



ROYAL COLLEGE OF
PHYSICIANS OF IRELAND

Position Paper on EWTD

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1. Executive Summary

The Royal College of Physicians of Ireland (RCPI) is responsible for the training of approximately 1,200 doctors annually in Ireland and contributes to continuous medical education and enhancing the standards of patient care. The continued long hours worked by junior or non-consultant hospital doctors (NCHDs) is of considerable concern as it may have an impact on the welfare of these doctors themselves and may compromise patient care.

Through a number of surveys RCPI has identified the concerns of NCHDs, which highlight that to date; the implementation of the European Working Time Directive has not progressed sufficiently. This is at the expense of patient care and the wellbeing of the NCHDs and trainees. The dissatisfaction of NCHDs with the delayed implementation of EWTD has been expressed in various fora, and is further evidenced in the high numbers of trainees and junior doctors leaving the country to work abroad.

We believe that there are a number of fundamental principles that should form the basis for any agreement regarding the implementation of EWTD.

1. Patient care should be the main objective and should not be compromised.
2. Professional development and training should be maintained and improved to run in parallel with a high standard of patient care.
3. The post-take ward round should be preserved as the main focus for consultant-led professional communication and transfer of clinical responsibility with an emphasis on continuity of patient care, in-service teaching and learning.
4. A reduction in the number of hours worked per individual NCHD will mean that more individuals are required to do the same amount of work. These will need to be mainly, but not exclusively, additional medical staff.

Progress towards implementation has been slow. A HSE implementation group on EWTD has not yet released details of actions plans on EWTD compliance for individual hospitals.

Low morale and continued frustration with long working hours and shift duration has recently found expression in the NCHD “24 No More - Enough is Enough” campaign launched in July 2013. In a recent ballot for industrial action as part of this campaign, NCHDs voted overwhelmingly (97%) in favour of escalating the campaign to include industrial action. Industrial action is now proposed for the upcoming months

Immediate progress on EWTD implementation is undoubtedly necessary. Achievement of EWTD will be challenging, and will require a series of actions. A one-size fits all solutions may not be appropriate. Action on EWTD should address the root of the problem, the NCHD workload, and not only the working hours. Additional staff will be needed and some tasks, especially at intern level, will have to be assigned to other staff in hospitals. Methods of ensuring continuity of care and efficient handover of patients between shifts need to be implemented. The HSE and individual hospitals will need to work with the training bodies and trainees to ensure that trainees get the appropriate level of experience and training hours, without extending the training period.

2. Background

2.1. RCPI

2.1.1. 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. Currently, it directs, oversees and delivers postgraduate training annually to approximately 1200 doctors across a wide range of specialties and it is one of the responsible bodies in Ireland for continuous medical education and professional development. In association With the Health Service Executive (HSE), it has established the Clinical Programmes which have led to significant improvements in the quality of patient care and the numbers of patients being seen and treated.

2.1.2. In light of its mission, 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.

2.1.3. In addition, RCPI supports research in medical education and physician well-being which contributes substantially to improvement in the training and

education provided. RCPI has also established a working group on physician well-being and has participated in discussions on retaining medical talent. It is in this context, and with the ultimate aim of improving patient care, that RCPI continues to highlight the issue of working hours.

2.2. EWTD

2.2.1. The European Working Time Directive (EWTD) was initially introduced to guarantee health and safety in manufacturing and service sectors. EWTD entered into Irish law in 1997, but activities of doctors were excluded until 2004, when a European directive amended the EWTD to limit working hours of doctors.

2.2.2. Implementation of EWTD in Irish Hospitals¹ was envisaged as follows:

- A 48 hour working week from August 2009
- A 30 min rest break for every 6 hours work
- 11 consecutive hours rest every 24 hours or equivalent compensatory rest before the next period of work
- 35 hours of consecutive rest every 7 days; or two periods of 35 hours; or one period of 59 hours consecutive rest every 14 days

2.2.3. RCPI supports the reduction in excessive working hours for all grades of doctor. In particular, the hours worked by non-consultant hospital doctors (NCHDs) and trainee doctors are excessive. Medicine has evolved substantially over recent decades, and as both conditions and procedures have become more complex. The number of hospital admissions has also increased. This implies a large and complex workload, which combined with long hours of duty and sleep deprivation can lead to severe stress and burnout risk for the physician. The impact on the quality of patient care provided is overwhelmingly negative and it is widely accepted that overtired doctors are more likely to make mistakes. Responses from NCHDs in working hours surveys carried out in May/June 2013 confirm that working excessively long hours without sufficient rest has an impact on the ability of the doctor to perform clinical tasks, and ultimately, may have adverse effects on the patient.

