the United Kingdom, intensivist staffing of the ICU is the norm, although these doctors operate an on-call system out of hours rather than being a permanent resident in the ICU. Since September 2004, intensivists here in Cardiff have abandoned the traditional on-call system in favor of providing a continuous resident service by working shifts.

We believe that this change is more likely to benefit patients than alter the work patterns of our trainees, and as such is truly "a shift for the better."²

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The authors have no conflict of interests.
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To the Editor

We thank Drs. Wise and Frost for their letter about our article (December 2005).¹ We agree that the suboptimal length and pattern of the shifts may have played confounding roles in our study. There are large differences in physicians' working hours between Europe and the United States. The European Working Hour Directive limits physicians in training to work a maximum of 58 h/ week.² In the United States, the Accreditation Council for Graduate Medical Education limits the working hours of residents and fellows to 80 h/week.³ Compared to the traditional work hours in many teaching institutions in this country, our shift model represented a step forward. There are powerful drivers of change in organization and delivery of critical care in this country. Concerns for patient safety and the efficient utilization of limited resources are fueling a debate on critical care training requirements, accreditation, optimal staffing models, and sustainable work hours.⁴,⁵ Prolonged working hours compromise both patient safety and housestaff education.⁶,⁷

Drs. Wise and Frost also highlight the importance of 24-h intensivist staffing in order to improve patient outcomes.

Although such staffing is unlikely to be universally implemented because of the shortage of critical care providers,⁸ their comment is well supported by several publications.⁹ Indeed, we know that consultant presence at the bedside increased as a byproduct of our resident shift work trial. However, as already acknowledged, our study was likely underpowered to demonstrate beneficial effects on patient outcomes. In recognition of the importance of intensivist presence at the bedside, we have recently implemented an in-house shift model for consultants and hope to describe the impact of this new staffing model on patient outcome as well as housestaff education in the future.

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Work Shift Model for Housestaff in the Medical ICU

To the Editor:

We read with interest the article by Afessa et al (December 2005)¹ describing the institution of a 14-h work shift for housestaff in the medical ICU (MICU). Another study² found a reduction in the rate of serious medical errors when interns worked shorter MICU shifts. In the article by Afessa et al³ no...