

European Working Time Directive: Implementation across Europe and consequences upon training in obstetrics and gynaecology

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Abstract

Objective: To review the compliance of the European Working Time Directive (EWTD) in different teaching hospitals across Europe and its consequences upon training.

Study design: It is an observational, descriptive, cross-sectional study. The sample is constituted by the answers from trainees selected by the representatives of 29 European Network of Trainees in Ob/Gyn (ENTOG) member countries to a survey designed by ENTOG Executive. The survey content was based on a joint survey by the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College for Paediatrics (RCP), carried out in 2008, but adapted for use on a European level.

Results: An answer rate of 75% was obtained. Only 5 countries out of 29 were compliant with EWTD two months before the compulsory adherence. Countries needed to introduce 1 to 4 changes to the system to make the rotas compliant. Positive effect on work and private life balance was noticed in 87% from all responses. Trainees notice the need to further improve training programmes in order to have the same quality of training and continuous care of patients.

Conclusions: Steps forward to implement EWTD are being made. Trainees should be involved with the introduction to optimize training conditions under the EWTD. Countries that still struggle to introduce the directive may learn from countries that already are compliant. It is suggested to organize a survey on senior society level to gain additional information to further investigate the effects on training quality and patient care.

Key words: ENTOG, survey, European Working Time Directive, Europe, trainees.

Introduction

The European Working Time Directive (EWTD), lays down regulations considering minimum safety and health requirements for the organisation of working time, in respect of periods of maximum weekly working time, breaks, daily and weekly rest (Council Directive 93/104/EC, 1993).

The directive was first implemented in 1998. For certain professions, amongst which seafarers but also medical specialist trainees, special

arrangements were negotiated. However, by August 2009, specialist trainees should fully comply with the directive too. As historically junior doctors worked much longer hours during their training, changes to the working pattern in training would become necessary in order to comply with European law.

The interpretation of the directive particularly with respect to the definition of working time and time on-call for junior doctors was further clarified by the SiMAP (European Court of Justice, 1998) and

Jaeger judgments (European Court of Justice, 2003) of the European Court of Justice.

Key components of the directive are outlined below.

- The average working time for each seven-day period, including overtime, does not exceed 48 hours (a reference period equal or inferior to four months)
- Every worker is entitled to a minimum daily rest period of 11 consecutive hours per 24-hour period
- Every worker is entitled to a rest break when the working day exceeds six hours
- Every worker is entitled to a minimum uninterrupted rest period of 24 hours plus the 11 hours daily rest (reference period equal or inferior to 14 days)
- Every worker is entitled to paid annual leave of at least four weeks

The European Network for Trainees in Obstetrics and Gynaecology (ENTOG) realised in 2008, based upon contacts with national trainee associations and previous surveys by the organisation that a majority of European countries might not be fully prepared for the introduction of the directive.

A number of additional potential problems were identified. It was realised that focus on weekly working hours might defer attention from the effects of implementation on training conditions and work/life balance as well as service sustainability. Although the directive was designed with the welfare of the employee in mind, trainees and trainers alike were concerned that suboptimal training might be a negative consequence of the introduction. This was especially been voiced by some surgical specialities⁴ which did not include obstetrics and gynaecology. ENTOG decided to conduct a survey in spring 2009 assuming this would reflect the EWTD compliance status in August 2009.

The aim of the survey was twofold. The main aim was to map the current situation across Europe including different types of hospitals (university, big training hospitals and smaller district general hospitals). In addition, it was aimed to get the point of view and impression of trainees throughout Europe with regards to the effects of EWTD introduction on the training program and quality of training.

Methods and Materials

The survey was designed by the current ENTOG Executive, based on a joint survey by the Royal College of Obstetricians and Gynaecologists (RCOG,) and the Royal College for Paediatrics (RCP)⁴, carried out in 2008, but adapted for use on a European level (RCOG, 2009). Whereas the

RCOG/RCP survey was aimed at trusts and hospitals and included hospital visits alongside the survey we focused on trainees and sampled with a web-based survey only. It mainly consisted of multiple choice questions with some open questions. The following domains were included; compliance to the EWTD, effects on training and work/life balance. All ENTOG member countries (29) were invited to participate. This includes mainly countries from the EU but also some non EU countries like Turkey and Norway. It was realised that situations within countries might be very diverse and, amongst others, depending on hospital size and trainee pool. Therefore it was decided to seek answers from differently sized hospitals. Three answers per country from three different trainees were requested; one from a university hospital, one from a big training hospital and one from a smaller district hospital. To confirm to size of hospital the number of deliveries per annum was requested. All together 87 answers were expected from 29 countries. Not all countries have training facilities in all three types of hospitals described above, in which situation fewer answers were accepted. If no answer was obtained after reminders, the national trainee networks were contacted to facilitate completion of the survey in their country.

