McMaster Program for Faculty Development (MacPFD)

# Spark Podcast

Official Transcript

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**Dr. Teresa Chan (00:02):**
Welcome to the MacPFD Spark Podcast. This podcast is meant to inspire you to take the next step in your development journey as a faculty member. We're really excited to bring you all sorts of content, from inspiring you to teach or supervise differently, to leading and managing your team, to thinking about new creative ways or humanistic ways to actually do your work. And finally to up your game in your scholarly practice. Are you excited yet? I certainly am. So sit back, listen, and enjoy this latest episode of the MacPFD Spark Podcast.

**Dr. Teresa Chan (00:40):**
Alright. Hello everyone. Welcome back. I am really thrilled to have with me as a guest Dr. Andrew Latchman. He is an Associate Professor in the Department of Pediatrics here at McMaster University, and he's been a role model of mine since I was a resident, so I know that he's a pretty awesome guy. But more recently, he has been appointed the faculty lead of a project around risk management of fatigue. And from that point of view, he is leading a group of people within the resident affairs to think about how we can manage our fatigue better, and I thought that he'd be a really great person for this podcast. So Andrew, can you say hello?

**Dr. Andrew Latchman (01:21):**
Thank you, Teresa, for that kind introduction. Looking forward to speaking to everyone today.

**Dr. Teresa Chan (01:25):**
So, every superhero has an origin story, so we're gonna ask you for your origin story. Can you tell me a little bit about what exactly got you into this space? Why did you become interested in Fatigue Risk Management? It seems like a very, very narrow niche for some who aren't in the space a lot, so can you tell me how you got here?

**Dr. Andrew Latchman (01:47):**
That's a great question. And the journey here has been a fascinating one for me. I started in residency in the department as a "wellness person". Still not 100% sure what that name means, but that was where people saw me and said, "Oh Andrew, oh yeah, he's the wellness guy," and I had often joked that I feel like I'm a well guy, but what wellness is to each individual person is very different. And as I tried to navigate and share all the different resources, at times I was overwhelmed with the amount of wellness I could achieve. It really wasn't resonating with people

around me. People were just burnt out, frankly tired, and what they were expressing was "I don't have time for this, I don't have space for this."

**Dr. Andrew Latchman (02:42):**
One day Britney Walsy reached out to me and she said, "Andrew there's this is project on Fatigue Risk Management," and this was soon after some wellness work within PGME. She thinks, "I think you'd be the right person for this." I said, "Well, this sounds interesting to me." Fatigue Risk Management is something, I think we all acknowledge as existing, perhaps something that is done in aviation, in mining, in different areas, not really medicine. And I said, "Well, let me look into this," and there's a great Fatigue Risk Management toolkit put together by the Royal College as well as RDoC. And I said, "Let's take this on, I'm happy to do this."

**Dr. Andrew Latchman (03:17):**
And as I dove into this literature, it really resonated with me. And it's something that I didn't know the name for, but something that I think I've been trying to live in my life, and the part of it that I wanna tie wellness into Fatigue Risk Management because everyone knows the term wellness, it's become pervasive in a very good way. I don't know if y'all know how to be well and what that looks like for each other, but the term wellness is something I think that resonates with people now.

**Dr. Andrew Latchman (03:44):**
But in the Fatigue Risk Management literature they went back to Maslow's Hierarchy of Needs, and I hadn't looked at it forever. And wellness is that fifth, that top of the pyramid, but Fatigue Risk Management points us back to the base of the pyramid, and rest is at the base of the pyramid. And that was the light bulb moment for me. "Aha, wait a minute. We are trying to build a new construct of wellness, but we're missing part of the foundation. How do we build up when we don't have the base and the support?" And that was the missing piece for me. Why wasn't the initiatives, all the different things I was trying to launch with wellness resonating with people.

**Dr. Andrew Latchman (04:28):**
And so for me, this is when I went all in with Fatigue Risk Management. And Fatigue Risk Management, yes, this project in this lead is for residents. I'm working with a team, this is we not me. They're excellent, they're dedicated. And what I wanna get out there is Fatigue Risk Management isn't a resident issue, it isn't a staff position issue, it's all of us. It's nursing, it's allied healthcare, it's researchers, it's anybody who's working long hours, working at night, Fatigue Risk Management is an issue for us all.

