

Is 48 hours enough for Obstetrics and Gynaecology training in Europe?

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Abstract

The European Working Time Directive, implemented by the European Union (EU) in 1993, was adopted in the medical profession to improve patient safety as well as the working lives of doctors. The Directive reduced the average amount of hours trainee doctors worked to 48 hours per week. However, its adoption has varied throughout the EU. Its potential effect on both the quality and total amount of hours of training has caused concern. This monograph presents data on Obstetrics and Gynaecology training in Europe obtained from several of the European Network of Trainees in Obstetrics & Gynaecology's (ENTOG) surveys. The monograph demonstrates large variations in training and explains the difficulties in ascertaining whether 48 hours of training a week is sufficient to become an Obstetrics and Gynaecology specialist in Europe.

Key words: Training, obstetrics, gynaecology, European Working Time Directive, ENTOG.

Introduction

Trainee doctors have traditionally provided health-care around the clock, frequently far exceeding working hours that were deemed safe for both patient and doctor. Excessive working time has been found to be a major cause of stress, depression and illness in doctors and their sleep deprivation has been linked a decline in performance (Pilcher & Huffcutt, 1996; Alhola and Polo-Kantola 2007; Sharpe, Koval et al. 2010).

In order to improve the safety and health of employees, the European Union implemented the European Working Time Directive (EWTG) in November 1993 (Council Directive 93/104/EC). The Directive ensured the employee's right to a minimum period of rest, paid breaks and annual leave in addition to an average weekly working time of a maximum 48 hours over a four-month period. Interpretation of the Directive with regards to the working hours of trainee doctors was further clarified by the

SiMAP (European Court of Justice, 1998) and Jaeger judgements of the European Court of Justice (2003).

The Directive stipulated that trainee doctors were no longer allowed to work a 24-hour period without a rest period of 11 consecutive hours and rest breaks had to be ensured when working more than six hours. In addition to 11 hours of rest a day, a minimum rest period of 24 consecutive hours had to be provided in every fortnight.

The Directive was officially implemented in 1998, however, its adoption varied largely throughout the various professions and European countries. The medical profession requested a phased introduction and many European countries requested an extension for full implementation. The Directive was received with mixed opinions and although largely campaigned for by several national associations for trainee doctors, the reduction in working hours left many concerned regarding the quality of training.

In many of the specialties concerns were raised regarding the reduction in training time and opportunities (Moss et al., 2011; West et al., 2007; Bowhay, 2008; Fernandez & Williams, 2009). Surgical specialties reported a reduction in surgical training experience and competence since implementing the EWTD. In order to remain compliant, rotas that required day and night trainee doctor cover were found to have a reduction in their day time working hours which consequently resulted in a reduction in theatre attendance.

A joint report published in 2009 by the Royal College of Obstetricians and Gynaecologist (RCOG) and the Royal College of Paediatrics and Child Health (RCPCH) highlighted that in order for units to become compliant, many UK hospitals had needed to apply more staff either at trainee or specialist level had redesigned their rotas or had restructured their services.

An independent government review published in 2010 (The Temple Report, 2010) assessed the impact of the EWTD on the quality of training in the UK. The report concluded that high quality training could be delivered in 48 hours in a consultant-delivered service with reduced trainee service delivery and increased supervision and training opportunities. Similar conclusions were drawn in studies from other European countries such as Germany (Friedrich et al., 2011) and the Netherlands (Sprangers, 2002).

As of August 2009 all European trainee doctor rotas should have been compliant, yet many countries have yet to adopt the EWTD within the medical profession.

In order to answer the question “Is 48 hours enough for Obstetrics and Gynaecology training in Europe?” the current compliance and training structures in each of the European countries needed to be assessed. On reviewing the literature, very little has been published comparing the training programmes in Obstetrics and Gynaecology throughout Europe.

