through Friday for Intern A). Interns staffed the unit on the traditional swing shift or the latter half of an extended on-call shift. Panel B shows the intervention schedule where interns provided continuous coverage on a repeated four-day schedule (e.g., Wednesday for Intern 1); day 2 is "day call" from 7 a.m. to 10 p.m. (e.g., Thursday for Intern 1); days 3 and 4 are "night call" from 9 p.m. to 7 a.m. (e.g., Friday through Saturday for Intern 1). The day-call intern and the incoming night-call intern (e.g., Wednesday for Intern 1) overlapped from 7 a.m. to 10 p.m. (e.g., Saturday for Intern 1); this overlap was often extended as clinically required on a Saturday, Sunday, or Monday (e.g., Sunday for Intern 1) swing day.

Table 3. Incidence of Serious Medical Errors.

Variable	Traditional Schedule	Intervention Schedule	P Value
	<i>no. of errors (rate/1000 patient-days)</i>		
Serious medical errors made by interns			
Serious medical errors	176 (136.0)	91 (100.1)	<0.001
Preventable adverse events	27 (20.9)	15 (16.5)	0.21
Intercepted serious errors	91 (70.3)	50 (55.0)	0.02
Nonintercepted serious errors	58 (44.8)	26 (28.6)	<0.001
Types of serious medical errors made by interns			
Medication	129 (99.7)	75 (82.5)	0.03
Procedural	11 (8.5)	6 (6.6)	0.34
Diagnostic	24 (18.6)	3 (3.3)	<0.001
Other	12 (9.3)	7 (7.7)	0.47
All serious medical errors, unit-wide			
Serious medical errors	250 (193.2)	144 (158.4)	<0.001
Preventable adverse events	50 (38.6)	35 (38.5)	0.91
Intercepted serious errors	123 (95.1)	63 (69.3)	<0.001
Nonintercepted serious errors	77 (59.5)	46 (50.6)	0.14
Types of serious medical errors, unit-wide			
Medication	175 (135.2)	105 (115.5)	0.03
Procedural	18 (13.9)	11 (12.1)	0.48
Diagnostic	28 (21.6)	10 (11.0)	<0.001
Other	29 (22.4)	18 (19.8)	0.45

+36%
+21%
+57%

+21%
X5,6

Understanding of Resident Education Analysis of

Katharine S. Devita
Frances C. Wright
and Najma Ahmed

Abstract

Purpose

Individuals representing surgical disciplines have concerns with the duty hours (RDH) resident education outcomes. This study published viewpoints on the effects of the surgery.

A Systematic

Najma Ahmed

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Richard J. Wa

Category 1: Impact of the RDH restrictions

Effects of the RDH restrictions on trainees

- › Service versus training
- › Professional identity
- › Quality of life
- › Preparedness for practice

Effects of the RDH restrictions on patient care

- › Quality of care
- › Improved patient safety via reduced resident fatigue
- › Continuity of care

Effects of the RDH restrictions on faculty

- › Supervision
- › Roles and responsibilities
- › Quality of life

Effects of the RDH restrictions on the health care system

- › Financial costs
- › Adaptation strategies

Category 2: Surgery has its own unique culture

Category 3: Strategies going forward

- › Changes to training modalities
- › Need for evidence
- › No new RDH restrictions
- › Enforcement of/compliance with the RDH restrictions
- › Flexibility in regulations

Figure 2 Summary of the overarching categories and themes that emerged from a qualitative review of published viewpoints on resident duty hours (RDH) restrictions in surgery, 2003–2015.

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A Reduced Duty Hours Model for Senior Internal Medicine Residents: A Qualitative Analysis of Residents' Experiences and Perceptions

Rebecca
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Conclusions

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Purpose

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A reduced duty hours model with night float has potential to improve residents' perceived fatigue on call and care continuity on the clinical teaching unit. This must be weighed against increased handover frequency and loss of the postcall day, which may negatively affect patient care and resident quality of life.