**Dr. Teresa Chan (05:02):**
Yeah, I would say if we had a law school, we'd be making sure that even the lawyers understood that this was a case because you're burning the midnight oil at 3:00 in the morning 'cause you're burning through a case and you drive home, you can get in an accident. You're an engineer, you've just been traveling all around the world, you come back into Pearson Airport and you're jet lagged and you're fatigued, maybe you need to think about whether or not you should be asking someone to pick you up. Or some of the colleagues that I know that are more experienced travellers, they just book airport limos because it's safer for them.

**Dr. Teresa Chan (05:34):**
So, I think that it's just an everyone problem. We're always going to have reasons why we're super tired, whether that's a home issue, maybe it's not even related to work. Maybe it's just that you

have a newborn, and newborns don't turn off, right? They're always on. And every couple of hours it's another feeding, and it's another diaper change, and it's been hell for a lot of parents who are in that first little bit. And so if you're a new parent, maybe this will hit the mark for you in terms of the things that you might be able to do as well.

**Dr. Andrew Latchman (06:00):** So, Teresa, you just touched on so many critical aspects of Fatigue Risk Management. I wanna ask you a question. And the question I'm gonna ask you is going back last year, because right now, if somebody... All our screens can be turned off and you don't know exactly what's going on, tell me how far into a talk that you would be doing before somebody would fall asleep, either nod off or close their eyes, what percentage of the time?

**Dr. Teresa Chan (06:30):**
I would say, I mean... To be honest, you dim the lights and some of them are out within seconds because they're so tired, right? Especially if there are morning rounds, and I think that that's just the way that our bodies are conditioned. The optimal is just warm enough, you may be just had a Danish and so you're fed and then you turn off the lights, and then it's like, boom, asleep.

**Dr. Andrew Latchman (06:53):**
So that's one way to look at it, and that's the way I always looked at it. And I kind of looked and said, "Oh, well, that's kind of funny somebody snores," or you're like, "Am I not engaging enough?" But what that actually represents is a microsleep. Our bodies are so fatigued that we're essentially just shutting down, like we're trying to get some form of restorative sleep that our bodies are shutting itself down. And so in grand rounds or inner rounds, no big deal. But you touched on another aspect, that exact same situation of the dim light, the constant speaking, my monotone voice, that can happen behind the wheel. And that microsleep no longer becomes funny.

**Dr. Andrew Latchman (07:41):**
That microsleep puts that individual as well as all the individuals around them in danger. We as healthcare providers, as researchers, we have just spent the last 12, 24, 30 plus hours working to keep people safe, either directly in providing patient care or in research to try and advance care to help society, but then we get into a car and put ourselves and society at risk. It doesn't make sense. So, we need to acknowledge that fatigue is a risk.

**Dr. Andrew Latchman (08:29):**
And the first part of Fatigue Risk Management, I think everyone would acknowledge that fatigue is a risk. It's the second part, doing something about it, that's the hard work, and that's why we need a Fatigue Risk Management system. Because Fatigue Risk Management systems are organizational structures that systematically look to identify areas of high fatigue risk and put in places processes and policies to mitigate them. You cannot eliminate fatigue. The second you have a 24 hour, the second you work at night, a 24 hour or seven-day-a-week society is gonna put you at risk of fatigue.

**Dr. Andrew Latchman (09:07):**
So, Fatigue Risk Management doesn't eliminate fatigue, but it mitigates fatigue. It puts us in the position to make safe choices. And that's where in medicine... And there's a global change happening with this, we're a little late to the party, but we often think this is something that pilots can do it, oil and gas can do it, transport can to do it, but medicine, we're different. Health Sciences, research we're different, that's always the mantra that we kind of said. "We can't do this here." It ignores the fact that all those industries are 24/7 high stakes industries as well. We need to get to

this point, and this isn't from a malicious standpoint. We are all trying to provide the best possible care, but we have to step back and say, "How can we do this that's safest for us and society around us?"

**Dr. Teresa Chan (10:00):**
It definitely resonates with me. In so many ways, we're often late to this party. You look at the dawn of Twitter for the whole world was probably around when it first started, it was... It became a thing, microblogging, changing countries and nations, took us almost a decade to get online and see the power of Twitter. And now we're really into it, but it's one of those things, it's an adoption curve. We've never been probably leading edge at anything. We're still beholden to our fax machines and pagers, and in fact, the whole world is like, there are medical students that don't know how to use a fax machine until they come to medical school because I have to show them how to use the fax machine because it's such old tech. They're like, "What is this?" And I'm like, "It's the fax machine. No one else uses it. It's very special to healthcare."

