

Carpe diem

Ann R Coll Surg Engl (Suppl) 2009; 91:42–43



The Royal
College
of
Surgeons
of
England



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In a recent article in *The Sunday Telegraph*, Dr James LeFanu referred to 'the ascendancy of that managerial and political class whose commitment to making the world a better place has come to blight our lives'.¹ There could not be a better example of this than the effect of the European Working Time Directive (EWTD) on those training to be surgeons. The EWTD has devastated the ability to deliver proper standards of surgical training and forced young surgeons to work shifts that are stressful, detested and unprofessional. For trainees to gain the necessary experience and competence, training will have to be extended for so long that becoming a consultant will be a very distant goal. This is all being done under social chapter legislation, supposed to make people's lives better!

With nobody able to work more than 48 hours a week from August 2009, the effects on patient care in the NHS are potentially disastrous. Compliant rotas are being populated in acute hospital trusts by a massive expansion of non-training-grade medical posts. These posts are becoming increasingly difficult to fill because the pool from which they were recruited in the past, international medical graduates, no longer exists. Doctors will come to Britain to do an apparent dead-end service job if there is a prospect, however slim, of getting into specialist training. They will not come if there is no chance at all, as is the case since the immigration rules were changed. We now have enough UK graduates each year to staff our health services and home graduates will not take posts that do not provide training or prospects of promotion. Obtaining locum cover at that level is already, as near as makes no difference, impossible.

With progressive reductions in hours of work, tiers of on-call junior doctors have been so reduced that most consultants find themselves coping with increasingly heavy emergency takes with fewer and much less experienced trainees. How much longer can they bear this burden when they themselves are limited to 48 hours a week? From August, out-of-hours cover will be so thin, on occasions non-existent, that major service failure with unplanned reconfiguration of services appears inevitable. It is well known that dangerous incidents are far more likely to happen at night and

weekends, and this will get worse with even fewer doctors available. This is not to mention the dangers of multiple handovers or the frustration and alarm felt by patients who rarely see the same doctor for more than a few hours. This will happen at a time when patient safety is rightly high on the Department of Health agenda.

You will be aware of the recent report issued by the College in conjunction with the Royal College of Anaesthetists.² This set out a number of measures that would allow a 48-hour week to be achieved but at a cost: not just financial. We are beginning to realise that the service is incapable of meeting these recommendations.

Is there a long-term solution? I believe there is. The Royal College of Surgeons, to quote my predecessor during the Modernising Medical Careers disaster of 2006, does not do sticking plaster – it carries out curative surgery. What has happened in other countries? The USA has decided to keep junior hospital doctors' weekly hours at 80, largely on patient safety grounds. Many European countries have adopted solutions varying from large-scale fudges to a simple decision to ignore the European law. Our inspiration has come from Germany, where the trade union representing hospital doctors in conjunction with the professional bodies has agreed that 61 hours is appropriate. Clearly a temporary derogation to 52 hours will have little effect. So what is the College doing about

1. I have asked the Association of Surgeons in Training (ASiT) and the British Orthopaedic Trainees Association (BOTA) to define the ideal working week for a surgical trainee to achieve good training, a reasonable lifestyle and to become a consultant within an acceptable time. This will include an upper limit on working hours, likely to be of the order of 65 to 70 hours.
2. I will be meeting Alan Johnson, secretary of state for health, on 10 February 2009. At that meeting we will present evidence for all I have said above, namely our concerns about patient safety, the likely service failures and the adverse effects on the quality of training.
3. I will formally request Mr Johnson to introduce a specialty opt-out for all the surgical specialties in England, to allow hours to be worked up to the figure defined by our trainee organisations. This must include a revision of the rest-break legislation, which has substituted inhumane shift patterns for apparently longer but much less tiring periods of on-call.
4. I will emphasise to Mr Johnson that we are seeking a long-term solution for the NHS in the interests of patient care and high standards of training.

this impending disaster? Our response is outlined in the box above.

I can already hear the objections: I have no doubt we will be told that it is impossible to alter or bypass the European law. I do not believe this. All manner of EC law must have been bent or ignored in nationalising a bank in 24 hours. The government can do it if it has the political will. What about the British Medical Association (BMA)? Well, they are doctors too and I detect that they are just as worried as I am. The craft specialties are represented much better than formerly in the BMA Junior Doctors Committee, which I hope will appreciate that surgeons are different and that the ideal week has been defined by the two professional trainee

organisations, ASiT and BOTA, and not by a trade union.

Will it cost a lot of money? No. With a reasonable number of hours worked by trainees, the number of doctors required for out-of-hours work will be fewer. The non-training grades, already difficult or impossible to recruit, will no longer be necessary.

What about a different safety issue, the tired doctor? Well, not a problem at all actually. There is evidence that the most exhausted doctor of all is someone after three or four days on a night shift. Properly organised on-call rotas with appropriate support are the best way to provide continuity of care and patient safety.

Finally, none of this is possible without a consultant-delivered service, which the College considers to be the best and indeed the only possible model of care in a service staffed by UK graduates. Patients want to be treated with continuity by fully trained consultants and by those training under close supervision to become consultants, whatever the time of day or night. A sensible approach to hours worked is necessary to achieve this and I believe the College has offered a viable permanent solution.

References

1. LeFanu, James. Certain values are rising in the crash. *The Sunday Telegraph*. 2008 Dec 21: 25.
2. The Royal College of Anaesthetists and The Royal College of Surgeons of England. *WTD – Implications and Practical Suggestions to Achieve Compliance*. Manchester: Skills for Health – Workforce Projects Team; 2008.