Temps de travail et Transmissions

- Coordination des soins
- Augmentation de la fréquence avec la diminution du temps de travail
- Questionne la continuité des soins, la qualité des soins et la formation médicale
- Différents outils informatisés
- Peu de formation à la conduite des transmissions
- Peu de formalisation dans les services

Temps de travail et transmission

- Evaluation de la répercussion des changements d'équipe
 - The july effect
 - Mortalité et WE
 - Durée de séjour et changement d'équipe
 - Retard de prise en charge
 - Biais de diagnostic ou de traitement
 - Multiplication des bilans, absence de récupération des examens

Increased Mortality Rates During Resident Handoff Periods and the Effect of ACGME Duty Hour Regulations



Joshua L. Denson, MD,^a Matthew McCarty, MD,^b Yixin Fang, PhD,^c Amit Uppal, MD,^d Laura Evans, MD, MSc^d

^aDepartment of Internal Medicine, Bellevue Hospital Center, New York University School of Medicine, New York; ^bDepartment of Emergency Medicine and ^cDivision of Biostatistics, Department of Population Health, New York University School of Medicine, New York;

^dDivision of Pulmonary, Critical Care and Sleep Medicine, Bellevue Hospital Center, New York University School of Medicine, New York.

Table 2 Risk of Mortality in Handoff Patients versus Control Patients

Outcomes	Handoff Group (%)	Control Group (%)	OR (95% CI)	P-Value
All-cause hospital mortality (2010-2012)				
Unadjusted	2.68	2.08	1.30 (1.08-1.57)	.007
Adjusted*			1.34 (1.10-1.62)	.003
Pre-duty-hour mortality (2010-2011)				
Unadjusted	2.87	2.01	1.44 (1.11-1.86)	.006
Adjusted*			1.50 (1.16-1.95)	.002
Post-duty-hour mortality (2011-2012)				
Unadjusted	2.48	2.15	1.16 (0.88-1.53)	.30
Adjusted*			1.18 (0.89-1.56)	.26

CI = confidence interval; OR = odds ratio.

*Multiple logistic regression model adjusted for age, sex, length of stay (outlier deleted), month, and modified Elixhauser Comorbidity Index.

mortality (OR 1.18; $P = .26$; 95% CI, 0.89-1.56).

CONCLUSIONS: Resident transition in care was significantly associated with an increase in unadjusted and adjusted hospital mortality. Although improved by 2011 ACGME duty-hour amendments, a trend toward higher mortality remained following resident handoff.

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I-PASS
BETTER HANDOFFS. SAFER CARE.

I	Illness Severity	<ul style="list-style-type: none"> Stable, “watcher,” unstable
P	Patient Summary	<ul style="list-style-type: none"> Summary statement Events leading up to admission Hospital course Ongoing assessment Plan
A	Action List	<ul style="list-style-type: none"> To do list Time line and ownership
S	Situation Awareness and Contingency Planning	<ul style="list-style-type: none"> Know what’s going on Plan for what might happen
S	Synthesis by Receiver	<ul style="list-style-type: none"> Receiver summarizes what was heard Asks questions Restates key action/to do items

FIGURE 1
Elements of the I-PASS mnemonic.

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2014

Sample Verbal Handoff

I	Illness Severity	OK, this is our sickest patient, and he’s full code.
P	Patient Summary	AJ is a 4-year-old boy with a history of ex 26-week gestation admitted with hypoxia and respiratory distress secondary to a left lower lobe pneumonia. He presented with cough and high fevers for 2 days before admission, and on the day he presented to the emergency department he had worsening respiratory distress. In the emergency department, he was found to have an Na of 130, likely secondary to volume depletion versus syndrome of inappropriate secretion of antidiuretic hormone. He received a fluid bolus and was started on O ₂ at 2.5 L. He is on Ceftriaxone.
A	Action List	Please look in on him at approximately midnight and make sure his vitals are unchanged and his oxygen saturation is stable. Check to determine if his blood culture is positive tonight.
S	Situation Awareness and Contingency Planning	If his respiratory status worsens, please get another chest radiograph to determine if he is developing an effusion.
S	Synthesis by Receiver	OK, so AJ is a 4-year-old ex-premie admitted with hypoxia and respiratory distress secondary to a left lower lobe pneumonia on Ceftriaxone, O ₂ , and fluids. You want me to check on him at midnight to make sure he’s stable and check his blood culture. If his respiratory status worsens, I will repeat a radiograph to look for an effusion. I think I have it.