**Dr. Teresa Chan (10:45):**
And I think that's the case with other things too. And Fatigue Risk Management is one of those other things that is definitely well-respected in many other disciplines, is something that, for instance, in the military is 100% because that's also a high-risk environment, you have to stay on attuned to things. Air traffic control, that is maybe less so now because we're not flying as much, but at the height of where we were before the pandemic, definitely air traffic control was one of those things where you couldn't afford to not be vigilant.

**Dr. Teresa Chan (11:20):**
So, all these industries, they take it very seriously, and I think we have to think about how we can do that too. But being serious about it means we can't just stumble upon strategies. We have to be intentional. We probably have to do research, scholarship. We probably have to actually carve out a niche in understanding this, so that we can teach it well too.

**Dr. Andrew Latchman (11:40):**
So, all of those things are key. I would say that the Fatigue Risk Management toolkit, which is a non-prescriptive, but an excellent pathway or guide to achieving Fatigue Risk Management structures, is highly based on references from Australia and medicine in Australia. So this actually is being done. There's a huge body of research and application in medical fields. I will focus on Australia, 'cause a lot of my research has been done from the literature and resources provided from there, but there are other places. But Australia I find has done an excellent job with this.

**Dr. Andrew Latchman (12:17):**
So, we not only have knowledge and research and education from other industries, but our own profession. So, I agree that all of those important aspects of research and scholarship and QI need to be incorporated, but I also believe that we can build on the work that has already been done. We do not have to reinvent wheels. We have excellent guidance that we can build on. Australia, they cite a young girl, a 10-year-old young girl in 2003, who fell off a bunk bed, was seen, was discharged home subsequently, passed away from an epidural bleed that was missed in the critical incident review. Fatigue was identified as a significant contributing factor. The physician was in the 20th hour of a 24-hour shift.

**Dr. Andrew Latchman (13:05):**
Now that was not the first patient to suffer morbidity or mortality from a fatigue-related incident, but Australia defines that as the watershed moment. In 2009 the first version of their Fatigue Risk Management toolkit was launched. They're on Version 3. So, it took them seven or eight years to get there. We can do it in a fraction of the time because they have shared their resources, they want this to be embraced.

**Dr. Andrew Latchman (13:34):**
And so, yes, we have to do all of those administrative things, but I also believe that we need to just say, "This is a priority." I'll ask you a second question. I know it's supposed to go one way, but we're gonna make this two-way 'cause this conversation is great. When you make your daily priority list, tell me when do you consider sleep? When you talk about your schedules, when you're talking about your week, when you're talking about your month, when do you consciously consider sleep?

**Dr. Teresa Chan (14:00):**
So, as an emergency physician, because this is something that we do talk about in training and then as a hobby almost, sleep is like a hobby for some of us, because we time shift so often. I'm actually quite mindful of sleeping patterns because sleep for me is something I almost need to schedule. And in fact, I have to sometimes be frustrated when my body decides that it's not ready for sleep because I have to actually... If I don't sleep now, I know I'll be too tired for my 9:00 PM shift or my midnight shift or I won't be able to get up for my 6:00 AM shift.

**Dr. Teresa Chan (14:33):**
Especially for clinical care, I am very, very intentional. I have a very fixed point of view on I need to have a nap in the afternoon before night shift, that is sacrosanct. I am privileged in some ways because I don't have small children running around. I don't have a family in that way, and so I can actually get that time. I imagine many parents are groaning right now, 'cause they're like, "That is impossible once you have a three and a five-year-old, and they're like, 'Mom, mom, mom.'"

**Dr. Teresa Chan (15:01):**
But that's not my life, and I've chosen my decisions for certain reasons. And part of it is actually optimizing my sleep is crucial for the jobs that I wanna do. So, understanding that is a design factor of my life, and I'm probably an anomaly and a little bit weird in that way because in the middle of the day, my family knows not to just randomly call me because I might be asleep.

**Dr. Andrew Latchman (15:24):**
That is fantastic. So, sleep is a conscious priority in your day. I would say for the majority of our society, sleep is an afterthought. Sleep is something we get to after we've achieved one to 10 on our list. And if I was to say, so how do we do this? 'Cause it seems overwhelming, you just listed all of the factors that contribute to fatigue levels. And so part of it is, often when we talk about fatigue, we jump right to shifts. We need to shorten shifts, we need to modify the shifts.

**Dr. Andrew Latchman (16:00):**
And as you know, when we looked at the literature on that, especially the resident literature, which is what I'm most familiar with. It is gray, it is murky, there is no... You shorten the shifts, you don't see the benefits, the bang for the buck that you would expect to see. And the reason is fatigue is impacted by so many things. It's impacted by, yes, the amount of work that you do. So, Fatigue Risk

Management acknowledges that shift scheduling and opportunity for sleep is necessary, but it's not sufficient, going back to university logic. And it's because individual characteristics impact sleep.