ENTOG Surveys

The European Network of Trainees in Obstetrics and Gynaecology (ENTOG) performed several surveys over the last decade to collect data regarding post-graduate Obstetrics and Gynaecology training in its member countries (Axelsen et al., 1999; Rodriguez et al., 2009; Pargmae et al., 2011). ENTOG currently consists of 29 European member countries including Austria (AT), Belgium (BE), Bulgaria (BG), Cyprus (CY), Czech Republic (CZ), Denmark (DK), Estonia (EE), Finland (FI), France (FR), Germany (DE), Greece (GR), Hungary (HU), Iceland (IS), Ireland (IE), Italy (IT), Latvia (LV), Lithuania (LT), Malta (MT), The Netherlands (NL), Norway (NO), Poland

National Number of Obstetric and Gynaecology Trainees

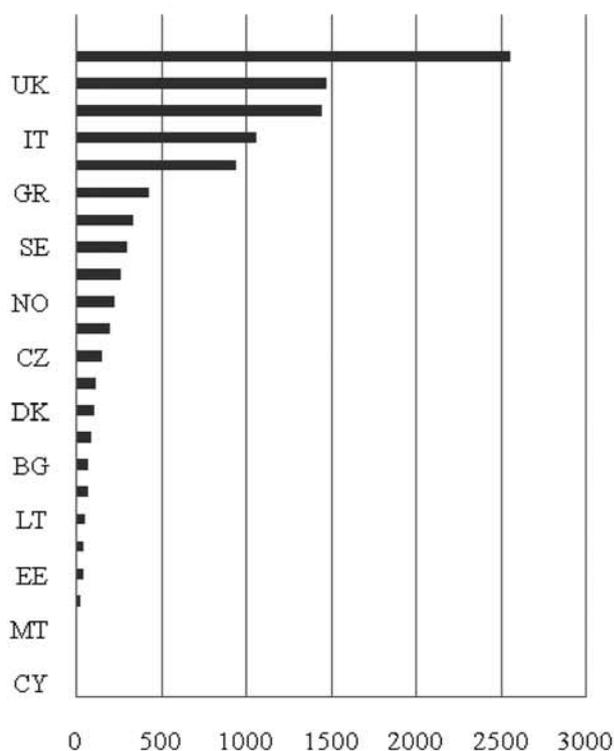


Fig. 1. — Number of trainees per country

(PL), Portugal (PT), Romania (RO), Slovak Republic (SK), Slovenia (SL), Spain (ES), Sweden (SE), Turkey (TR), United Kingdom (UK). Each member country has an established national trainee network and an appointed ENTOG representative.

ENTOG’s latest surveys performed in 2011 were designed by the ENTOG Executive and consisted of a combination of multiple choice and open-ended questions. One of the surveys was electronically sent to each of the 29 ENTOG country representatives of which 24 responded. The other survey was distributed to the trainees that were selected by their national networks to attend the annual ENTOG exchange held in the UK in May 2011. Twenty four of the 29 countries were involved in the exchange and each provided responses to the survey.

The results of the surveys demonstrated a large variation in national trainee numbers ranging from nine trainees in Cyprus to 2560 trainees in Germany (Fig. 1). In the majority of the countries trainees were appointed by their government or national training programmes. However, several countries did not have fixed national training posts and appointed trainees according to the requirements of the individual department.