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Changes in Medical Errors after Implementation of a Handoff Program

A.J. Starmer, N.D. Spector, R. Srivastava, D.C. West, G. Rosenbluth, A.D. Allen, E.L. Noble, L.L. Tse, A.K. Dalal, C.A. Keohane, S.R. Lipsitz, J.M. Rothschild, M.F. Wien, C.S. Yoon, K.R. Zigmont, K.M. Wilson, J.K. O'Toole, L.G. Solan, M. Aylor, Z. Bismilla, M. Coffey, S. Mahant, R.L. Blankenburg, L.A. Destino, J.L. Everhart, S.J. Patel, J.F. Bale, Jr., J.B. Spackman, A.T. Stevenson, S. Calaman, F.S. Cole, D.F. Balmer, J.H. Hepps, J.O. Lopreiato, C.E. Yu, T.C. Sectish, and C.P. Landrigan, for the I-PASS Study Group*

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Table 2. Incidence of Medical Errors, Preventable Adverse Events, and Medical-Error Subtypes before and after Implementation of the I-PASS Handoff Bundle.

Variable	Before Implementation (N=5516)	After Implementation (N=5224)	P Value
	<i>total no. (no./100 admissions)</i>		
Overall medical errors	1349 (24.5)	981 (18.8)	<0.001
Preventable adverse events	261 (4.7)	173 (3.3)	<0.001
Near misses and nonharmful medical errors	1088 (19.7)	808 (15.5)	<0.001
Medical-error subtype			
Errors related to diagnosis (incorrect, delayed, omitted)	184 (3.3)	111 (2.1)	<0.001
Errors related to therapy other than medication or procedure	112 (2.0)	77 (1.5)	0.04
Errors related to history and physical examination	43 (0.8)	0	<0.001

Diminution relative de 23% du nombre d'erreurs
Diminution relative de 30% des erreurs évitables

ACGME

- Temps de travail et erreur médicale (50% des AR dans une étude USA)
- FRM: Fatigue Risk Management
- Limitation du temps travail (clinique et éducation) : 80 H/WK sur 4 semaines
- Augmentation temps travail continu pour R1 de 16 à 24 H
- Suppression de la limite du nombre de nuits consécutives
- Suppression de la déclaration administrative si Résident retourne ou reste pour assure continuité des soins d'un malade grave après avoir fait sa relève des autres responsabilités.

JE NE PARS PAS EN VACANCES,
... J'AI PEUR DE NE PAS AVOIR
ENVIE DE REVENIR!



Impact diminution temps de travail

- Amélioration qualité de vie perso
- Diminution erreurs médicales mais pondération avec périodes de relève augmentées
- Augmentation durée de séjour et transferts en réanimation
- Pas d'effet sur la mortalité
- Pas d'effet sur la formation pour internes en médecine, impact différent pour chirurgiens

Across a Decade of Progressive Work Hours Limitations

Limitations

Michael F. Krug, MD, Anna L. Golob, MD, Pandora L. Wander, MD, MS, and Joyce E. Wipf, MD

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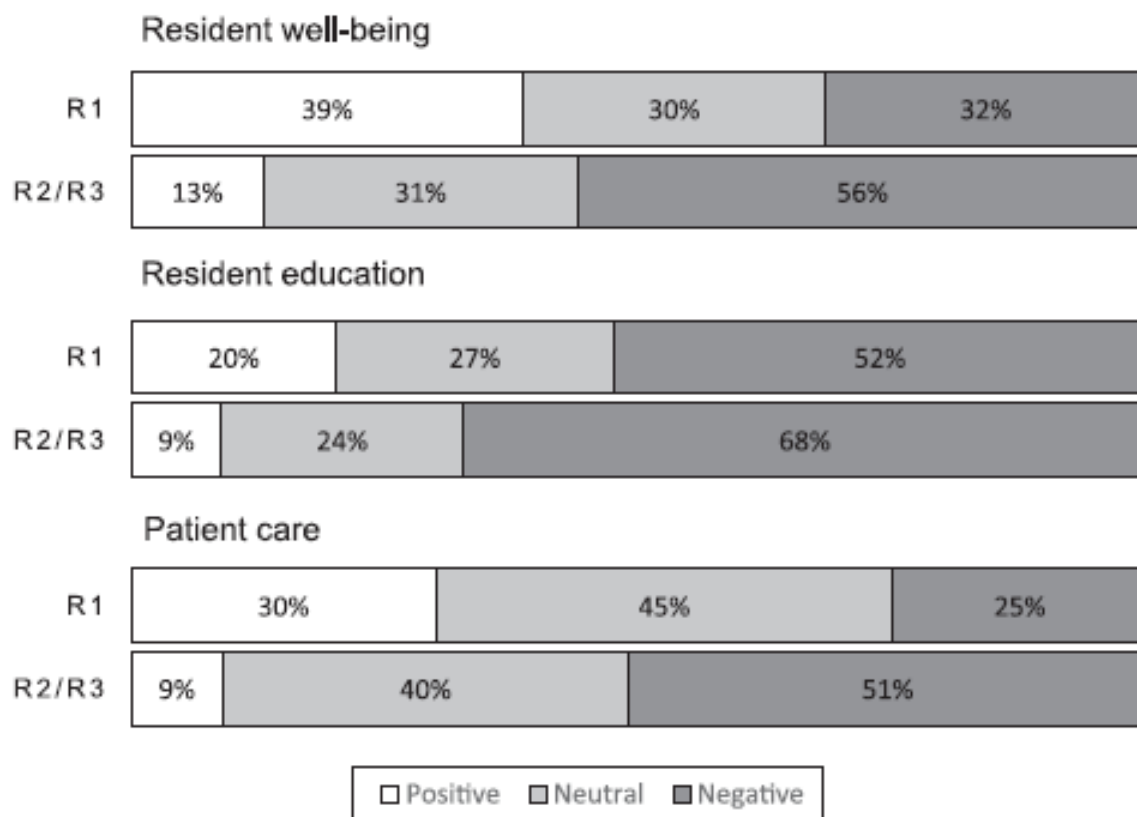