**Dr. Andrew Latchman (16:35):**
This idea that all of a sudden you get into medicine, you go into surgery, you become a "surgeon", you become a "emerge doc", and we have to fit this mould. But there has to be flexibility. Age, we don't take into account the age. I can't play basketball like I did when I'm 30, how can I assume I can work the exact same as when I was 30? Let's talk about financial planning in those who work in a fee-for-service environment. "Oh, this is how much money I'm gonna make for the rest of my life." Well, you have to work this hard for the rest of your life to make it. You don't want to pin yourself to certain criteria that you can't maintain.

**Dr. Andrew Latchman (17:12):**
Let's talk about private commitments like family. We all have family. Our fatigue risks will ebb and flow throughout life, and you can think that as overwhelming or something you can't tackle or you can look at it like an opportunity. So, if you know that you have a young baby at home, you're gonna have to look at the other aspects of your life and modify it so you can get that sleep. What does that mean? It means your social schedule may be impacted. It means certain other aspects of your life will be impacted, and that's a challenge because all of us give up so much. It's a privilege to do the work we do. But it's also sacrifices to do the work we do. And the idea of sacrificing more doesn't resonate, it doesn't make sense, but it's our health that is at stake.

**Dr. Andrew Latchman (17:57):**
The only cure for fatigue is sleep, there's no getting around it. You have to sleep to fix fatigue. And it is debt that we accumulate, if you don't pay it back with sleep, the interest cost will be your health. Sleep impacts our health and there's no denying it. Cardiovascular health, gastrointestinal health, cancer risk, immunity, mental health, it is all impacted by sleep. And part of the problem, I think, is the way we phrase things.

**Dr. Andrew Latchman (18:29):**
In the Faculty of Health Sciences, all of us, we wouldn't necessarily consider ourselves average, not in an egotistical way, but as we get in and we achieve and all of those things, everyone tells us how unique we are, how amazing we are, how above average we are. And then people say, "Oh, the average person needs seven to nine hours of sleep." Well, if your whole life, you've been told that you're not average, you might say, "Well, I don't need the average hours of sleep," and it's a fallacy.

**Dr. Andrew Latchman (19:00):**
We need seven to nine hours of sleep. And if you're working shifts, you're working long hours, you're pulling all-nighters running in your lab doing research, that sleep needs to be recovered in some way, shape, or form. And that principle, that focus on what do we put priority on, is the key at an individual role. At an organizational level, we can employ a defences-in-depth model, where we talk about proactive and then subsequently reactive processes. And proactive is acknowledging Fatigue Risk Management is a key issue. It's something we focus on almost as another pillar, in all the different pillars we talk about of organizations, talking about ensuring there's education, that people are supported in achieving rest, looking at day-to-day.

**Dr. Andrew Latchman (19:46):**
We fill out a COVID risk tool every day, right? Why don't we do a fatigue risk tool every day? That's done in Australia. That's done in transport. And if you show us high fatigue, there's different zones... There's a zone where you're told to go take a nap, have a coffee, or sometimes even sent home. You know, if you have a fever now, you get sent home from work, right? If you've been up for 26 hours and you're functioning beyond 24 hours, your blood... You can function at a blood alcohol level of 0.05. If you were functioning at that level... Oh, you had a fever? You weren't coping. Isn't it safer for that person to call in a backup and to have that person go home? And so these are the aspects at an organizational... We move from individual to organizational level that we can employ to wholeheartedly embrace Fatigue Risk Management.

**Dr. Teresa Chan (20:39):**
And I would say one of the big things that we wanna think about, too, is that some of the systems are there for your taking. So not for everyone, because some of our faculty aren't full-time, but for those of you who are, parental leave is real. And whether you're a man, a woman, or someone who identifies as many of the other genders that exist, if you're a new parent, whether it's through adoption or by giving birth or having your partner give birth, these are the kind of things that you can 100% be folding into your life. And I know it's not normal for everyone to take parental leave, but we should try to strive for it to be, because not only is it better for the newborn, but it's actually Fatigue Risk Management, 'cause when you have to wake up for feeding every two hours, guess what? That baby brain that people talk about is real, regardless of whether or not you gave birth or not.

