

Like Night and Day — Shedding Light on Off-Hours Care

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Lately, I've been coming to work at midnight. You see, I've begun making late-night administrative rounds at the hospital where I am president and chief executive officer. No, I'm not nostalgic for my harrowing days as a resident. Rather, these middle-of-the-nighters are part of an initiative of mine intended to address a matter that is of increasing concern at hospitals throughout the country: the stark discrepancy in quality between daytime and nighttime inpatient services.

Like many hospital executives, I've come to appreciate the fact that I work in two distinct places, though they share the same address. One is a hospital that operates from approximately 7 a.m. until 7 p.m., Monday through Friday. The other is a hospital that operates in the evening, through the night, and on weekends. Although these facilities appear to be one and the same, they in fact represent two very different medical environments.

The weekday hospital has a full administrative team, department chairs and service chiefs, experienced nurse managers, and a full complement of professional staff. The off-hours hospital, on the other hand, rarely, if ever, has senior managers present. Nurse-to-patient ratios are significantly lower. Even the number of residents is considerably lower — certainly lower than during my days of training — because of mandated work-hour restrictions.

The positive spin on these

differences is that we are trying to achieve a calmer and quieter environment at night and on the weekend so that our patients can rest and recuperate. But there are serious downsides. Silent hospital corridors can also reflect sparse staffing and a lack of institutional leadership, which make important hospital services and consultative expertise difficult to obtain. This discrepancy in provider care between daytime and nighttime inpatient services is a matter of growing concern to health care professionals, because people get sick 24 hours a day. In fact, 50 to 70% of patients are admitted to the hospital at night or on the weekend.^{1,2}

The consequences of service deficiencies during off-hours include higher mortality and readmission rates,³ more surgical complications,⁴ and more medical errors.⁵ Given the health care industry's renewed focus on ensuring patient safety and providing high-quality medical care, why hasn't the situation changed at the "other hospital"?

Financial constraints play a role in the lack of provider services. Shrinking reimbursements from government programs and third-party payers make it economically prohibitive for many hospitals to fully staff their facilities 24 hours a day. (And that's before one takes into account the millions of dollars in uncompensated care that hospitals provide.) Instituting longer hours for care providers is not a reasonable solution to the problem, since medical professionals

who work for too long at a stretch become fatigued and make more errors. Another major obstacle is the nursing shortage. More-experienced nurses understandably choose desirable day shifts. As a result, night and weekend shifts are filled with a greater percentage of temporary or agency nursing staff, many of whom have less training and less familiarity with the hospital.

Some modest changes have been made to address the differential in inpatient services between daytime and nighttime. Some teaching hospitals have mandated 24-hour coverage by attending physicians in key clinical areas, such as intensive care units — a move that has led to improvements in the supervision of residents. And off-hour coverage by hospitalists — salaried physicians who specialize in providing inpatient care — is more common than ever. System improvements, such as the deployment of rapid-response teams, are becoming more common, making lifesaving interventions accessible throughout a hospital. In addition, technological advances have led to improved outcomes and reductions in medical errors. Electronically monitored intensive care units and other strategies for remote monitoring create safety nets and permit better medical supervision, even when attending physicians are not present. Many hospitals have begun using digital and Internet-based methods to have imaging studies read during off-hours by radiologists

in different time zones, and experienced physicians can now provide their medical-imaging expertise from home.

Yet it's extraordinary that, despite these changes, we have not done more to eliminate differences in outcome that are attributable solely to the time of day. Perhaps one reason is that we take for granted that hospitals are run differently during off-hours, when instead we should be establishing equal standards for staffing and service and striving for acceptable outcomes for every hour of the week. Public policymakers, insurance companies, patient-advocacy groups, and nursing and medical educators must work together with hospital leaders to support this broader goal.

Within each hospital, physicians, nurses, and ancillary staff members need to be directly engaged in improving nighttime and weekend clinical services. It makes sense to explore pay-for-performance strategies to support these changes. In addition, hospitals need to publicize their off-hour improvements in a consumer-friendly way that helps patients make informed decisions. This year, more than 80 Massachusetts hospitals went public with their staffing numbers for every shift of the day (www.patientsfirstma.org). I've always felt that a little competition never hurt anyone.

Twenty years ago, when I was in training, my fellow residents and I firmly believed that we were the ones running our hospitals on nights and weekends. We had much more freedom back then and therefore did much more by ourselves. But

with greater responsibility came a greater sense of ownership. For me, this meant taking a stronger interest in improving the quality of patient care and safety. I pursued a career in hospital administration to gain a better understanding of how hospital systems work and how



a hospital can respond to change when needed.

Which brings me back to my midnight rounds. They are proving to be a good way to help me understand and address the concerns of our off-hours staff. Recently, I surveyed our evening and weekend hospital managers and was surprised to learn that many of them had never before been asked their opinions.

In order to identify problems and design effective solutions, it is critical to gather such front-line information, and to do so, senior hospital administrators need to see firsthand the workings of the "other hospital." I strongly encourage my counterparts elsewhere to conduct at least 1 week's worth of night rounds each quarter. Administrators on weekend calls should spend some time on the hospital floors. Close attention should be paid to the needs of patients and their families, any proce-

dural and communications issues among staff members, and most important, the quality of dialogue between administration and staff members regarding the organization's inpatient service and safety priorities.

Improvement takes time. The wheels are turning slowly, but lately, I'm more confident that we have them moving in the right direction. As a chief executive officer, I am just as responsible for managing the "other hospital" as I am for managing the one where I show up to work each weekday morning. The bottom line is that we must always strive to improve the overall quality of care — in "both" of our hospitals. There's still a lot to learn and accomplish, but we can do it. We just have to be willing to get a little less sleep once in a while.

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