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## Editorial

## The European Working Time Directive: A practical review for surgical trainees

## A B S T R A C T

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The European Working Time Directive (EWTD) 2003/88/EC is a Union Directive laying down minimum health and safety requirements for the organisation of working time. Originally primarily intended as labour law, its progressive introduction up to full implementation for doctors-in-training in August 2009 has substantially reduced duty-hours and caused widespread concern in surgery. Detrimental effects on the continuity of patient care, reduced availability of medical staff with associated rota difficulties, and the reduction in time for training junior doctors have been widely cited. Craft-specialities such as surgery and those providing an acute service have faced particular challenges. This review offers a practical guide for surgical trainees, explaining the European regulations in the context of current terms and conditions of doctor's employment in the UK. Information is provided on protecting training, opting-out, seeking remuneration for this, and ensuring doctors and patients are protected with appropriate medical indemnity cover in place.

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## 1. Introduction

The European Working Time Directive (EWTD) is European-wide legislation setting out minimum health and safety requirements for the organisation of working time.<sup>1</sup> This includes defining the legal parameters for minimum rest-breaks, working hours, holidays and night-time work. Since August 2009 the Directive has been fully implemented for doctors in training, leading to widespread changes in work patterns and numerous concerns regarding the effects on patient care, medical staffing, and reduced clinical experience.

This document aims to provide a simplified, practical guide specific to surgical trainees, giving an overview of the relevant issues, answering some of the most common queries, and setting out EWTD and UK 'New Deal' law as it currently stands.

In preparing this document we have brought together the latest advice from a range of organisations, including the surgical Royal Colleges, the British Medical Association (BMA) and NHS Employers. Where their advice is unclear we have sought to clarify this and the outcome of our correspondence forms the basis of this guide. Where ambiguity remains we have highlighted this.

What this guide cannot do is give recommendations about what is right for individual surgical trainees. A decision to opt-out of the EWTD remains a personal choice. What is important is that trainees fully understand the risks and benefits of doing so – and equally of not doing so, and continuing to work or train beyond the allotted hours.

If having read the information provided here surgical trainees remain in any doubt about these issues it is important to seek further guidance. This may mean contacting relevant professional associations such as the Hospital Consultants & Specialists Association or the BMA. Your indemnity organisation may also be able to offer more specific advice.

The bottom-line is that trainees need to be pro-active in protecting training while at the same time remaining professional and ensuring patient safety. Trainees also need to be pro-active in ensuring they are contractually safe and legally indemnified for the hours actually worked and training undertaken in these.

## 2. Background to the EWTD in surgery

*"We got into this mess because a group of professional people, surgeons, have had their hours of work defined for them by others with little or no knowledge of the work concerned"* John Black, President of the Royal College of Surgeons of England<sup>2</sup>

Following its original adoption in November 1993, the final stage of the European Working Time Directive was introduced for doctors-in-training in August 2009. This ended the special 9-year transition period originally established for junior doctors in 2000. Since then we have seen the introduction of an interim 58-h average working week from 1 August 2004, 56-h from August 2007 and now 48-h.

Medicine is a heterogeneous profession and surgery, as a craft-speciality providing acute care, is particularly affected by working-time restrictions. Surgical trainees remain opposed to this restriction of working hours.<sup>3</sup> The reasons for this are numerous. Patient safety can be jeopardised through reduced rota cover, multiple handovers, and a lack of continuity in patient care as highlighted in recent coroner's inquest findings. In the longer term, reduction in training opportunities and the inevitable focus on service provision will impact on the clinical and operative experience of surgical trainees. The assertion that EWTD is essential health and safety legislation for doctors-in-training is disingenuous given that the resulting shift work results in more irregular hours of shift-work

and longer periods of on-call. In surgical specialities this does not result in well-rested doctors or the healthier work-life balance that some have sought to promote.<sup>4,5</sup> The effects of the sleep deprivation seen with on-call shifts on surgical proficiency are controversial, with studies demonstrating conflicting results.<sup>6–17</sup>

Although a cross-speciality systematic review of postgraduate medical education and patient outcomes following a reduction in working hours in the UK was inconclusive,<sup>18</sup> the specific reduction in surgical training opportunities has been widely documented.<sup>19–23</sup> Furthermore, many hospitals and specialities in the UK have not been able to fully implement compliant rotas, and many surgical trainees and hospital units disregard it.<sup>24</sup> This has led to the rise of the ‘grey rota’ whereby actual hours of work bear little resemblance to those set out on any official rota.<sup>25</sup>

In the United Kingdom these concerns across the medical profession culminated in the Secretary of State for Health inviting Medical Education England (MEE) to arrange a review of the impact of the EWTD on training. This was chaired by Professor Sir John Temple and reported in May 2010.<sup>26</sup> Amongst the findings, rota compliance with EWTD was universally highlighted as problematic and a decrease training opportunities was confirmed through the move to shift work, with a decrease in opportunities for interaction with trainers and loss of continuity in patient care. The recommendations are listed in Table 1.