**Dr. Teresa Chan (21:32):**
Because when you're acclimatizing a new child into your life, you have to restructure your life, and it's gonna be frustrating, and you're gonna have some sleepless nights, and the kid's gonna have fever once in a while, and then you have to take your whole day. And I think that all of those things factor into whether or not you can get rest because parenting is hard. And I would like to put out there that those are systemic things that people can do, but often don't. And I would challenge the paradigm that this bravado that people have, whether you're, again, a man or a woman and identify with any gender, you really do have to think about whether or not you're trying to... What are you trying to say by not taking the leaves that are baked in your benefits, right?

**Dr. Andrew Latchman (22:15):**
That is in the context of culture. And let's talk about culture change to move to a culture of support and a culture of acceptance and setting realistic goals for individuals. And this idea that you can just keep going, you could push through anything. "Sleep is for the weak. I'll sleep when I'm dead." It is a culture that has been bred into us. "Naps? Naps are for the weak." No. Naps are for the strong. A team who supports each other and says, "You look really tired. Why don't you go have a nap and then a coffee after to get through your shift?" That individual isn't weak. That's 30 minutes. That's 30 minutes in a 12-hour shift.

**Dr. Andrew Latchman (23:02):**
If that person subsequently becomes highly productive in that time, that is leadership. Letting someone sleep after a call shift or an emerge shift, that is keeping them safe, so they can get home safe to their family, to keep society and the community safe. Letting that person be alert keeps our patients safe. There is literature to show in transport that if you advise your team that you're tired, they will be more vigilant looking out for you. Could you imagine... What part of your training would

have said that you could go to a nurse and say, "I am exhausted. If I write something down that doesn't make sense, can you please tell me?" Can we have that be a conversation, a respectful conversation that I am asking for your help to support me? That is not something that's in our culture. "I have a newborn at home. I'm gonna reduce my call shifts this much to allow me to catch up on sleep." Yes, that has financial impact. Yes, that has academic impact. But to look in a period of time over a whole career, over decades, can we find that support for each other, change the culture, change the conversation, so that it is acknowledged that there are repercussions for this and we need to support each other?

**Dr. Andrew Latchman (24:21):**
And if that's the wholesale culture change that we need to accept... So, it goes beyond platitudes and nodding our head and acknowledging, "Oh yeah, fatigue's important. Yeah, yeah, we need to get sleep." But if we do nothing to allow people to get sleep, it is meaningless. We need to acknowledge, "Yes, fatigue is an issue," and then we need to follow through with culture, support, and processes that allow us to mitigate. This concept of managing... We talk about Fatigue Risk Management. I prefer mitigation, 'cause I don't think we can control all of these things. But we can mitigate all the different points and at different times. If you have a new baby at home and you're commuting an hour and a half to work every day, you kind of need to look at your life and make those choices. And so when we look at Fatigue Risk Management, there are organizational responsibilities, but there are also individual responsibilities. The organization needs to educate and facilitate the capacity to ensure fatigue risk is minimized and people can achieve adequate rest while also having a fulsome lifestyle. But the individual also needs to look at their individual characteristics and achieve those goals.

**Dr. Andrew Latchman (25:34):**
So, it's a dual responsibility with bidirectional communication. If you're snoring and you think you have obstructive sleep apnea, you have a responsibility to go get yourself checked out and taken care of, 'cause that's your individual responsibility. The organization has that global goal of setting up the processes to allow you to get it. But then at an individual level, we also have to make those choices that facilitate fatigue reduction.

**Dr. Teresa Chan (26:00):**
And I do think that the thing that we should think about is that... I think about these systems as micro, meso, and macro. The macro is a system. The macro is Faculty of Health Sciences. The macro is the hospital. The macro is, for us, most of the time, that's the level we're talking about. We're not talking about macro as in Health Canada or... Or the Ministry of Health. Although they are part of that macro zone as well, because if there was any kind of a deduction that would happen because you had worked too many hours, then I'm sure that people would stop working that many hours. So I think there are systems changes that can actually incentivize good behavior. That being said, I think the meso level is really important to attend to. So if you're an attending on a team or you're a senior resident who's listening to a faculty workshop 'cause you're into this stuff, you're leading a team. If you're in charge of a lab, you need to make sure that maybe you're not sending emails at 3 in the morning on a Friday night as a good role model should, regardless of when the CHR deadline is.