¹ http://www.dohc.ie/issues/european_working_time_directive/transposition.pdf?direct=1

2.3. RCPI Surveys- Listening to the trainees

2.3.1. In 2011 RCPI carried out a survey of trainees and trainers to assess the impact the implementation the EWTd was having on patient care, training, morale and job satisfaction. The results of this survey (number of respondents was 228 SHOs, 96 registrars, 279 SpRs) demonstrated

- Over half of those surveyed were working in excess of a 48 hour working week with over 24 hour of continuous on call duty. Almost 70% of those indicated that the excess hours were required to meet clinical responsibilities.
- Almost half (48.4%) were not being remunerated for working in excess of the rostered hours.
- Overall morale was low, and high numbers of respondents reported experiencing stress as a result of their job, or observing stress in colleagues. Many of those surveyed indicated a desire to leave Ireland. A very high number (91%) believed that working abroad would be beneficial for their career. Australasia UK, USA and Canada were mentioned as potential destinations.
- No single reason for low morale or motivation for leaving stood out. Respondents mentioned better training opportunities elsewhere, lack of consultant posts in Ireland, worklife balance, and working conditions.

2.3.2. In February 2013, RCPI Council established a Working Group to co-ordinate RCPI's initiatives to support trainee doctors and to assist with the introduction of measures to improve their working conditions and in particular the hours they work. At the initial meeting, the group agreed to focus on working conditions of Senior House Officers (SHOs) and Registrars (middle grades) in particular. The most pressing issue for those groups was the length of shifts (in excess of 24-36 hours) rather than the total hours worked per week.

2.3.3. In March 2013, the HSE told an Oireachtas committee on Health that by the end of March, no NCHD would have to work more than 68 hours in a week, and that by June, no NCHD would have to work more than 24 continuous hours on-site. However, in June 2013, a second RCPI survey of 1st and 2nd year SHOs

showed that this target had not been reached. The survey was completed by 187 SHOs and 122 Specialist Registrars (SpRs), indicating a response rate of 32% for SHOs and 23% for SpRs.

- Almost half of SHO's surveyed (45%) were working 24 hour on call followed by full commitment the following day.
- While only a minority of SHO's were rostered for over 60 hours per week (approx 17%), almost 90% were actually working in excess of the rostered hours to meet their clinical responsibilities.
- The majority of SpRs (65%) were also working 24 hour on call with full commitment the following day. Most of them (76%) were also working in excess of the rostered hours.
- Both the SHO and SpR surveys highlighted that insufficient time was rostered for training (77% of SHOs and 53% of SpRs).

2.3.4. Excessive working hours contribute to low morale and are among the reasons that trainee doctors are going abroad to work. The 2013 survey showed that more than half (55.8%) of those engaged in Higher Specialist Training intended to take up a consultant position or fellowship abroad. Other factors influencing this decision included:

- Ensuring competitiveness for consultants' posts in Ireland, through gaining experience abroad.
- Pay and unattractive consultant contract in Ireland.
- Poor job prospects/lack of posts.
- Poor working conditions.

2.4. Recent developments

2.4.1. In 2013, a HSE implementation group on EWTD conducted inspections of every hospital to focus their efforts on implementation of EWTD. This group's primary initial focus was on reducing the weekly hours worked, and not on reducing the length of shift. A report is to be issued shortly, but indications are that most hospitals are not fully compliant, and doctors are still working excessive hours.

2.4.2. A recent IMO campaign, "24 No More - Enough is Enough" highlighted the dissatisfaction among NCHDs at the lack of progress towards implementation of EWTD, particularly in relation to shift length. In a ballot on industrial

action in August/September 2013, an overwhelming majority of NCHDs (97%) voted for industrial action and industrial action has been planned, indicating that a critical point has been reached in this debate.

