**EXPECTATIONS RE CALLS AT ZITHULELE**

**Doctors' call roster**

- The call roster is built around a "week of nights". The length of any one cycle is therefore determined by how many MOs we have at a time. It's usually around 3 months.
- The calls are averaged out over the call roster period – aiming for an average of 16 hours per week as per Group 3.2 of commuted overtime (which is technically 12-20 hours every week with an average of 16).
- Ben does the call roster. There is opportunity to bring requests in addition to periods of leave. These are taken into account as far as possible.
- Calls are tracked over the course of a year to ensure maximum fairness despite the fact that getting things exactly equal is impossible if we want flexibility in leave and life.
- The call roster has a slightly new format in 2021 as it includes interns and has therefore undergone some other changes too.

**Night doctor**

- The "night doctor" is the first port of call for nurses between 19h00 and the next morning.
- Ideally, the aim is to participate in the morning team activity, but this isn't always practical. Once the night work is done and the team activity finished, you are free to leave.
- The night doctor's first responsibility is to Maternity, thereafter to Casualty and any issues that have been handed over by the day team.
- The night doctor also does the post-natal maternity round

**MO 1 call (weeks)**

- In the week the evening (from 17h00) is covered by a call we are now calling "MO1" They are the first port of call for nurses from 17h00 to 19h00 and help the night doctor once they come on.
- The call lasts until 21h00 and is an on-site call.
- The responsibilities are maternity and Casualty, and attending to any urgent handovers. They are assisted by the Intern.
- From 19h00 to 21h00 the hospital is therefore staffed by three on site doctors, allowing any left over procedures from the day to be attended to.
- From 21h00 until the next morning, they are on standby for Caesarean sections or anything else urgent that needs two hands.

**MO 1 call (weekends)**

- On weekends the call starts at 08h00. They are the first port of call until handover at 19h00. Details re weekend roles and responsibilities are below.

**MO 2 call and MO 3 call (weekends)**

- See below

**Interns**

- Interns are a new feature of life at Zithulele. Regardless of your own experience of internship, our goal here is to see the interns as a "value add" allowing us to improve the level of care we provide, shorten waiting times and generally add to the quality of life of the other staff on duty by helping us feel less overwhelmed.
- Intern calls in the week last from 17h00 to 23h00 and are on site.
- Their responsibility is to help clear Casualty. If it is quiet, assistance with the postnatal ward round is suggested.
- Additionally, they are expected to *walk through the wards at least once during the evening* to check on patients needing review, blood results, hydration checks etc.
- The intern should check the "doctors' cupboard" during the call and give feedback to pharmacy.
- Unless it is extremely busy they should also be included when patients go to theatre for Caesar.
- Other "left over" procedures from the day should also be attended to, in partnership with the Night Doctor and MO 1.

**Senior call**

- The Senior call is done by an experienced doctor who is there to give advice and help in complicated cases.
- Please do not feel bad about calling them to ask even "simple" questions.

- The senior will come in to help when (or hopefully just before) the wheels are falling off or if there is something to do requiring more experience.
- The senior should be made aware of critically ill patients in any ward as well as “pending problems”, e.g. all pre-eclamptic patients who we choose to manage here should be discussed with the senior on call.
- The Senior is also something of a backstop politically and perhaps a reassurance that there’s help at hand. The purpose is not, however, to take away responsibility from the other doctors on call.

**Weekends**
There is plenty to do and having more (intern) hands on deck allows us to pay a little more attention to some areas we’ve neglected, while also making the weekend call a bit less burdensome.

Fridays
- MO1 and MO2 lead the team into the weekend, with the assistance of MO3 and an Intern.
- The additional people give us more capacity to deal with Casualty busyness (reducing waiting times and therefore hopefully also sleepovers), while not neglecting Maternity.
- The Intern must do a “Ward walk through” at least once during the afternoon (See above)
- The staggered times off will hopefully allow people to get rest as needed.
- The Friday intern and MO3 are off the rest of the weekend after their Friday shift. Although the weekend is delayed, it can hopefully still be enjoyed!

Saturdays and Sundays
- Full ward rounds must be done in Maternity and Paeds wards. This is usually done by MO1 and MO2, but if the Senior has been in one of the wards, or prefers, this responsibility can be swapped around.
- The Intern should do a “problem round” in General ward. The idea is to see “red flags” but also to engage with nursing staff about any concerns etc. It is important that Red Flags are recorded on the Team Google Calendar or handed over directly to the weekend intern. If blood results have been awaited pre-discharge, it may be possible to activate discharge plans too.
- In the Covid era, the intern (or whoever finishes their ward round first) should also do a full round in the Covid Ward too. The purpose here is to assess oxygen needs of each patient, clear beds through discharge and assess capacity for accepting outside referrals.
- The senior usually starts in OPD, helping clear sleepovers and see the newly arrived Casualty patients. The senior can leave when the “ship is sailing smoothly”
- Once ward rounds are done, the MOs and Intern join in for Casualty.
- The MO2 should be released at 16h00 (on standby thereafter for Caesars), but the intern call continues, so there should always be someone keeping Casualty going – and be time for lunch.