**Dr. Teresa Chan (27:00):**
And you may need to think about how do you act as a friend or a colleague when you notice that someone is snoring in rounds, and how to get them home safely, and say, "I'll pay for your Uber. I don't care if you live in Toronto. It's fine. I'll come pick you up to get your car back later, or your

partner can help you with that." I think these are the kind of things that we need to have conversations about at that meso level, where it's maybe just a smaller group of people, a unit, a team. We need to look out for each other. That also is huge inter-professionally. The people who have been savviest in teaching me about my sleep have not been physician role models, have been nursing role models. So a lot of our nursing colleagues have been great at being able to teach me about what that looks like, because they have a much stronger culture around that amount of support.

**Dr. Andrew Latchman (27:42):**
You have raised so many excellent points. And what I wanna focus on is the learning from nurses. So, again, to reiterate, sharing and communication around fatigue is important so we can be vigilant for each other. But let's look at nursing, and let's look at breaks, and let's look at that culture. And I have to say, I was bred to this conversation or idea... "Breaks, what? What do you mean you have scheduled breaks? What is this scheduled break bit?" You roll your eyes. Oh my gosh, how limited was my thinking? Breaks are great leadership. Breaks allow you to mentally decompress and then refocus and be a better doctor.

**Dr. Andrew Latchman (28:24):**
There is a... If you look on the PGME Fatigue Risk Management, there'll be a section there, and we're building the educational resources. On it, there is a Fatigue Risk Matrix calculator, and you can put in your hours, and what's your risk of fatigue. And so a Monday to Friday, 9:00 to 5:00, it will put you in the green. It'll put in a score of two. Anything above 20 is high. So a colleague of mine looked and says, "Andrew, this Fatigue Risk Management matrix tool calculator, it doesn't work. We work all day with no breaks, high-intensity work, and you're telling me my schedule is green?" And I turned around and I said, "Hold on a second. You're telling me you need a toolkit and a calculator to tell you working 10 hours a day with no possible opportunity to drink, eat, or pee needs a toolkit to figure it out? Needs a calculator to figure out that's a bad idea? Come on!"

**Dr. Andrew Latchman (29:24):**
And this is where we have to step back and say, "We gotta change the way we do business." We need to at some point just say, "Building a day that has lunch scheduled makes sense." Yes, we're gonna have terrible days. Yes, your day is gonna get blown up sometimes. But if at least you start with an amount of work that will at least on paper allow you to get those breaks... If that's where we start... Having a napping culture, supporting that. Let's talk about tangible things we're trying to look at at postgrad. We are looking to implement a safe ride-home taxi program. We are gonna say, "If you are so exhausted that you can't drive home, that you feel you're at risk to drive home... First, we're gonna educate you on knowing those symptoms and signs. We're gonna educate your colleagues to let you know, 'cause sometimes you're so tired you don't recognize it." And then we're gonna say, "We're gonna get you home and get you to cab back to get your car after you've had some rest." Let's talk about blocking off time and actually making call rooms for sleep. Let's protect that. We hear that call rooms are sometimes being used by other people to get work done, 'cause they can't find a computer.

**Dr. Andrew Latchman (30:34):**
No, no. Call rooms are for sleep. And guess what? This isn't beauty sleep. This isn't fun sleep. This is safety sleep. So the sleep on call is not a luxury. It is safety. It is patient safety. So two tangible things: As we look for a global wholesale change, we are also looking for incremental change. And that incremental change is, "Let's do a safe ride home program. Let's put signs up on the door to tell

people this is an area for sleeping." People... That sleep needs to be protected, so that they can be excellent physicians, they can provide the best possible care for their patient, and they can also take care of themselves. And we can learn so much, not from outside industries, but you're right, from our nursing colleagues. And we can change the tone that, "Breaks, who needs breaks?" That bravado, that shield, that, "I can work straight, I don't need to eat, drink, or pee." Come on.

**Dr. Teresa Chan (31:30):**
I think our nephrology colleagues will point out that if you don't drink, you probably won't pee, so you do need to hydrate. [chuckle] On demand. So part of the problem is that you're not gonna need to. And that's the problem is if you're so busy, especially right now with the masks and the shields, right? It's like a whole to-do to even just take a sip of water. And so it's important right now, especially during the pandemic, to be cognizant of that, to actually program that in. And our emergency medicine group actually created a new schedule in the fall of last year, and we have overlap time now, so that when... I've been manning the fort, let's say, for three hours in the emergency department on the major care side. The next person comes in at the end of that third hour. I have an hour where I can have a snack, have a break... Even 10, 15 minutes, and you come back energized and you're better at your job.