2.5. Concerns on EWTD implementation

2.5.1. RCPI has in the past expressed its concerns on EWTD implementation and its impact on medical training and the continuity of patient care. In 2009, RCPI convened a working group on this and issued a number of recommendations². It was RCPI's opinion in 2009 that implementation in the acute medical sector in particular would be difficult. The statement issued then highlighted that safeguards should be in place to ensure that care is not compromised. A further RCPI statement³ in 2013 on trainees' working conditions also raised the issue of excessive working hours in the wider context of retaining medical talent.

2.5.2. There were some fears initially that EWTD would be viewed as a way to make cost savings within the health system. This will not be the case, as methods will have to be found to manage the same volume of work, while respecting reduced working hours, instead of simply requiring doctors to complete the same volume of work in a reduced timeframe (the phenomenon of 'work compression', which has been observed in the US). This will imply work being carried out by additional doctors, or other appropriate medical staff. Some investment and resourcing will be necessary, but there may also opportunities for re-alignment and disinvestment in some older practices and roles, without the requirement for new funding.

2.5.3. Implementation of EWTD necessitates the introduction of a shift system. From the outset, RCPI has been concerned that, unless planned carefully, the shift system would have a negative impact on clinical care outcomes, team coherence, continuity of care and NCHD training. Reducing shift duration

² <http://www.rcpi.ie/article.php?locID=1.11.30&itemID=320>

³ <http://www.rcpi.ie/article.php?locID=1.11.30&itemID=73>

means that there would be an increased number of shifts, with increased handover, which can increase the risk of patient care being compromised.

2.5.4. There was also a concern that availability of skilled NCHDs to provide essential diagnostic out-patient procedures would be diminished, with implementation of EWTD, where the clinical team on call the night before would be unavailable the following day for morning ward rounds to review the patient admitted on call, for general in-patient care and also for assigned OPD services. There may also be a negative impact on length of stay.

2.5.5. EWTD, implemented without due consideration for training impact may have adverse consequences. There is some concern that experience gained in out-patient clinics and on post-call ward rounds would be reduced, and that exposure to sub-specialty training and mentorship/supervision from senior clinicians would be compromised. With reduced working hours, it remains vital to ensure that trainees gain the appropriate experience level of experience, without extending the training period.

2.5.6. Reservations on EWTD implementation in the UK have been raised by the RCP London. In 2012 they issued a number of recommendations⁴ to parliament on implementation of EWTD, some of which may be relevant in Ireland. They also developed a toolkit⁵ to improve handover between shifts to ensure continuity of care for patients, thus maximising patient safety. This may be a useful reference if something similar is to be developed in hospitals here.

3. RCPI recommendations on implementation of EWTD

RCPI's recommendations on reducing working hours and the implementation of EWTD are underpinned by the following principles:

- Patient care should be the main objective and should not be compromised in any way.

⁴ http://www.rcplondon.ac.uk/sites/default/files/documents/rcp_parliamentary_briefing_ewtd_and_new_deal.pdf

⁵ <http://www.rcplondon.ac.uk/resources/acute-care-toolkit-1-handover>

- Professional development and training should be maintained and improved to run in parallel with a high standard of patient care.
- The post-take ward round should be preserved as the main focus for consultant-led professional communication and transfer of clinical responsibility with an emphasis on continuity of patient care, in-service teaching and learning.
- A reduction in the number of hours worked per individual NCHD will mean that additional individuals are required to do the work. These will need to be mainly, but not exclusively medical staff.

3.1. Patient Care

An important aspect of patient care that may be adversely impact by EWTD is the continuity of care, and handover between shifts. It is important that the limitations of handover must be recognised e.g. increasing numbers of shifts leads to increased handover which can increase risk. Patient safety should maintain priority, and details of cross cover and tiered on-call should be agreed taking this into account.

3.2. Training standards

As always, professional development and training should run in parallel with a high standard of patient care, because appropriate training, professional development, service continuity and patient outcome are critically inter-related.

It will be vital to ensure that training is not compromised by introduction of EWTD. Trainees must get adequate training hours and experience without extending the overall training period. We believe that the post-take ward round should be preserved as the main focus for consultant lead professional communication and transfer of clinical responsibility with an emphasis on continuity of patient care, in-service teaching and learning.

3.3. Duration of shifts and number of hours

The duration of shifts and number of hours worked by NCHDs must be reduced. RCPI recommends that the maximum on-call duration should be 24 hours. This period of on-call should be followed by a rest period of 16 hours. An average working week of 48 hours must be complied with, as per EWTD.