Figure 1 Residents' perceptions of the impact of the 2011 work hours limitations on resident well-being, resident education, and patient care, from a study of internal medicine residents' well-being and work hours limitations, University of Washington Affiliated Hospitals Internal Medicine Residency Program, 2012.

Abbreviations: R1 indicates first-year residents; R2, second-year residents; R3, third-year residents.

Across a Decade of Progressive Work Hours Limitations

Michael F. Kr...

Abstract

Purpose

To measure of resident well-being and progressive work hours limitations (WHLs) were investigated relative to 2011 WHLs.

Method

A survey study of residents was conducted in the University of Washington program in 2001, 2004, and 2012. A validated well-being questionnaire (Maslach Burnout Inventory) and career satisfaction questionnaire (PRIME) were used. Chi-square tests were used to compare aspects of resident well-being among the three time points. A *P* value < .05 was used to determine statistical significance (values in bold text). Missing values were handled consistently across the three surveys. Within the three domains of the Maslach Burnout Inventory, if respondents failed to answer one question in a domain, the score for the domain was imputed using the equation: Domain_Score = [sum(domain question scores) * number_of_questions_in_the_domain] / [number_of_questions_answered]. If they failed to respond to more than one question in a domain, their score for the domain was coded as missing.

Table 2

Prevalence of Burnout, Positive Depression Screen, and Career Satisfaction From Surveys of Internal Medicine Residents, From a Study of Residents' Well-Being and Work Hours Limitations, University of Washington Affiliated Hospitals Internal Medicine Residency Program, 2001, 2004, and 2012

Questionnaire item	No. (%) of respondents			<i>P</i> value ^c
	2001 ^a (n = 115)	2004 ^b (n = 118)	2012 (n = 112)	
Maslach Burnout Inventory subscales				
High score for emotional exhaustion (≥ 27)	61 (53)	45 (38)	46 (41)	.054
High score for depersonalization (≥ 10)	74 (64)	72 (61)	60 (54)	.239
Low score for personal accomplishment (≤ 33)	36 (31)	33 (28)	21 (19)	.083
Met burnout criteria	87 (76)	75 (64)	68 (61)	.039
"Happy with career choice," responded yes	76 (66)	94 (80)	89 (79)	.024
"Not sure would choose to become a physician again," responded yes	25 (22)	18 (15)	18 (16)	.372
Positive result on depression screening	52 (45)	65 (55)	35 (31)	.001

^aIndicates 2001 survey of residents in the same internal medicine residency program (Shanafelt et al²).