**Dr. Teresa Chan (32:23):**
And so having that mid-shift reprieve is something that we're trying to change the culture around. And I think, hopefully, most people are starting to disappear for a couple of minutes, and that's, I think, a big advancement because it's taken a systemic change. Changing the schedule is not a small feat in my field. It's actually a fairly complex art. And so that the leadership was willing to do that and create that space was really important.

**Dr. Andrew Latchman (32:47):**
That's always the but, right? Everyone acknowledges that Fatigue Risk Management is important. And then the second you try and implement something, there's a but. And there are a 1000 buts, or we can't, or, "These are the reasons why we cannot do something." And there's a quote in the toolkit that I just wanna read, 'cause I think it's huge. So, "Fatigue Risk Management includes the ongoing incorporation of meaningful actionable steps that improve the safety of the clinical learning environment. The risk of doing nothing is greater and the status quo is not acceptable." The risk of doing nothing is greater and the status quo is not acceptable.

**Dr. Andrew Latchman (33:32):**
That's where we have to start. We have to start with, "You have to accept this change," and then we have to find a way to do it. So for every but... Every but is legitimate, but the but isn't the stop. The but is the beginning of the conversation of how we make it. And these masks in all of these situations, it actually... The good... Some of the good that may came out of it is it's gonna force us to book in some break time, 'cause before, especially in your environment in the emerge, it was just, "Get that drink in whenever you can. Have the drinks, the food," it's just lying around. It's an infection control nightmare.

**Dr. Andrew Latchman (34:11):**
But that's how you got through your shift, 'cause you weren't ever allowed to stop. We have to say, "You're allowed to stop," and it's gonna make things harder in other ways. You may have to come in an extra 15 minutes. The shift schedule, the impacts, they're gonna be there, and we have to balance them with the personal impacts, so the organizational impacts, and how that impacts each

individual personally. But the global effect is to make everyone's life better. If in your day, you are having sanity as opposed to insanity, when you go home that personal effect will be positive, and hopefully, it will generalize. So, if you spent an extra 15 minutes or 20 minutes, whatever that is, if you had to do instead of one weekend a month, you did two weekends a month, but half the time... You think, "No, no, no, I don't wanna do that." I wanna "get it out of the way." How many times am I gonna hear that? "I get it out of the way so that I have more free time." You have the opportunity then to be better in those other moments.

**Dr. Andrew Latchman (35:10):**
One of the greatest things that we've done with this committee is that we've incorporated family members of physicians, and the insight that they bring to us is huge. We often say, "I'm fine, everything's okay," but then you talk to the person who's not living it, and they're like, "I know they think they're okay, but guess what, they're not. I would rather them work less, take whatever hit to the income is, but have them present, available, engaged." These are quotes from family members of residents, physicians, fellows. And I'm not trying to be resident or physician-specific, I can just share the information that I've had from the committee. But we often think that we're fine, but the people around us know that we're not.

**Dr. Andrew Latchman (35:57):**
And so that's the taking the step back. And what seems like more sacrifice pays dividends globally, and we don't recognize that until we change it. There's been examples where people have moved from... CTU examples I can give you of colleagues. They did seven days straight, and they thought there was no way... Doing call for your team seven days straight. That there's no way we could move off that. That's the best way to provide care. They moved off it. Now they just do one and three, which, again, we can talk about that, but they're like, "Whoa, our life is appreciably better. We never thought this." So having the opportunity to re-envision, re-imagine, and for every but, not letting the but be the stop, but saying the status quo is not acceptable. We have to move beyond that, and how do we change?

**Dr. Teresa Chan (36:47):**
100%. As a daughter of a physician, I watched my dad be relatively different amounts of engagement, let's say, depending on his call schedule, and there was heavy, not burden, but awareness, let's say, as a kid that if dad was post-call. We didn't disturb him, right? And so, for me, call was always this legendary thing that made you very, very, very tired. So I had a lot of respect, even as a medical person, as a student. But I come from that privilege of having lived it as a kid and seeing it on the other side, so everything you say resonates with me.

**Dr. Teresa Chan (37:21):**
I do say, though, that I think there's great ways that we can be folding in those conversations with our partners, our families. Making sure that there's someone who checks on you. My mom, certainly, as the physician's wife, and now the mom of two physicians, definitely is that person that reminds me. She's like, "Have you eaten today? Did you sleep today? [chuckle] When are you working next?" Those are all of her things that she checks on. And I wonder if we can normalize that it's okay to be asking those things of each other too, now going beyond your actual nuclear family might be, that... Our urban families, right? Our colleagues may be able to open that conversation to make sure that we're checking each other's sleep and wellness and other things as well.