The survey was sent out to all ENTOG member networks for national distribution in early 2009. The preliminary results were presented in Budapest, Hungary during the XIX European meeting and exchange program of trainees in obstetrics and gynaecology.

Results

The total number of answers is 52 from 22 countries, corresponding to a 75% response-rate: Belgium (Be), Bulgaria (Bg), Czech Republic (Cz), Denmark (Dk), Estonia (Ee), Finland (Fi), France (Fr), Germany (De), Greece (Gr), Hungary (Hu), Italy (It), Latvia (Lv), Malta (Mt), Norway (No), Portugal (Pt), Slovakia (Sk), Slovenia (Si), Spain (Es), Sweden (Se), The Netherlands (NI), Turkey (Tr) and United Kingdom (Uk). On average, 2.4 answers per country were obtained. The answers were distributed evenly across Europe.

Answers divided as follows: 50% of answers were from university hospitals, 30, 7% from district general hospitals and 19, 2% from big teaching hospitals. It should be mentioned that some countries lack small training hospitals and rendering this number slightly lower.

At the time of survey five countries were already nationally compliant or mentioned to be nationally compliant in August 2009 (Dk, De, Mt, Se, NI). Some countries were or would be locally compliant

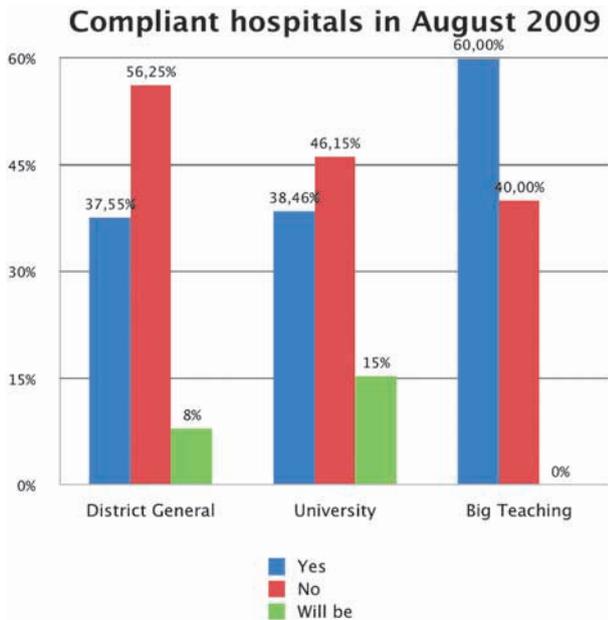


Fig. 1. — Shows the EWTD compliance status in different types of hospital.

in August 2009 (Gr, It, Si, UK, Ee, Fi, No). Es, Be, Bg, Cz, Fr, Hu, Lv, Pt, Sk and Tr were not compliant during the survey on neither national nor local level and would not reach compliance in August 2009. (Fig. 1)

From the total of 52 answers received, 10/26 (38%) of the university hospitals and 6/16 (37,5%) of the district general hospitals were compliant. From the large teaching hospitals 6/10 (60%) were compliant. No relation was found between the size of the hospital and the compliance with EWTD, with

12/32 (37%) of hospitals with less than 3000 deliveries annually compliant and 9/19 (47%) of hospitals over 3000 deliveries.

The trainees noticed one to four structural changes in the hospital/training program to achieve compliance with EWTD. This number is rather low due to the fact that some hospitals were already compliant on national levels for a long time already and therefore did not need any changes altogether. Hospitals that are currently compliant introduced the following changes in reducing frequency; redesign of rota (29%), extra junior doctors (16%), other professionals (midwives e.g.) taking over junior doctor jobs (12%), less doctors on call simultaneously (12%), restructuring of training (6%), consultants resident on call (3%) (Fig. 2).

Hospitals that were currently not compliant saw the following changes as likely necessary: redesign of the rota (23%), restructuring of training (25%), more junior doctors (18%), consultants more hands on work (18%), midwives/ others taking over the doctor jobs (10%).

The questionnaire enquired into specific effects EWTD had or could have on training. Respondents were able to select more than one option if desired. Positive changes included a better work/life balance (85%) and more consultants available in out of hours (15%) (Fig. 3).