Shift preferences

The detail of how this is implemented may vary depending on the individual hospital size and configuration, and will have to take into account the view of

trainees. Results from RCPI's 2013 survey indicate that preferences as to shift duration vary between trainees.

- Almost 40% SHOs and 56% of SpRs expressed a preference for a 24-26 hour on-call period aiming to get home the following morning.
- 28% of SHOs and 20% of SpRs were in favour of working a 12-13 hour night shift for 7 days followed by 7 days off.
- 35% of SHOs and 27% of SpRs would prefer to work 12-13 hours night shift for 3-4 days, followed by 2-3 days off.

There is some indication that preferences vary between specialities. Almost half of paediatrics SHOs, for example, expressed a preference for a 12-13 hour night shift for 3-4 days followed by 2-3 days off; while a slight majority (43%) of SHOs in general medicine indicated a preference for the 24-26 hours shift. RCPI recognises that it is up to each individual hospital and speciality to determine the system that best fits its needs whilst maintaining quality in training and meeting curriculum content and competencies.

Night float system

In some larger hospitals, , a night float system may help to achieve EWTD compliance.

- Instead of working 24 or 36 hours shifts, each SHO would work one week of nights, followed by a week off approximately every 3-4 months during their training period.
- The SHO on call for the team for the day would work from 8am to 10pm and then go home with no further responsibility. There would be a period of handover between this SHO and the SHO working nights- who would work from 9pm to 9am.
- In the morning, formal rounds would be performed and patients admitted on call during the night would be handed over by the SHO working nights to the SHO on call that day (8am to 10pm).

The implementation of shifts like this may help to reduce the number of hours worked by each individual and result in the fall in the volume of activity worked by each individual. This would have negative consequences to outpatient lists, day to day ward care, endoscopy, echo, exercise stress tests etc. In order to maintain those services, it will be essential that extra medical and non-medical staff should be employed to backfill those individuals covering night float shifts. The fact that

less hours are worked per individual, and in particular, less overtime hours, means that there will be savings which could be utilised to employ extra NCHDs and other staff at the appropriate grade to allow services to be maintained. This model is cost efficient, in that the savings per individual may be used to employ more individuals to ensure patient care.

It should be emphasised that the above model may not be appropriate for all hospitals, and a ‘one size fits all’ approach is not advised.

Reassignment of tasks currently done by NCHDs

Reassignment of tasks performed by NCHDs is an essential element needed to achieve EWTD and will maintain patient care, reduce time worked by NCHDs, and allow more time for training. Suggested changes include phlebotomy teams, online blood test ordering, IV cannulation teams, upskilling Care Assistants to perform ECGs and reducing the amount of time spent on paperwork and unnecessary administration by Interns and SHOs.

Avoiding adverse unintended consequences

Implementation of EWTD needs to be observed and analysed in order to determine whether there are any adverse consequences on patients or doctors. A 2013 study on implementation of EWTD in Germany⁶ showed that changes in working conditions as a result of EWTD were not accompanied by reduced stress and risk of burnout for physicians. Instead, the data pointed to greater intensification of work.

This adverse phenomenon of ‘work compression’ has also been documented in the US when they reduced resident working hours⁷. Doctors are possibly doing more, in less time, for more and sicker patients. Novel ways of reducing workload e.g. advanced nursing practice etc. need to evolve to optimise training. Literature has also highlighted the possibility that time-pressured trainees would initiate excessive testing of patients (rather than take the time to fully examine them and interpret their findings appropriately).

⁶ <http://www.ncbi.nlm.nih.gov/pubmed/23423279>

⁷ <http://archinte.jamanetwork.com/article.aspx?articleid=1672290>

4. Conclusion

Ireland is currently in breach of EU regulations on the EWTD. NCHDs are working under great pressures and over long hours, and patient welfare is being endangered. The RCPI in its capacity as a major medical training body is committed to contributing to the solutions that will address these issues. Such solutions include some NCHDs working shifts, a night float system and the employment of additional staff including NCHDs. There may be opportunity to use money saved on overtime costs to fund additional staff to maintain current levels of service.

Repeated RCPI surveys have demonstrated considerable discontent and distress amongst NCHDs. This is contributing to significant medical emigration. Compliance with the EWTD must be implemented by the HSE and this will significantly improve the welfare and morale of NCHDs and contribute to the safety of patient care.