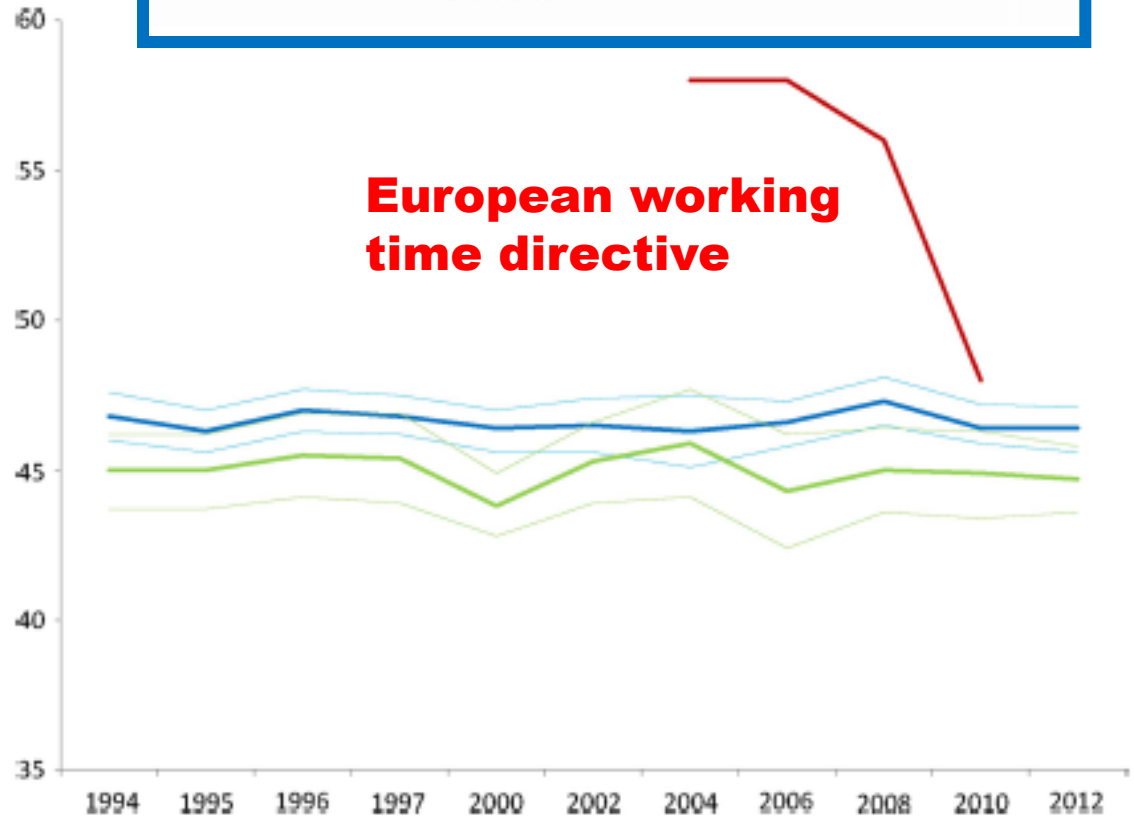
^bIndicates 2004 survey of residents in the same internal medicine residency program (Goitein et al⁴).

^cThe authors used chi-square tests to compare aspects of resident well-being among the three time points. A *P* value < .05 was used to determine statistical significance (values in bold text). Missing values were handled consistently across the three surveys. Within the three domains of the Maslach Burnout Inventory, if respondents failed to answer one question in a domain, the score for the domain was imputed using the equation: Domain_Score = [sum(domain question scores) * number_of_questions_in_the_domain] / [number_of_questions_answered]. If they failed to respond to more than one question in a domain, their score for the domain was coded as missing.



Figure 2 Average weekly working hours for senior (blue) and junior (green) hospital doctors in full-time, with 95% CI, from 1994 to 2012, and in relation to the requirements of the European Working Time Directive (red).