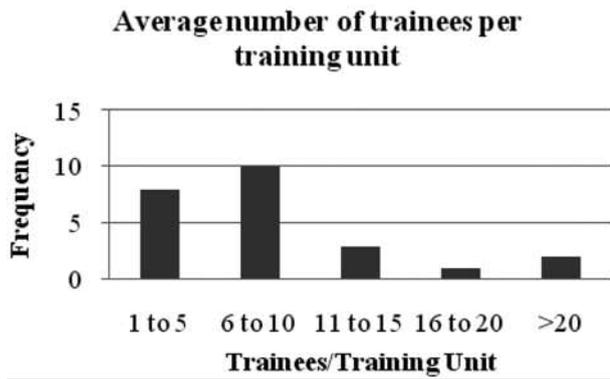


Fig. 2. — Average number of trainees per training unit

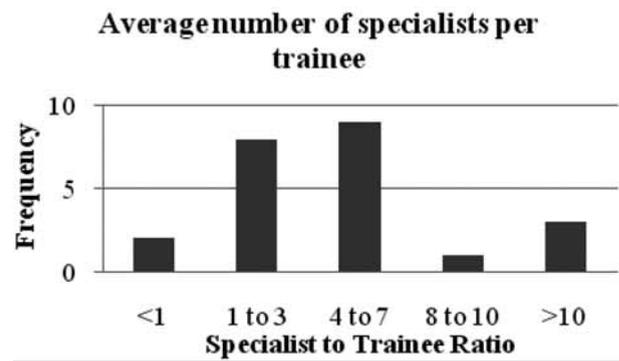


Fig. 3. — Average number of specialists per trainee

The survey demonstrated large disparities amongst the 24 countries in the average number of trainees per training unit (Fig. 2) as well as the specialist to trainee ratio (Fig. 3). Countries such as Belgium, Bulgaria, Cyprus, Denmark, Germany, Ireland, Slovak Republic and Slovenia were found to have on average between one and five trainees per training unit in comparison to Italy and Lithuania that reported an average of more than 20 trainees per training unit. Bulgaria, Estonia, Latvia, and Lithuania reported the highest specialist to trainee ratio (>8:1) whilst countries such as Italy and Malta were found to have more trainees than specialists. The variations in these ratios highlighted the contrasting degrees of service commitments incorporated into the trainee's clinical training programmes.

Half of the trainee representatives reported receiving a great deal of one-to-one supervision throughout their training. Four country representatives (17%) reported their trainees receiving supervision 'as required' whilst eight countries reported rare or no one-to-one supervision (33%).

The European Board and College of Obstetrics and Gynaecology (EBCOG) recommend that basic training should consist of a five-year training programme. The ENTOG survey revealed large variations in the duration of training throughout Europe ranging from three years in Romania to seven years in the United Kingdom and Ireland. Nineteen of the 24 countries (79%) were either compliant or had longer training programmes than recommended.

An ENTOG survey performed in 1997 demonstrated that only seven of the then 13 member countries used logbooks to record progress in training, list procedures performed and document participation in teaching programmes in accordance with recommendations from their national societies (Axelsen et al., 1999). Since that survey, EBCOG developed and accredited a postgraduate core training programme and logbook which was designed to be a platform on

which individual European countries could develop national training programmes that would meet the EBCOG training standards. In ENTOG's latest 2011 survey, all of the 24 countries reported having a national logbook and only one reported not having a national curriculum.

Despite the marked progress towards standardisation of training, the 2011 ENTOG survey demonstrated continuing large variations amongst the methods and timing of trainee assessments. The majority of the training programmes included examinations (87%) although these varied largely in timing and style. The survey revealed a mixture of annual, modular and exit examinations some of which were set by an individual department and others by national societies. The examinations themselves were either practical (involving live operating) or theoretical with either written and or oral components. Continuous assessment was demonstrated in 71% of the national training programmes although the type of assessment varied from the traditional numbers based (42%) to competency based (25%) or a combination of both (33%).

EWTD Survey

In the run up to the August 2009 deadline for EWTD compliance amongst trainee doctors, ENTOG designed a survey based on the 2008 joint survey by the RCOG and RCPCH to assess compliance of various teaching hospitals across Europe (Pargmae et al., 2011). The survey predominantly consisted of multiple choice questions with some open questions and evaluated domains such as compliance to the EWTD as well as effects on training and work/life balance. The survey was sent out in early 2009 to all ENTOG member networks who then distributed it nationally. Responses were requested from university hospitals as well as from large and small district general teaching hospitals. Fifty-two responses were

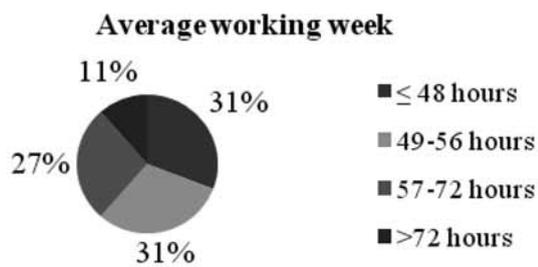


Fig. 4. — Average working week

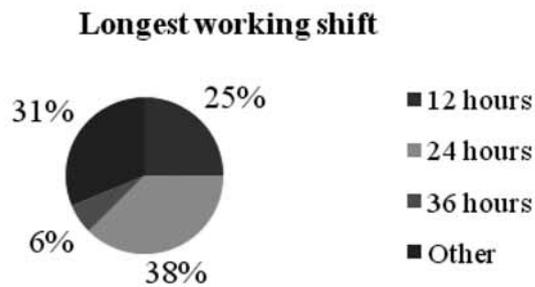


Fig. 5. — Longest working shift

received from 22 countries (75% response rate). The results demonstrated that 43% of the countries were not compliant and had not planned changes leading to compliance in the run up to the August deadline. Only 33% were found to be nationally compliant, some of which had been so for some time due to their stricter national legislations.

