



Surgery and the European Working Time Directive - Background Briefing

What is the EWTD?

The European Working Time Directive (EWTD) is part of the EU health and safety legislation which lays down requirements in relation to working hours, arrangements for night workers, rest periods and annual leave.

The directive was transposed into UK law under the Working Time Regulations (WTR) in 1998 and means most workers must not work over 48 hours a week (by an average calculated over a six month reference period). These regulations were phased in, finally reducing maximum working week hours to 48 hours in August 2009. Further regulations in the Working Time Regulations include:

- 24-hour rest every seven days (or a minimum 48 hours rest every 14 days)
- 11 hours of continuous rest in a 24-hour period
- A 20-minute break when working time exceeds six hours
- Four weeks of annual leave
- Maximum eight hours of work in 24 hours for night workers

These regulations were further defined in European court rulings (SiMAP and Jaegar), establishing that on-call hours count towards the total hours worked per week, even if those hours are not spent working. These rulings also established the principle that if the required continuous rest of 11 hours in a 24-hour period is interrupted by work, that compensatory rest must be taken immediately.

Does the European Commission plan to review the EWTD?

A review of the Directive was initiated by the European Commission in 2003. This led to proposals to the European Parliament to exclude non-working on-call time as contributing to total working week hours. These proposals were however rejected by the European Parliament.

At the beginning of his second term in 2009, the President of the European commission, José Manuel Barroso, stated that he would consult with social partners (employers and trade unions) to come up with a comprehensive legislative proposal to amend the Directive¹. Further to this statement, the European Commission encouraged 'social partners' to come to an agreement about how to moderate the EWTD. While proposals agreed by consensus with the 'social partners' would allow amendments to the Directive without approval by the European Parliament, this could not be reached by the closure of negotiations in December 2012. Unless these negotiations restart, further amendments would have to be proposed by the European Commission before submission to the European Parliament for approval.

What does this mean for hospitals?

While individual doctors can choose to opt-out of the working time regulations, NHS trusts cannot force staff to opt-out, consequently rotas must be planned to comply

¹ http://europa.eu/rapid/press-release_SPEECH-09-391_en.htm



with these Regulations. The reduction in hours for doctors and surgeons has meant that NHS trusts have had to make changes in how they staff hospitals. In the past, doctors would work a standard day-time week and participate in an on-call rota to provide cover at nights and weekends. This might mean that one day and weekend in six they would be expected to be ready if needed. The system meant there was always a range of people available with the right level of skills to deal with problems or emergency admissions out-of-hours.

However because time spent on-call would count toward a doctor's and surgeon's limit of 48 hours a week, hospitals have had to scrap 'on-call' arrangements in favour of full-shift rotas. This meets the hours' requirements but replaces 'on-call' with continuous work.

What are the problems for hospitals and the NHS?

While most consultants opt-out of the restrictions, junior doctors comply with the EWTR in large numbers as part of their contractual arrangements.

A survey of the latter reported that 86% of surgical trainees working a EWTR compliant rota have seen their work life balance deteriorate². A survey - by the Pulse publication - of 500 junior doctors on the impact of the EWTR reported that 66% of respondents felt that EWTR is having a detrimental effect on their training, and 75% that since August 2009 there was now insufficient cover on the wards³. In 2013 the BMA Junior Doctors' conference passed a motion saying that the EWTR has meant some doctors are 'struggling to get appropriate training'. As a result, they believe the length of some training programmes should be extended⁴.

