

Surgical Training in the UK and the European Working Time Directive

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Opinion

Since the inception of the United Kingdom National Health Service (NHS) in July 1948 this system of ‘socialized’ medicine, in spite of its many problems, has served the British people well. As one might expect over more than 70 years there have been numerous changes and innovations, many of which were responses to political initiatives.

Perhaps few changes have been more profound in their effect and some would say even detrimental than the introduction of the European Working Time Directive (EWTD), imposed on the UK by the European Union in October 1998. Initially the ruling applied to Consultant staff but in 2004 was extended to cover junior doctors with a reduction in working hours to 56 per week at first but then reduced to 48 hours in 2009. It was also stipulated by the European Court of Justice that there should be protected rest periods and time spent on-call at the workplace classed as work.

There were immediate concerns voiced by the profession that such a drastic restriction in working practices and hours spent in working and training would have a profoundly adverse effect on both the quality of care delivered to the patient and to the training of junior surgical staff.

Undoubtedly the motives behind the introduction of the EWTD were sincere with the Health and Safety objectives of reducing both doctor fatigue and consequent risk of clinical error. There would however seem to be little doubt that such restrictions, although appropriate for the regulation of many professions and working practices, were not well suited to the demands of a complex hands-on craft based specialty such as surgery where the hours spent in apprentice training were paramount to the objectives of delivering high quality clinical care and producing a newly trained surgeon capable of undertaking safe, high quality independent clinical practice.

There have long been concerns about the length and quality of surgical training in the NHS with the introduction of time-limited surgical training in 1994 following the Calman report [1] but few could have anticipated the drastic changes which would follow the implementation of the EWTD in its present form.

John Black, the President of Royal College of Surgeons of England has been one of the Directive’s most vocal critics and was in no doubt that it would inevitably result in a reduction of skill levels of future surgeons [2].

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Can surgeons be trained in a 48 hour working week?

Trainees are gaining less hands-on surgical experience than previously and as in most series procedural outcomes are directly correlated with the number of procedures performed, this is indeed a worrying development.

Another unwanted effect of these restrictions in working practices has been the necessity to introduce rota and shift systems into the working of surgical teams.

This fundamental change is likely to have a detrimental effect on trainee experience and training and also profoundly disturb the concept of continuity of care, so essential in the demanding clinical work place of surgery. It also introduces the problematic issue of effective and informative handover between shifts.

The problem is compounded by the need to frequently recruit locum doctors to fill gaps in the rotas.

Traditionally the 'firm' system headed by a consultant, working with a junior team in a hierarchal team system, has been capable of delivering the highest quality of clinical care, education and junior staff training all within a framework with a clear chain of command. This excellent scheme with a proven track record is now under direct threat from the above EWTD changes and soon may become extinct.

Of course the move to reduce the often excessive hours worked by junior surgical staff is not unique to the UK. Similar steps have been implemented throughout mainland Europe, with it must be said variable interpretations of the precise rulings of the EWTD.

In the UK there is a potential 'opt out' clause which might allow trainees to work beyond their contracted hours. This has become something of a minefield with many questions being asked about indemnity cover and the risk of litigation.

Also, in the USA there have been drastic reductions in the working hours of young surgeons although it would seem that the usually quoted 80 hours per week might be more reasonable for the demands of surgery.

There is probably no 'turning the clock back' and today it is imperative that surgical training remains increasingly focused so that the trainee can gain the maximum teaching and experience from his time in the junior grades, in spite of the reduced hours of clinical exposure. Although there would be considerable opposition within the profession, especially from the trainees, perhaps the overall length of surgical training may ultimately need to be extended.

With this pragmatic, targeted and realistic approach, maybe supplemented by simulation technology [3], hopefully the problems can be overcome and we will continue to produce the very best and competent surgeons for tomorrow.

References

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