

# **European Working Time Directive**

## **Summary of positions of other postgrad training bodies, and issues specific to**

### **Faculty of Radiologists, RCSI**

#### **Introduction:**

Efforts are being made to implement The European Working Time Directive (EWTD) for non-consultant hospital doctors (NCHDs) by the end of October 2009. A number of Irish postgraduate training bodies have already issued documents outlining their positions on this matter. These positions are summarised below. It is intended that all postgraduate training body positions on the EWTD will be co-ordinated through the Forum for Postgraduate Training Bodies, and this position paper will be shared with other bodies through the Forum.

The Faculty of Radiologists broadly agrees with the positions already outlined by other training bodies. While the Faculty recognises that the EWTD is now law, and therefore must legally be applied, many concerns exist with respect to the impact of its implementation on training and service provision. Most of these have already been identified by other bodies, but a number of issues arising from EWTD implementation which particularly concern The Faculty of Radiologists are listed towards the end of this document.

#### **College of Anaesthetists of Ireland (26/6/09)**

- EWTD National Implementation Group concluded (Dec 2008) that major reconfiguration of acute hospital services and manpower structures would be required to meet provisions of EWTD
- NCHD on-call rotas, esp. in smaller hospitals, are not currently compatible with a 48-hour week. If the aim is to maintain current levels of service, a manpower deficit will exist. This may be remedied in the medium to long term by significant expansion of consultant posts, and potentially by introduction of other medical grades. More thinly-spread manpower may cause a drop in standards of care, with risks to patients.
- 48 hour week is not appropriate for training purposes. Loss of contact time with trainers and loss of training experience during daytime hours will occur. In UK, annual anaesthesia trainee caseloads have halved over past 5 years arising from EWTD provisions, giving rise to concerns that trainees are not acquiring basic skills and experience needed for safe practice. Adverse effect of reducing working hours on training could be partially compensated by targeting trainees at high value training situations in hospitals with sufficient volume of appropriately complex casemix; however, this would mean removing trainees from many hospitals in Ireland, with service implications.
- Trainees do not support EWTD-compliant shift system, because of disruption of life, sleep and training opportunities.

- College believes that EWTD implementation will require
  - Restructuring of numbers of consultants vs. numbers of NCHDs
  - Restructuring of medical career pathways including potential for new grades of NCHDs, specialists and consultants
  - Restructuring of hospital services in terms of what can realistically be delivered by individual hospitals under these new circumstances
  - Redesignation of some non-clinical roles currently undertaken by NCHDs
  - Restructuring and concentration of training to take maximum advantage of high grade posts in high-grade hospitals and of non-clinical training opportunities.
- College believes that EWTD implementation should be delayed until correct conditions can exist

**Royal College of Physicians of Ireland (June 24, 2009)**

- RCPI believes that implementation of EWTD as currently envisaged does not benefit patients, but serves to undermine medical care standards and to compromise quality of professional education and training of specialists. EWTD poses a very significant threat to continued provision of quality healthcare to acutely ill patients.
- Implementation will also affect provision of timely out-patient diagnostic procedures, initiatives to reduce out-patient waiting lists, integration of services between acute and primary care and specialist training
- Many countries have amended implementation of EWTD to accommodate the healthcare needs of their population. Royal College of Physicians of London has called for blanket derogation from EWTD for acute specialties. UK Health Secretary recently ordered a review of the impact of EWTD-based shift patterns on quality of training and patient care.
- Government-appointed EWTD National Implementation Group concluded in Dec 2008 final report that any changes must
  - Ensure that the quality and safety of healthcare provision is maintained
  - Promote multidisciplinary healthcare collaboration between healthcare professionals, including redesignation of existing roles
  - Provide optimum educational and training opportunities for junior doctors and other healthcare professionals. New working arrangements should not jeopardize quality of education and training programmes.
- EWTD implementation will result in
  - Loss of continuity of care of patients and individual responsibility of doctors for their patients
  - Reduced out-patient clinic staffing levels, with increased waiting times
  - Worsening in Emergency Dept overcrowding
  - Increased waiting times for diagnostic procedures, including radiological imaging
  - Increased strain on primary care
  - Worsening perception of quality of care by general public due to increased delays
  - Loss of crucial training experience and mentorship
- RCPI recommendations:
  - Rosters prepared against background of EWTD should

- Demonstrate how continuity of care is to be supported
- Maintain current levels of out-patient clinic staffing and throughput
- Maintain staffing levels for diagnostic procedures
- Support specialist training requirements
- New rosters should not be introduced without a clear understanding of how current workloads will be assigned across multidisciplinary teams
- Reduced working hours introduction should be aligned with ongoing changes to service configuration and governance structures, taking account of workforce planning issues of consultant and junior doctor numbers. It is likely that this will require additional trainees and consultants
- Implementation of EWTD may be achievable for certain non-acute medical specialties and within certain institutions. In general, RCPI recommends retaining current 24 hour on-call system, with minimum working week of 52-56 hours (incl. training activities). No doctor should be on acute medical in-house call for > 24 hours. Doctors post-call will be expected to leave hospital after completion of post-call ward round for a consecutive rest period of at least 16 hours.

