
Statement on Implementation of the European Working Time Directive

Royal College of
Physicians of Ireland

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The mission of the Royal College of Physicians of Ireland (RCPI) is to enhance and improve professional standards, deliver medical training and safeguard the quality and safety of patient care.

In light of this purpose, RCPI is entirely supportive of the ongoing reconfiguration of the health service that is directed towards the provision of higher standards of patient care. This support is evidenced by RCPI's position on the consolidation of specialist care into large centres and its active participation in a range of other change initiatives including professional competence assurance, introduction of cross-sectoral clinical directorates, implementation of the recommendations of the Commission on Patient Safety, and the development of national standards, clinical treatment guidelines and quality assurance programmes.

The commitment of RCPI to achieving the highest standards of medical education, training and medical practice is specifically in the interests of high quality patient care and safety. RCPI also strongly supports the utilisation of national medical resources in the most effective and efficient manner possible – in this time of extreme financial difficulties, it is especially important that resources be allocated as fairly and effectively as possible in the interests of patient care.

It is in this context that RCPI raises serious concerns regarding the implementation of the European Working Time Directive (EWTD). RCPI believes that the implementation of the EWTD as currently envisaged does not benefit patients but serves to undermine medical care standards and to compromise the quality of professional education and training of specialists. In particular, RCPI believes that the EWTD poses a very significant threat to the continued provision of quality healthcare to acutely ill patients.

The full implementation of the EWTD will have the following impact on working hours for Irish doctors:

- A maximum period of 48 hours on-site per week.
- A maximum on-call shift of 13 hours, to be followed by a period of 11 hours consecutive daily rest.
- A 15 minute rest break for every 4 hours and 30 minutes worked or a 30 minute rest break for every 6 hours worked.
- The resultant necessary introduction of a shift system which would replace the traditional 24 hour on-call rota.

This directive was initially introduced in employment sectors such as manufacturing and services and was intended to protect the health and safety of workers in these sectors. The blanket application of such a directive across all employment situations is fraught with difficulties and the consequences are likely to be particularly detrimental in the acute medical sector.

RCPI supports the reduction in excessive working hours for all grades of doctor and recognises that there are specialist areas within the health service which are minimally impacted by the EWTD. However, the implementation of this directive as currently envisaged is likely to have serious consequences not only for the provision of care to acutely ill in-patients, but also for the provision of timely out-patient diagnostic procedures, for initiatives to reduce out-patient waiting lists, for the integration of services between acute and primary care, and for specialist training.

The implementation of this directive cannot be viewed simply as an administrative task which can be carried out with little or no impact on patient care as it presents a fundamental re-arrangement of the method in which acute and out-patient care is provided in this country.

RCPI is not alone in expressing its concerns on the implementation of the EWTD and its effect on patient care. Many countries in Europe have experienced serious problems concerning the significantly reduced hours for junior doctors, and it is clear that many countries have amended the implementation of the EWTD to accommodate the healthcare needs of their population. Some countries have recognised and sought to minimise the adverse effect on medical training due, for example, to the lack of mentorship for junior doctors. A conciliation process between the Council of Employment Ministers and the European Parliament, facilitated by the European Commission, was unable to reach agreement in relation to concerns regarding the implementation of the EWTD across the European Union.

In the UK, the Department of Health set aside a total of £310 million to support the EWTD implementation, yet the UK remains largely EWTD non-compliant. Eighty percent of consultants and trainee doctors surveyed expressed significant reservations on the impact both on patient care and on medical training and felt the EWTD should not and could not be implemented safely in their area. The Royal College of Physicians London (RCPL) does not support the introduction of the EWTD and had supported derogation from the EWTD for individual trusts where compliance is likely to compromise patient safety or quality of training. However, based on experience to date, RCPL has now called for blanket derogation for acute specialties. The UK Health Secretary recently ordered a review of the impact of EWTD-based shift patterns on the quality of training and patient care.

In Ireland, a National Implementation Group (NIG) was appointed by government in 2005 charged with overseeing the implementation of the EWTD and in December 2008 this group published its final report. It found that no hospital in Ireland is currently fully-compliant with the EWTD and to achieve full compliance would require a fundamental re-organisation of the structures of healthcare provision in Ireland. The authors concluded that any changes must:

- ensure that the quality and safety of healthcare provision is maintained,
- promote multidisciplinary healthcare collaboration between healthcare professionals, including the redesignation of existing roles, and
- provide optimum educational and training opportunities for junior doctors and other healthcare professionals. New working arrangements should not jeopardize the quality of education and training programmes.

RCPI believes that such a significant restructuring of the Irish hospital system is not a reasonable goal in the short to medium term and is certainly not achievable by August 1 2009. Indeed for certain medical disciplines we do not believe that a target of 48 hours is appropriate or feasible.

There are three primary areas of concern to RCPI.

1. Care of the Acutely Ill Medical Patient

The concept of the clinical team appropriately lies at the heart of the care of the acutely ill patient. From the moment the patient enters hospital all decisions relating to the care of that patient are the responsibility of a single team, comprising consultant, specialist registrars, registrars and other junior doctors/non-consultant hospital doctors. There is no confusion as to this line of responsibility. The core benefit of this clinical team approach is that all members of the team share responsibility for the continuity of care of the patient.

