European Working Time Directive: Implications for Surgical Training

The forthcoming implementation of the European Working Time Directive (EWTD) for non-consultant hospital doctors (NCHDs) poses a number of challenges to surgical training. There are unique challenges to providing satisfactory care while producing adequately trained surgeons. It is clear that the way forward for surgery is to limit the maximum working week for higher surgical trainees to 60-70 hours per week, transaction of all existing working time off site as working hours. HSTs have little to gain from education with weekends or nights shifts but should be available to be called in for episodes that would be beneficial to their training. They should not be required to provide inappropriate cross-cover. Posts will vary in order to provide more experience in a setting where fewer junior posts are present or have the requisite skill levels. Shift-working patterns and increased cross-cover arrangements seem an inevitable consequence of the EWTD. A similar recommendation has been made in Sweden. However, the EWTD allows for the training of surgical trainees as little surgery is carried out at night. In addition, many of the benefits derived from the EWTD are under negotiation at the present time.

References

4. Sindicato de Medicos de Asistencia Publica (SiMAP) v Clnsellaria de Sanidad y Consumo de la Generalidad Valencia C-303/98 EC 2000
11. Donohoe CL, Sayana MK, Kennedy MT, Miall DM. Midland Regional Hospital, Tullamore, Co Offaly

12. The Irish Medical Organisation (IMO) and Health Service Executive (HSE) entered into a process of negotiations under the auspices of the Labour Court in order to implement the European Union Working Time Directive (EWTD). The Labour Court has issued its recommendations in order that Non-Consultant Hospital Doctors (NCHDs) be working time directive compliant by 1 August 2009. The Labour Court's recommendations concern hours of work which is designed to protect the health and safety of workers. A summary of the legislation is enlisted in Table 1. The directive, hereafter EWTD, has been European law since 23 November 1995. The EWTD was introduced in order to enact the Directive within individual member states. The European Commission may take action against a member state if it fails to implement a Directive. Ireland incorporated the Directive into Irish law as the Organisation of Working Time Act 1997.

The legislation has been further clarified within the European Court of Justice by the SIMAP v Clnsellaria de Sanidad y Consumo de la Generalidad Valencia (C-303/98) case, which established that revised working patterns adversely affected their training. Numerous studies have consistently shown a 20% decrease in the number of logistic operative procedures since the reduction to a 58 hour working week in the UK. Within the Irish setting, surgeons were asked to evaluate changes in surgical practice after changing to a 58-hour shift system. Both of these issues are under negotiation at the present time.

In summary, both the Irish and the UK responses have been negative. “The enforced reduction in hours of work has completely destroyed a training system that has been developed and continuously improved over four decades.” Surgery is different from other medical specialties. There are unique challenges to providing satisfactory care while producing adequately trained surgeons. It is clear that the way forward for surgery is to limit the maximum working week for higher surgical trainees to 60-70 hours per week, transaction of all existing working time off site as working hours. HSTs have little to gain from education with weekends or nights shifts but should be available to be called in for episodes that would be beneficial to their training. They should not be required to provide inappropriate cross-cover. Posts will vary in order to provide more experience in a setting where fewer junior posts are present or have the requisite skill levels. Shift-working patterns and increased cross-cover arrangements seem an inevitable consequence of the EWTD. A similar recommendation has been made in Sweden. However, the EWTD allows for the training of surgical trainees as little surgery is carried out at night. Added to this, the compulsory rest periods for surgical trainees means that much of their time is taken up on day time learning. There will be a change in the traditional Master-Mentor model of training whereby trainees spend less time with their assigned trainer.

The National Confidential Enquiry into Perioperative Deaths (NCEPOD) in the UK estimated that 30% of time spent operating was wasted as consultation. Almost three-quarters thought direct contact time with their trainer(s) had fallen. Almost half of junior trainees in their first two years of training spent 40% or less of their working time in training. The Health Service Executive has recently acknowledged the difference still exists. Inevitably, technical skills courses and simulator training will not replace the real life situations where clinical decisions and potential errors can have devastating consequences.

Implications for training

Changing towards EWTD compliance is an opportunity to make adequate training and supervised learning a fundamental tenet of work practice. At the time of the Hanly report, only 4% of total hours worked in Ireland were spent in training work. More recently, the Hospital Activity survey in Ireland reported that less than 1% of working hours in training activities was spent in training work. The Health Service Executive (HSE) has established a Medical Education and Training (MET) group lead by Dr. John Buttimer to identify areas of training to ensure the appropriate training and training is not adversely affected by EWTD.

It has been estimated that a typical surgical trainee would spend 30,000 hours in training for the first stage of training and 17,000 hours during the second stage. The number of surgeons required to perform surgery is increased by the EWTD, with surgical trainees being fewer hours in total training but the number of surgical trainees is increased by the EWTD, with surgical trainees being fewer hours in total training but the number of surgical trainees is increased by the EWTD, with surgical trainees being fewer hours in total training. In 2008, it was predicted that 18.2% of surgeons in training would be engaged in simulation training. In the future, the number of surgical trainees will be increased by the EWTD, with surgical trainees being fewer hours in total training. In 2008, it was predicted that 18.2% of surgeons in training would be engaged in simulation training.