**Who should be in theatre?**
- After hours, it is essential that at least two doctors are in theatre for a Caesarean section.
- This should almost always be at least two MOs. Interns should be present as well and should be given opportunity to learn on both sides of the table, but in general, certainly while still orientating to things, should not be expected to manage a side single-handedly. Between 17h00 and 19h00 this may mean calling the senior to help, but otherwise usually means MO2 should be called.

**When can you go home?**
- Home, or at least some form of it, is close to work. It would be pedantic to say you cannot go home if the work is done. There is no point in sitting around doing nothing.
- Having said that, we want to be using paid doctor time for patient benefit, so if it’s within your working hours and there are patients to see, please use your time for their benefit (even if things are “under control” you’ll be shortening waiting times).

**“Left over procedures”**
- Determining what is a procedure that there just wasn’t time for and what is left over ward work because a colleague was slow or distracted is hard to define. It is essential that we trust each other to work hard and not leave day-time work unnecessarily for the night team. What goes around comes around 😊

**What happens if you are sick?**
- The answer to this is longer and more complicated than you think. Or as simple as saying: “you need to swap it out”. The full answer follows:

***Policy***
The latest ECDOH policy I have a copy of is 2015. It does not address the issue in much detail but states the following:

> d. Commuted overtime is not payable during periods of absence from duty e.g. sabbatical leave, absences due to special, family responsibility, maternity or sick leave (including temporary and permanent disability leave).The commuted overtime rate will be reduced on a pro-rata basis accordingly should such absences occur during a month.

National policy, dated September 2016 includes the same provision, but then addresses the practical nuances like this:

> With regard to periods of sick leave where the individual is rostered to perform after-hour duties, but is able to meet his/her after-hour commitment by interchanging (swopping) his/her after-hour duties with other doctors in a specific month. This arrangement must be approved by the supervisor (Clinical Manager). The supervisor (Clinical Manager) must certify on the Z1(a) (leave form) that the commuted overtime commitment for the sick leave period was worked in.

Simply put, once the call roster is issued, the call is each individual's responsibility to cover. Sick leave, however, is also a right enshrined in law. The options, if you are sick, are to leave the cover of the call to the hospital and take a requisite pay cut, or to swap it out.

***Local practice and precedent***
We've never formally discussed this topic at Zithulele, but I think it is safe to summarise our usual practice as choosing the "swap option" with respect to sick leave. Whether or not you were aware of the potential for a pay cut, the practice in place has developed specifically to avoid that becoming a reality. The other advantage of this approach is that it maximises our autonomy and flexibility. In a setting where the hospital could, unpredictably and at short notice, be left with the need to cover calls, the possibility of flexibility also becomes diminished. In essence, we would move from a collegial approach to an authoritarian one.

There are certain exceptions to this. We've had examples where a doctor has required urgent mental health leave due to breakdown. Or a parent has passed away. Obviously, expecting someone in that state of mind to worry about their calls is insensitive. The same would apply to anyone unexpectedly admitted to hospital for another reason, where expecting the individual to fulfil or reassign their call responsibility is simply unrealistic. We want to be a team, and teams need to trust and extend grace to each other. (This is of course also a reason to try and get on with your colleagues!). *In most cases, however, the rule is that the person who is sick at least makes a clear and unambiguous request to the doctor group, or to me as the manager, to assist with a swap. Failure to do this will result in HR deducting money from your salary.*

**Philosophy**
- Lastly, a philosophical note…
- We try to make calls as humane as possible. Hopefully, this is self-evident from the call roster.
- When you are off-duty we encourage you to ensure you get sufficient sleep. If you haven't read "the sleep book", do. Then you'll know why. (*Why we Sleep* by Matthew Walker)
- The flip side of that is that when we're on call we want to really add value. Not only do we get paid a lot of money, but we get to help people in their hour of need. It's also a great time to learn, taking responsibility and being at the frontline. I know that sounds soppy, but it can be helpful to remember in the middle of the night when you're wondering why you did medicine!

As with everything, this document is a work in progress. We will continue to refine it and improve it as we find better ways to do things. Please feel free to ask if anything is ambiguous, or to make suggestions for future improvements.

Dr Ben Gaunt
Clinical Manager
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