Negative consequences were noticed as well, including less exposure to special interest sessions (22%), less possibility to attend meetings (18%), less continuity of care (14%), less flexibility in the rota (14%), busier on calls due to a reduced number of trainees on call (12%) and relatively more time spent

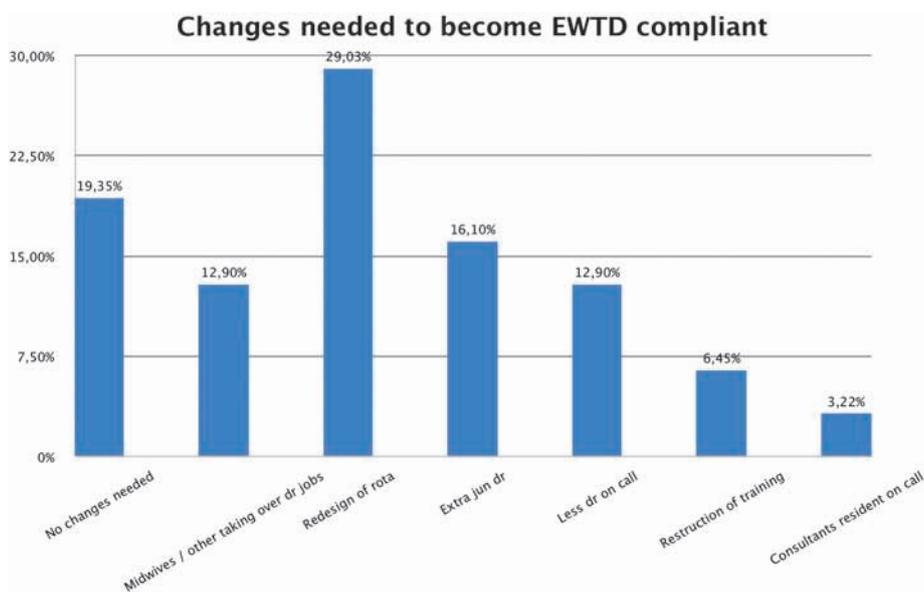


Fig. 2. — Shows the expected changes needed to implement EWTD with current rotas

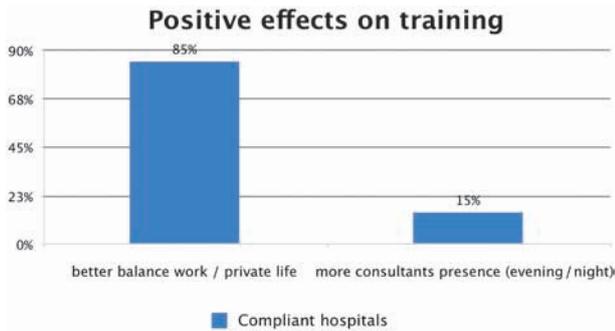


Fig. 3. — Shows the positive effects noticed by trainees who are working under EWTD.

out of hours (10%). Countries that had already introduced the EWTD/ a similar national system in the past were mainly neutral (no positive nor negative changes), presumably as they were unable to compare with a previous system.

When specifying into current compliance/future compliance, it was noted that presence of negative changes was more pronounced in countries that were already compliant. The survey enquired into suggestions to optimise training with reduction of working hours.

Hospitals/countries that are compliant with the EWTD should in trainees’ opinion:

- introduce more dedicated training sessions (31%)
- set up regular labour ward drills (21%)
- reduce administrative tasks (21%)
- set up laboratories to train operative skills (17%)
- prolong duration of training (7%) or reduce service provision (3%) (Fig. 4).

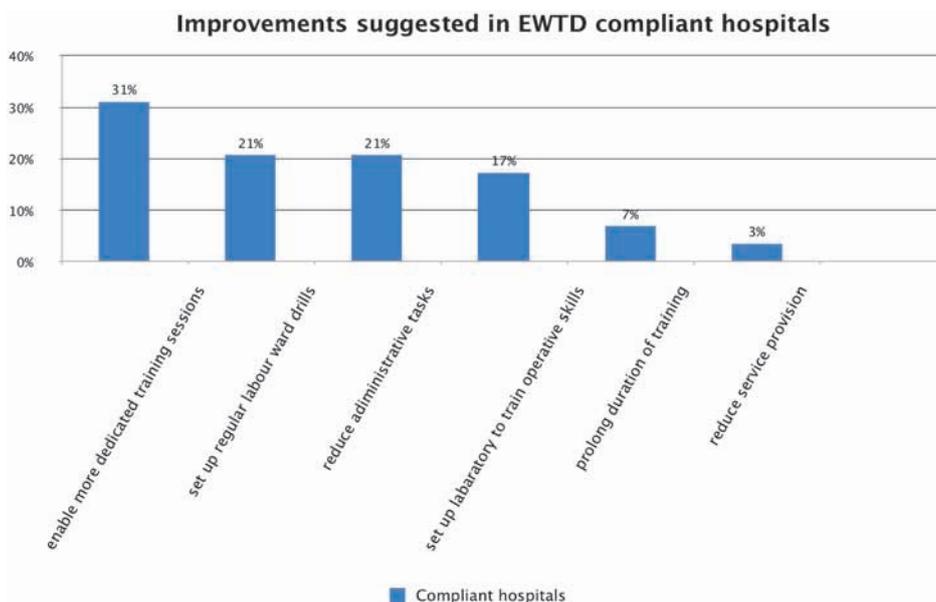


Fig. 4. — Recommendations how to further improve training with working hours allowed by EWTD