**Dr. Andrew Latchman (38:09):**
That's the culture change. That's the shift. That's the daily check-in, almost the COVID assessment. You check your levels of COVID risk. What if when you logged in... We have Epica. Odyssey Project. What if the first time you logged in... And Transport Canada, this has been implemented in Australia as well in the medical side. You filled out a four-question sheet that looked at prior sleep and fatigue risk, and it put you in green, yellow, orange, red. And then after that, tend to the education: "Hey, based on the sleep you've entered, your fatigue risk is in this zone. You need to do X." What if we did that every day? That's 30 seconds of our time. You only do it on your first login. You know starting your shift where you're at. You see, the work doesn't disappear. When we look at the roster study, the most recent study that was done published in The New England Journal, looking in the PICU.

**Dr. Andrew Latchman (39:08):**
Or the PCCU, looking at reduced shift or reduced hour shift schedule versus standard. The residents who got more sleep actually had more errors in their group, contrary to the hypothesis. They were better rested, but they had more errors. But the rub was they also had more patients. When they accounted for the increased patient load, the error difference disappeared. But the work can't disappear. We're not all of a sudden gonna get doubling at resources to have all of us work half as much. That's not the case. So we have to acknowledge that the work gets done. It's how we do the work that we have to look at and change. How we check in with each other on that day-to-day level to say there are actionable things we can do. We can hydrate. We can have a place to nap. We can use caffeine appropriately. Judicious use of caffeine, not the widespread 10 cups of coffee a day use of caffeine. Education around all those things. And that's the culture change. So you're right, it's not just your nuclear family, whatever that looks like, looking out for you. But it's your colleagues, and subsequently the whole organization and system looking out for each other.

**Dr. Teresa Chan (40:24):**
Excellent. We've talked a lot about different things today. It's been a whirlwind of a discussion. But Andrew, do you have any final take-home points that you just wanna drive home one more time? You've been really good at repeating some of the key points, but if you're wanna sum it all up with one thing that you want people to take home with them or continue on beyond this podcast, what would that be?

**Dr. Andrew Latchman (40:42):**
I would encourage people to put sleep as a priority, to acknowledge that sleep needs to move to the top of the list, not to the bottom of the list. And when we start with that, that's the individual level that can start to drive incremental change. And once we start making incremental change at an individual level, we can incorporate and advocate for that change at a divisional level, at a departmental level, and then subsequently at an organizational level. Take the opportunity to take care of ourselves. To be well, we need to be well-rested. Start with sleep as a priority. And then when we start with sleep as a priority, we look at our whole life through a different lens. And through that lens, we look at our schedules. Through that lens, we look at our commitments. People ask me, "After doing this talk, after doing all this research, what have you changed in your life?" One of the big things? I used to book my weekends non-stop. So many family things, so many great things you wanna live life to the fullest. But I would start my service weeks tired.

**Dr. Andrew Latchman (41:55):**
I now don't book heavy socially, personally going into a service week, so I am well-rested. Doing home call as an opportunity... When I did home call, we would sometimes do... I would sometimes

do home call while on service, Monday to Thursday. I don't do that anymore. I'm rolling the dice. We can make individual changes to facilitate mitigation of fatigue. And by doing those individual changes, we can advocate for those larger structural changes. And so let us all work together to push this forward, to make this a priority. Not to have it be a talking point, not to be something we acknowledge that something is important but then not live it. So we need to acknowledge it, and then we need to embrace it and live it, and the dividends will pay across the board. So, I will leave it with the only cure for fatigue is sleep.

**Dr. Teresa Chan (42:53):**
I love it. Thank you so much. And we'll have to have you back another time to talk about other interventions or other systems that we could set up to support each other. But thank you so much for a great chat.

**Dr. Andrew Latchman (43:03):**
Thank you for having me.

**Dr. Teresa Chan (43:09):**
Thank you so much for tuning into the MacPFD Spark podcast. Just so you know, this podcast has been brought to you by the McMaster Faculty of Health Sciences, and specifically the Office of Continuing Professional Development and the Program for Faculty Development. If you're interested in finding out more about what we can offer for faculty development, check out our website at www.macpfd.ca. That's www dot M-A-C-P-F-D dot CA. Many of our events are actually web events that are free. Finally, I'd like to thank our sound engineer, Mr. Nick Hoskin who's been an amazing asset to our team. Thanks so much, Nick for all that you do. And also thank you to Scott Holmes for supplying us the music that you've been listening to. Alright, so until next time, this is MacPFD Spark signing off.