- **Less time to learn.** The quality of training for surgeons of the future is being endangered as the amount of time available for training has been dramatically reduced. Indeed 55% of trainees report having been pressurised to falsely declare their actual hours, highlighting the significant constraints on the time for trainees to learn⁵. Analysis by the Royal College of Surgeons (RCS) on the number of hours available to surgical trainees for training and experience in compliance with the EWTD, has been significantly reduced; every month 280,000 surgical training hours are lost due to EWTD; and doctors beginning their surgical training today will have 3,000 fewer hours to learn throughout their training, the equivalent of 128 whole days.
- **Continuity of care worsening.** The shift system means a surgeon may not see a patient through their surgical treatment. Handovers have always happened, but the shift system means they happen more frequently and thus the risk of

² http://www.asit.org/news/wtd_implementation (accessed 25/04/2013)

³ <http://www.pulsejobs.com/resource-centre/news/press-releases/8/48-hour-week-a-ticking-time-bomb-for-future-doctors-skills/> (accessed 02/04/13)

⁴ <http://bma.org.uk/news-views-analysis/news/2013/may/juniors-push-for-longer-training-programmes>

⁵ Association of Surgeons in Training (2009) Optimising working hours to provide quality in training and patient safety

something important getting missed also increases⁶, and can be further disrupted with rules regarding compensatory rest.

- **Not enough staff to adequately cover shifts.** The limiting of working hours has resulted in a shortage of surgeons and other hospital doctors in the NHS being available to staff full shift rotas. This has meant that staff are being stretched too thin, particularly over nights and weekends, with hospitals struggling to cope and patient safety being put at risk⁷.
- **Poor availability of experienced staff.** Under the on-call system a network of surgeons at all levels of experience and expertise could be called upon if needed. The rota system means whole levels of cover have been removed, often leaving only a junior surgeon and consultant.
- **Increased locum costs for medical staff to cover rota gaps.** Research by the RCS⁸ at the end of 2010 shows that the cost of hiring locum or temporary doctors has increased to more than £750 million a year since the introduction of EU regulations to reduce doctors' hours.
- **Staff too tired.** Part of the intention of restricting working hours was to reduce the tiredness of staff. However, there is evidence that it has had the opposite effect. The move to working 48 hours a week through full shift rotas is exhausting surgical staff. We know from our members^{9,10} and academic research¹¹ that working in a full shift pattern is more tiring when compared to working using an 'on-call' system, as work intensity during a shift is significantly higher than during on-call working. Furthermore, rotating shift work to cover nights disrupts sleeping patterns and further exacerbates exhaustion to a greater extent than on-call cover.
- **Shift working pattern is damaging quality of training.** The nature of working a full shift pattern has resulted in surgical trainees being exhausted. This is a mode of working that is not conducive to surgical training as it also makes it impossible for surgical teams to stay together at all times, damaging the trainee-consultant relationship¹².
- **Lack of professionalism.** Medicine is a vocation – patients' needs must be paramount in care. While many consultant surgeons work beyond their contracted hours, some also believe that the EWTD is undermining this

⁶ General Medical Council (2013) The Impact of the Working Time Regulations on Medical Education and Training: Literature Review http://www.gmc-uk.org/The_Impact_of_the_Working_Time_Regulations_on_Medical_Education_and_Training_Literature_Review.pdf_51155615.pdf (Accessed 18/03/13)

⁷ <http://web.bma.org.uk/pressrel.nsf/wall/E03F966CDAC65864802576D200498A84?OpenDocument> (Accessed 18/03/13)

⁸ Royal College of Surgeons (2010) Locum doctor costs in NHS Trusts in England

<http://www.rcseng.ac.uk/publications/docs/locum-doctor-costs-in-nhs-trusts-in-england>

⁹ Association of Surgeons in Training (2009) Optimising working hours to provide quality in training and patient safety

¹⁰ British Orthopaedic Trainees Association (2009) BOTA position statement on EQTD and training in trauma & orthopaedic surgery

¹¹ Richter A, Kostova P, Baur X, Wegner R. (2013) Less work: more burnout? A comparison of working conditions and the risk of burnout by German physicians before and after the implementation of the EU Working Time Directive. *Int Arch Occup Environ Health.*

¹² *Ibid*



professionalism by encouraging a culture of clock-watching by staff. Many medical doctors also object to the paternalism of the EWTD.