Their current rota is considered workable for over 80% of trainees. Trainees in hospitals that were working already under EWTD and those who would be in August felt that their quality of life has improved or will be improved with EWTD (86%). In some countries it was feared that in spite of the EWTD many more hours will be worked due to incorrect documentation of worked hours.

The rota was monitored for compliance with EWTD in nine out of ten countries, predominantly locally.

Most trainees work additional hours on a weekly basis. In the hospitals that are working compliant with EWTD this is less (average 8h/week) than in hospitals not compliant (average 13h/week).

Different countries used different bodies to introduce the EWTD (or a similar law). Answers varied between local initiative (five) and national medical association (seven).

In some countries trainees were involved in the introduction of the EWTD, which can optimise the workability and reduce negative impact on training. This was the case in 12 out of 22 countries (in 17 out of 52 hospitals).

Discussion

The EWTD is an important issue. It involves minimum health and safety requirements for doctors and therefore directly relates to patient safety. It has implications for the amount of hours spent on the working floor and therefore for the amount of time available for training and/or service provision. This survey, carried out just before the EWTD was

introduced in August 2009, aimed to sample the implementation of the directive in Europe, the implications for training and quality of life. The latter has been shown to be one of the most important criteria by choosing the specialty (RCOG, 2006; Jackson *et al.*, 2003).

The most important observation is that just a few months prior to the legally required implementation of the EWTD most countries and most training hospitals were not prepared for its introduction; not on paper and not in practice. 43% of countries were not compliant and had not planned changes leading to compliance in the future. In only 33% countries were nationally compliant, some already for a long time due to similar or even stricter national legislation.

The response rate was 75% of ENTOG member-countries, with an average of 2.4 answers per country. As there was a good representation of countries across Europe, including different types and sizes of hospitals, the survey should give a good reflection of the situation in Europe up to June 2009. No relation was found between the size of the hospital and the compliance with the EWTD. Neither was there a relation between the type of hospital and compliance.

Most countries that were now compliant had to introduce various changes to the working pattern. The 'Big three' very significantly mentioned: redesign of rota, more junior doctors and restructuring of training. This indicates that most countries struggled to reduce working hours without affecting training quality.

These results are compatible with the results of the 'children's and maternity services in 2009: working time solutions from the UK' in 2008 which showed that most hospitals there needed two to four 'initiatives' to achieve compliance. Most frequently cited were 'redesign of the rota' and 'application of more medical staff' (RCOG, 2009).

Trainees who work under the EWTD did note a positive change in work-life balance. They also specified various negative effects on training quality due to the EWTD introduction. It is therefore extremely important to consider effects on training of planned changes and to look into possibilities to create and optimise training moments. It was worrying to note that currently non-compliant hospitals seemed less worried regarding possible negative consequences of introduction of the directive.

Most if not all trainees work extra hours to finish off work. It is interesting to see that trainees within a EWTD compatible rota seemed to work less additional hours than trainees not compliant with EWTD. It is a positive development that under the EWTD trainees seem more able work in agreement to their scheduled hours. It is due to these 'grey hours' that trainees in some countries were very sceptical

and feared that the EWTD in their country might be implemented on paper only. This is a sign that should be taken seriously. Therefore adherence to the EWTD should be recorded, including overhours, ideally by an independent body on (inter) national level.

In most countries trainees were not involved in the process of the EWTD introduction. It is felt that this is suboptimal in view of the significant effects this law has on training quality and rota. Trainees should actively seek involvement to guarantee optimal training prerequisites such as reducing the administrative workload or the introduction of more training dedicated sessions. The opt-out of the EWTD is limited in duration and adherence therefore is not optional. It is important that a good strategy has been found prior to forced introduction.

As most countries struggle with the same problems regarding the directive, it is important for currently non-compliant countries to learn from countries which already (successfully) introduced it into the specialist training programmes. It is felt however that several remaining questions can only be answered at senior level. These include financial aspects, long term effect on care of patients and training quality etc of the EWTD introduction and supposed barriers to the implementation. This would require a survey on senior level.

Ultimately EWTD does not only protect employees (trainees) but it will also increase patient safety, as a fit doctor is a better doctor. What happens today will define the skills and knowledge of tomorrow's specialists.

Ethics

No ethics approval was needed.

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