Senior
Junior



Norway: 45 Hours

Right

Longer hours

Shorter

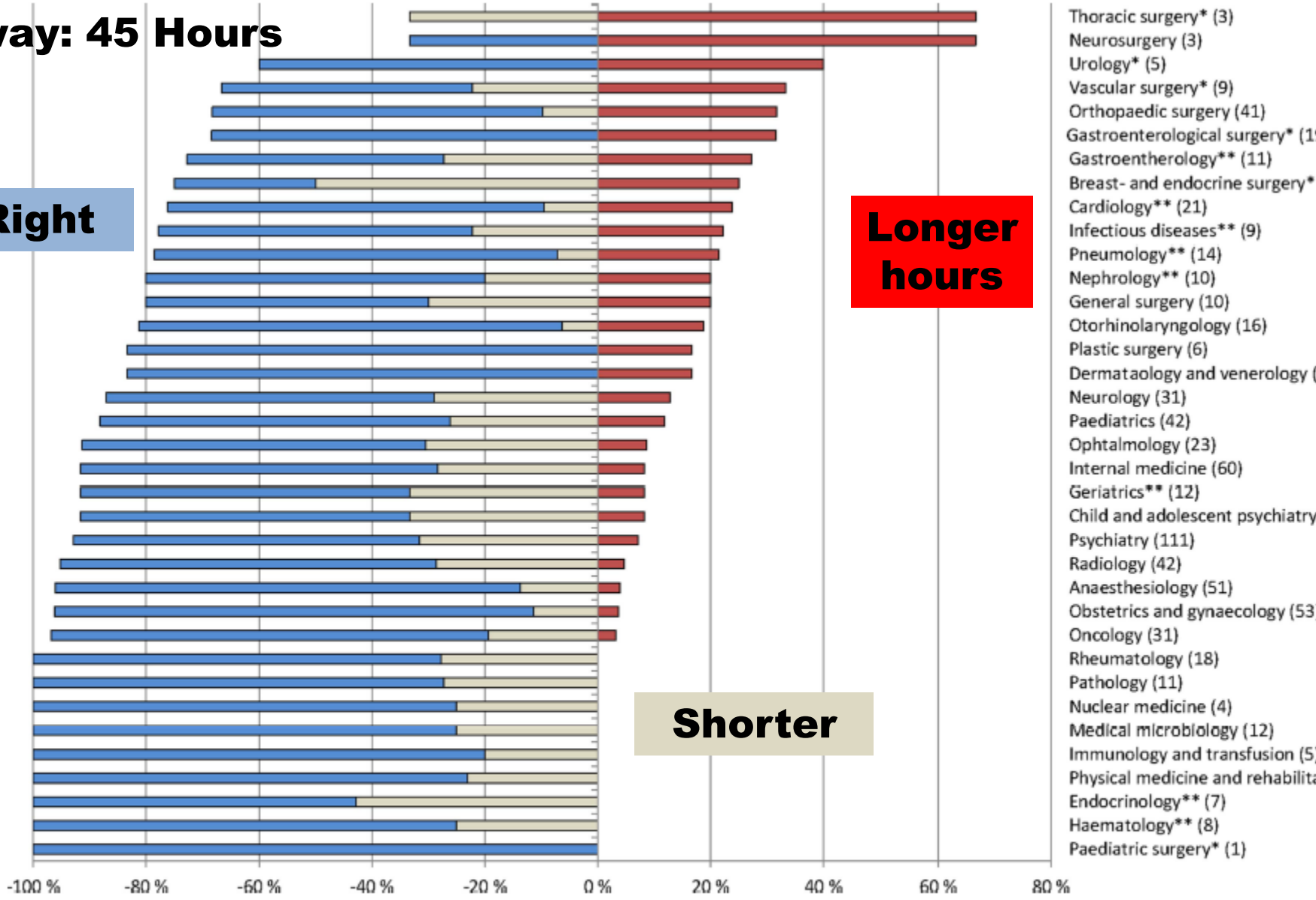


Figure 4 Proportion of different hospital-based specialties in Norway who think a 45 h working week is about right (blue), shorter (grey) and could have been longer (red) in relation to the quality of specialist training in 2012. Specialties marked * are surgical subspecialties that require three extra years of training after authorisation in general surgery. Specialties marked ** are medical subspecialties that require three extra years of training after authorisation in general (internal) medicine. Numbers of respondents are in parentheses.