In keeping with the findings of the 2008 joint RCOG/RCPC survey, the ENTOG EWTD survey found that the predominant changes made within units to become EWTD compliant included re-designing of the rota, employment of more medical staff as well as redistribution of the trainee doctor's role.

Interestingly, trainees working within EWTD compliant hospitals felt that their training would be optimised by the introduction of dedicated training sessions including labour-ward drills and dry laboratory operative skills training. A reduction in administrative tasks as well as general service provision was also suggested. However, only 7% of the EWTD compliant hospitals suggested a prolongation of training to improve the quantity of training following the reduction of weekly training hours.

National EWTD compliance was reassessed in ENTOGs 2011 survey. Each of the 29 ENTOG country representatives was asked to comment on the average number of hours worked by the trainees throughout their country. Only 31% of the 24 country responses were found to be compliant with the EWTD and unfortunately 11% reported regularly working more than 72-hour weeks (Fig. 4). Although a third of the countries were compliant to the 48-hour working week, only a quarter of the 24 countries adhered to working no longer than 12-hour shifts (Fig. 5).

Discussion

The question of whether a 48-hour working week is enough for trainees to be trained to become specialists in Obstetrics and Gynaecology is a long-standing question that has sparked a great deal of worldwide debate. Although studies suggest that the reduction

in working hours for doctors in training does not compromise patient safety or training (Cappuccio et al., 2009; Moonasinghe et al., 2011) many still feel that the new generation of trainees are missing out on essential clinical exposure.

Standardising doctors training in Europe has been a longstanding quest and the Mutual Recognition Directive in the 1975 EC Treaty insisted on the recognition of European medical diplomas in each of the member states (Council Directives 75/362/EEC). Despite an update on the Council Directive in 1993 (Council Directive 93/16/EEC), the original Co-ordination Directive which advocated the need for minimum education and training required for the award of a mutually recognised diploma has yet to be fully implemented.

The ENTOG surveys have highlighted that in addition to the large variation in compliance amongst European trainee's rotas, other and potentially more important training discrepancies remain. Large inconsistencies remain in styles and duration of training programmes as well as amount of service commitments run by trainees. Considerable variations remain in the degree of supervision offered as well as the style and number of assessments delivered throughout the training. The effect of the various national health care infrastructures on training has not been assessed nor has the degree of training received from other multidisciplinary health care professionals such as midwives and nurses.

Another challenge in assessing whether 48 hours is enough for training Obstetrics and Gynaecology trainees throughout Europe is the difference in requirements from trainees at the end of their training in each individual country. Countries such as the United Kingdom and the Netherlands expect their newly appointed specialists to be independent practitioners within their unit, whereas graduating trainees in Poland and Hungary are appointed as junior specialists into units with a great deal of support and supervision from their senior specialists. This significant discrepancy highlights the current difficulties in recognising all European medical diplomas as equal and in allowing the free movement of newly

appointed specialists throughout the European member states without the need for further educational requirements.

Despite several European countries having been EWTD compliant for numerous years, there is not enough published data available to confirm whether or not the 48-hour working week is enough for training Obstetrics and Gynaecology trainees throughout Europe. Unfortunately, at this stage it is difficult to predict the more subtle changes in the new training programmes throughout Europe and only time will tell whether the new generation of doctors will become confident, competent specialists using the skills and experiences they have acquired in their EWTD compliant training.

This monograph highlights that the quality of training cannot be measured by the quantity of working hours alone. In order to evaluate the quality of Obstetrics and Gynaecology training programmes in Europe, one must appreciate their individual objectives as well as their methods of delivering and assessing the training. Future surveys are required to understand the requirements of newly appointed specialists in each of the European countries in addition to re-audits of their current training programmes.

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