A report for the General Medical Council by the Centre for Medical Education Research at Durham University¹³ provided evidence that while many trainees were supportive of the 48-hour limit, many also felt that a number of problems remained, including:

- Some working patterns resulting from implementation of the Regulations are particularly fatiguing, with long hours and long periods without days off, raising concerns that this may impact on the quality of care.
- Shorter working hours have increased work intensity in some areas as workload has not proportionately decreased.
- Workload and work intensity are exacerbated by understaffed rotas

How can we change the law on working hours for surgeons?

We do not want to return to a time when doctors worked excessively long working hours, but we believe the EWTR is also having a negative impact on patients and staff. Some of the negative impacts of the EWTR may be addressed in the new NHS consultants' and junior doctors' contracts by incentivising appropriate overtime and patterns of working hours, while still being consistent with the EWTR. Negotiations on these contracts are ongoing with agreed principles due in 2013, and implementation from April 2014¹⁴. While changes must also be made to the Working Time Directive, we recognise that this will be politically difficult due to intransigence at a European level. Similarly, it is largely unviable to change the Regulations at a UK level as this would be challenged by the courts and would not represent a long-term solution. The RCS is therefore looking to achieve greater flexibility in how the Directive impacts healthcare:

- The RCS believes that the European social partners should resume discussions on moderating the impact of the European Working Time Directive. In the absence of a general agreement, they should seek a sectoral agreement for healthcare.
- If the social partners fail to resume discussions, the European Commission should propose new changes as a matter of urgency.
- We support the review of the junior doctors' contract and welcome the Government and NHS employers' intentions to incentivise appropriate overtime and patterns of working hours. At present the contract discourages NHS hospitals from encouraging overtime.

¹³ General Medical Council (2013) The Impact of the Working Time Regulations on Medical Education and Training: Final Report on Primary Research http://www.gmc-uk.org/The_Impact_of_the_Working_Time_Regulations_on_Medical_Education_and_Training_Final_Report_on_Primary_Research.pdf_51157039.pdf (Accessed 18/03/13)

¹⁴ Rt Hon Jeremy Hunt MP (17 December 2012) Written ministerial statements. Hansard. Column 74-5WS <http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121217/wmstext/121217m0001.htm#1212171000100>



- We will also support any proposed treaty negotiations for establishing an opt-out of EWTD legislation as it applies to healthcare for the UK.

There is also evidence that, unlike the UK, the vast majority of other European countries are not strictly adhering to the working time rules or have found ways around the legislation. For example, it is understood that the Italian government has decided that doctors employed in public hospitals in Italy are considered equivalent under national law to managing executives. They are therefore excluded from the scope of the national legislation transposing the Working Time Directive¹⁵. The Department of Health should review whether similar flexibilities could apply to the UK.

What do other organisations say?

- The Royal College of Physicians have published a study showing that sickness leave has increased since EWTD was introduced. They have also submitted evidence to the European Commission review on EWTD, highlighting the impact of the Regulations on patient care and training.¹⁶
- April 2010: The Royal College of Obstetricians and Gynaecologists were critical of EWTD saying that it has contributed to maternity ward closures. “The possible reasons for the high number of closures last year were the shortage of midwives and the implementation of the European Working Time Directive”
- NHS Employers have highlighted concerns of the impact of EWTD on staffing levels, costs, and time available for training and patient care.¹⁷
- While the British Medical Association has broadly supported EWTD, they have also raised concerns of the effect of regulations on training.¹⁸

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¹⁵ <http://www.europarl.europa.eu/sides/getAllAnswers.do?reference=E-2013-003084&language=EN>

¹⁶ Royal College of Physicians (2011) European Working Time Directive Second phase consultation of the EU social partners

¹⁷ <http://www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/EWTD/Pages/EWTD.aspx> (accessed 02/04/13)

¹⁸ British Medical Association (2011) BMA response to the European Commission second stage consultation of social partners on the revision of the European Working Time Directive