Table 1. Duty-Hour Requirements and Adherence Rates According to Study Group.*

Requirement Category	Standard-Policy Group		Flexible-Policy Group	
	Standard ACGME Policies	Adherent Programs†	Policies‡	Adherent Programs†
		no. (%)		no. (%)
Maximum shift length	PGY 1 (interns): Duty periods may not exceed 16 hr	59 (100)	PGY 1 (interns): Duty periods can exceed 16 hr	58 (100)
	PGY 2–5 (residents): Duty periods may not exceed 28 hr (24 hr plus 4 hr for transition)	59 (100)	PGY 2–5 (residents): Duty periods can exceed 28 hr (24 hr plus 4 hr for transition)	49 (84)
Minimum time off between shifts	Residents must have ≥8 hr off between shifts but should have 10 hr off between shifts	59 (100)	Residents are not required to have ≥8–10 hr off between shifts	47 (81)
	Residents must have ≥14 hr off after 24 hr of continuous duty	57 (97)	Residents are not required to have ≥14 hr off after 24 hr of continuous duty	51 (88)
Maximum work hr/wk	Residents must not work >80 hr/wk, averaged over 4 wk§	—	Residents must not work >80 hr/wk, averaged over 4 wk§	—
Mandatory time free of duty	Residents must have 1 in every 7 days off from all educational and clinical duties, averaged over 4 wk§	—	Residents must have 1 in every 7 days off from all educational and clinical duties, averaged over 4 wk§	—
Frequency of on-call duty	Residents must not be on call more frequently than every third night§	—	Residents must not be on call more frequently than every third night§	—

* ACGME denotes Accreditation Council for Graduate Medical Education, and PGY postgraduate year.

† Program adherence was defined by residency program directors regarding which policies were followed at their institution during the trial period (100% response rate).

‡ Residency programs assigned to the flexible-policy group were allowed to waive four ACGME duty-hour requirements concerning maximum shift length and minimum time off between shifts.

§ These ACGME duty-hour requirements remained the same in both study groups.

Flexible-policy residents were significantly less likely than standard-policy residents to perceive a negative effect (vs. a positive effect or no effect) of institutional duty-hour policies on patient safety, continuity of care, clinical-skills acquisition, operative-skills acquisition, autonomy, operative volume, availability for elective and urgent cases, conference attendance, time for teaching medical students, the relationship between interns and residents, and professionalism (all odds ratios <1.00, P<0.001 for all comparisons except P=0.003 for professionalism) (Table 3). However, flexible-policy residents were more likely to perceive negative effects of duty-hour policies on resident outcomes that depended on time away from the hospital, such as case preparation after work, research participation, time with family and friends, time for extracurricular activities, rest, and health (all odds ratios >1.00, P<0.001 for all comparisons). Nonetheless, there were no significant differences between study groups regarding the perceived effects of duty hours on job satisfaction, satisfaction with career choice,

CONCLUSIONS

As compared with standard policies for surgical residents, there was no significant difference in resident outcomes (FIRST ClinicalTrials.gov).

hour policies did not have a significant effect on resident outcomes or patient care quality.

The Well-Being of Physicians

April 15, 2003 THE AMERICAN JOURNAL OF MEDICINE® Volume 114

Association of Professors of Medicine

Table 1. An Interpretation of the Key Concepts of Wellness Strategies Used by Physicians

-
- I. Relationships:

Grasp the importance of “protecting” time to spend with family and significant other. Develop a sense of connection with colleagues. Pursue opportunities to reflect on and share with colleagues about the emotional and existential aspects of being a physician.
 - II. Religious Beliefs/Spiritual Practice:

Personal attentiveness to and nurturing of the spiritual aspects of self.
 - III. Work Attitudes:
 - A. Finding meaning in work (Flow)
 - B. Actively choosing and limiting type of medical practice. Examples: working part time, being involved in medical education, pursuing research interests, managing schedule, discontinuing unfulfilling aspects of practice.
 - IV. Self-Care Practices:

Actively cultivating personal interests and self-awareness in addition to professional and family responsibilities. Seeking professional help for personal physical or psychologic illness as needed. Examples: reading, exercise, self-expression activities, fostering personal awareness, adequate sleep, nutrition, regular medical care, professional counseling.
 - V. Life Philosophy:

Develop a philosophic approach to life that incorporates a positive outlook, identifying and acting on values, and stressing balance between personal and professional life.
-

Physician wellness: a missing quality indicator

Jean E Wallace, Jane B Lemaire, William A Ghali

Lancet 2009; 374: 1714-21



l'époque
de Hionde

Balance ton job



Fini le plan
de carrière !
L'heure est
à l'injonction à
la reconversion
professionnelle.
Crises
existentielles
ou crise
du salariat ?

2

ENQUÊTE

Temps de travail
Satisfaction - Burn out -
Qualité des soins - Qualité
de la formation - Type
d'activité - Environnement
- Homme - Femme -
Charge de travail - Travail
de nuit - Autonomie
Bien être