The inevitable consequence of the introduction of a shift system will be to fragment the coherence of the clinical team and lead to a fundamental loss of continuity of care. It will re-orientate the junior doctor towards the task rather than responsibility for the patient. Doctors will no longer be able to manage the patient from time of admission to discharge from hospital. As a consequence, continuity of care and the individual responsibility of a

doctor for a patient will become redundant. This is a serious and an unnecessary downgrading of the current clinical responsibility and patient care infrastructure.

There is evidence that excessive working hours can lead to medical error, and RCPI supports the reduction of excessive working hours. There is also emerging evidence that a shift system does not eliminate error. Shift work in medicine is associated with fatigue, deterioration in work/life balance and has a negative impact on medical training. Experience from non-medical areas have shown a direct correlation between shift work and increased risk of accidents in shift workers as a consequence of the day/night shift pattern. No system is free of risk. However, we do not yet have the appropriate infrastructure or resources to implement a shift system safely across the health service.

2. Out-patient Care

Outpatient clinics are an integral element of the continuum of patient care. The interface between acute medical care and chronic disease management is of crucial importance in the provision of high quality care. The introduction of the EWTD will have a severe impact on the management and operation of out-patient clinics and out-patient diagnostic evaluation. Essentially, where a clinical team currently provides out-patient services the day after a night on-call, under EWTD, members of that team will no longer be available to provide the out-patient service. A number of adverse consequences are anticipated:

- Staffing levels at out-patient clinics will be diminished significantly because the team's availability will be reduced by the on-call shift approach. This will inevitably and immediately lead to smaller clinic and an increase in out-patient waiting lists with a consequent deterioration in health outcomes.
- Increased waiting times for out-patient clinics will result in a deterioration of the current problems of overcrowding in the Emergency Department due to reduced accessibility of out-patient services.
- Waiting times for essential diagnostic procedures will significantly increase because the availability of skilled non-consultant hospital doctors will be reduced by the on-call shifts leading to longer waiting times for important diagnostic procedures such as echocardiography, gastroscopy, colonoscopy, bronchoscopy, coronary angiography, radiological imaging and cancer screening investigations. This will lead in turn to longer delays in the diagnosis and treatment of a wide range of acute medical conditions such as gastric and colon cancers and coronary heart disease. It is unrealistic to expect that the extra workload can be taken on by the existing number of consultants.
- Increased strain will be placed on primary care as it attempts to cope with the long waiting times for hospital out-patient clinics and on the integration of services between acute and primary care.
- Finally, the perception of patients and the general public of the quality of care is likely to suffer owing to the ever-increasing delays in the system resulting in a further loss of confidence in the health system.

3. Medical Training

A key concern to RCPI in relation to the EWTD is the adverse impact on medical training. High quality training has a direct, immediate and positive impact on the quality of patient care and on patient safety.

The core principles of the RCPI training programmes are to ensure that trainees receive the necessary clinical experience (direct patient care under supervision from senior clinicians), that continuity of patient care is ensured, that professional and ethical practice is gained through mentorship by senior clinicians, and that academic knowledge is promoted.

To facilitate these core principles it is mandatory that trainees are exposed to consultant-led ward rounds, out-patient clinics, procedural sessions, on-call and post-take handover sessions, teaching sessions and journal clubs.

The introduction of the EWTD, as currently envisaged, will fundamentally undermine these principles. Specifically, the crucial training experience gained in out-patient clinics and at post-take ward rounds is likely to be significantly reduced. Other significant, negative consequences include a lack of adequate exposure to sub-specialty training and lack of mentorship from senior clinicians. In craft-based specialties such as Obstetrics & Gynaecology, Gastroenterology, Cardiology and Respiratory Medicine, shift systems have a significant negative impact on training as trainees are unable to attend essential fixed sessions on a weekly basis with a specific consultant mentor.

In summary, it is not possible to significantly reduce the total hours worked by trainee hospital doctors without having a significant, detrimental impact on the care of patients and the training of tomorrow's consultants and specialists.

Recommendations

RCPI believes that the implementation of the EWTD within certain specialties and in certain institutions is not achievable in its current state and in the current environment. The key issues that must be addressed are outlined below:

1. Rosters prepared against the background of the EWTD should:
 - Demonstrate how continuity of patient care is to be supported.
 - Maintain current levels of throughput and staffing for out-patient clinics.
 - Maintain staffing levels for diagnostic procedures in areas such as cardiology, GI endoscopy and bronchoscopy departments.
 - Support the specialist training requirements of postgraduate trainees.
2. New rosters should not be introduced without a clear understanding of how current workloads will be assigned across the multidisciplinary teams.
3. The introduction of reduced working hours should be planned and aligned with ongoing changes to service configuration and governance structures within the health service. Such planning should also take into account the critical workforce planning issue of consultant and junior doctor numbers. It is likely that these recommendations cannot be delivered without the appointment of additional trainees and consultants.
4. Implementation of the EWTD may be achievable for certain non-acute medical specialties and within certain institutions. However, until the necessary infrastructure, configuration and resource allocation changes are made to the current environment to support the reduction in hours, RCPI suggests that the current 24 hour on-call system should continue. The minimum working week should be between 52-56 hours – a component of which must be secured for training activities. No doctor should be on acute medical in-house call for more than 24 hours. Doctors post-call will be expected to leave the hospital after completion of their post-call ward round for a consecutive rest period of at least 16 hours.

As a matter of urgency, we propose that the HSE and RCPI, together with other stakeholders, should engage at a national level to discuss how these issues can be addressed effectively.