#### **Royal College of Surgeons in Ireland (5/5/2009)**

- Compliance with EWTD only possible with introduction of shift working, which will result in deterioration in patient care and quality of surgical training, increased fatigue and more medical errors
- If reconfiguration of existing acute hospital system and/or establishment of new staffing structures cannot be achieved within short to medium term, RCSI believes that government should seek specialty opt-out for all surgical specialties from EWTD, with working week of 65-70 hours with quality rest periods

#### **Royal College of Radiologists**

- Statement from President 20/1/09
  - The medical profession has never kept “office hours”
  - Many European countries have either ignored the directive or have complied with it only nominally
  - USA has kept working hours of junior hospital doctors to 80/week
- Statement from Deans 19/3/09
  - NHS is providing £110m to support EWTD compliance in 2008-09, increasing to £310m in 2009-10, with further uplift of £150m to NHS trusts. Funding will be provided to 24/7 specialties which are locally led and clinically driven where there are robust business cases
  - Applications for derogations could also be made by 31/1/09. No possibility of derogation from rest break requirements, implying it would no longer be possible to work a full weekend on call

#### **Specific points relevant to Faculty of Radiologists**

1. Faculty agrees with broad thrust of comments by above bodies

2. Faculty notes that UK authorities are permitting applications for derogations, and providing funding to support implementation of EWTD (and thus to increase NCHD numbers). No such provisions exist here, and the thrust of government and HSE policy seems to be to decrease NCHD numbers. Services cannot be maintained at current levels if EWTD is implemented as planned.
3. Implementation of EWTD will have specific impacts on radiology
  - a. MDMs will have to be conducted during the normal working day, rather than early morning/lunchtime; this will diminish the time available in departments to provide direct patient services
  - b. On-call availability of services will diminish; at present, in most hospitals which provide training to Radiology SpRs, on-call commitments are an integral part of training. Demand for on-call radiology services has grown massively in recent years. In most departments, at least 10-15% of radiology activity is now provided out of normal working hours. If insufficient SpRs are available to fulfil on-call rosters and maintain normal working-day services (and to avail of training opportunities during normal working days), on-call availability of radiology services may have to be curtailed, with significant detrimental effects on patient care and safety. This is likely to result in diminished radiology support for in-patient and emergency dept. activity, with increased waiting times for patients.
  - c. In general, waiting lists for radiological services will increase if the EWTD is implemented as envisaged; less available staff will inevitably result in less throughput. This is incompatible with government and HSE efforts to move as much patient investigation and management as possible to out-patient or day-case models.
  - d. Radiology departments respond to the demands of referring doctors, and are rarely in a position to control the demand for their services. The demand for radiology services cannot be expected to diminish. In the absence of adequate NCHD numbers, increased pressure will be applied to Consultant Radiologists (who are exempt from the EWTD provisions) to cope with demand. The new HSE consultant contract provides for a working week of 37 hours, and the HSE insisted that consultants provide a work schedule not exceeding 37 hours per week when signing the new contract. In practice, many Consultants already work well in excess of 37 hours per week. It is likely that Consultants will be expected to increase their work activity and hours to cope with demands, regardless of safety issues, and ignoring the work schedule required of them by employers, once the EWTD is implemented.
  - e. It should be noted that the Consultant to SpR ratio in radiology is higher than in many other specialties (i.e. more Consultants per SpRs in radiology). The HSE lists a total of 234 approved permanent posts of Consultant Radiologist. There are 78 paid SpRs in diagnostic radiology in post in the Republic of Ireland, working in 8 teaching radiology departments. Most radiology work in Ireland is already delivered by Consultants. There is no scope for shifting workload from NCHDs to Consultants with EWTD implementation. Equally, a diminution of hours worked by trainees will impact adversely on training of the next generation of Consultants.

Approved by the Board of the Faculty of Radiologists, 2/10/2009.