Similar concerns have been raised in other European countries<sup>27</sup> and the Section of Surgery of the European Union of Medical Specialists (UEMS) has published a position statement stating that the working time directive is “in direct and severe conflict with former EU legislation to train competent surgical specialists”.<sup>28</sup> The UK General Medical Council (GMC) also commissioned a qualitative research report investigating the impact of the implementation of the EWTD, which was presented in April 2011.<sup>29</sup> This concentrated on the opinions and experiences of European regulators and speciality societies and confirmed widespread concerns surrounding the directive’s negative effects on training.

In the UK the NHS and medical profession have had a many years to prepare for the introduction of the EWTD. Surgical trainees have watched the Department of Health’s implementation schedule closely during this time, however to-date no significant initiatives have been introduced to compensate for the loss of training time. Given that the introduction of any compensatory changes will now inevitably take several years to establish, surgical trainee groups continue to call for the current legislation to be repealed in order that the patients of today get the first-class care they deserve.<sup>30</sup>

The Association of Surgeons in Training have recommended a maximum average working week of 65-h.<sup>31</sup> Similarly, a national trainee survey by the Royal Australasian College of Surgeons’ Trainees Association suggested a 60-h week provided an appropriate balance for ‘technical’ and ‘non-technical’ training needs.<sup>32</sup> Both are still some way behind the 80-h limit imposed on surgical training in the United States by the Accreditation Council for Graduate Medical Education (ACGME) in 2003.<sup>33</sup>

Currently, the EWTD is undergoing scheduled review in the European Parliament and the outcomes from this are awaited.

**Table 1**  
Recommendations from the Temple report “Time for training: a review of the impact of the European Working Time Directive on the quality of training”.<sup>26</sup>

<ul style="list-style-type: none"> <li>• Implement a consultant delivered service</li> <li>• Service delivery must explicitly support training</li> <li>• Make every moment count [in training]</li> <li>• Recognise, develop and reward trainers</li> <li>• Training excellence requires regular planning and monitoring</li> </ul>
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**3. EWTD and ‘New Deal’ rules**

The terminology used to describe shifts, workers and working time relating to the EWTD is specific and explanations are provided in Table 2. There is frequent confusion over the rules governing junior doctor’s working hours. There are two relevant areas of legislation:

1. Working Time Regulations (the UK implementation of the EWTD)
2. ‘New Deal’ Contract (the UK junior doctor employment contract)

Current legislation limiting working hours, together with mandatory breaks and rest periods, are now formed by a combination of these. Whilst the New Deal only applies to junior doctors, the EWTD applies to all staff (including Consultants). Some exclusions to the EWTD still apply for those working in the armed forces and emergency services in certain circumstances. The key points of the New Deal and EWTD legislation are outlined in Table 3.

*3.1. What counts as EWTD work?*

As well as carrying out your normal duties, your working-time includes job-related training, job-related travelling time, paid and some unpaid overtime, or time spent ‘on-call’ (note: non-resident on-call doctors only count the hours actually spent working as ‘work’).

If you work two jobs you can either consider signing an opt-out agreement with your employers if your total time worked is over 48-h or reduce your hours to meet the 48-h limit.

*3.2. SiMAP and Jaeger case law*

Since the implementation of the EWTD several important areas regarding what counts as ‘work’ have been clarified by case law at the European Court of Justice.

The SiMAP ruling related to whether time spent on-call, whether working at the place of employment or away from it, counted as working-time. The Court judged that any time a doctor is on-call counts as working time if the doctor is present at the place

**Table 2**  
Relevant EWTD definitions.

Term	Definition
Working time	Any period during which the worker is working, at the employer’s disposal and carrying out his activity or duties, in accordance with national laws and/or practice.
Rest period	Any period which is not working time.
Night time	Any period of not less than 7 h, as defined by national law, and which must include, in any case, the period between midnight and 05.00.
Shift work	Any method of organising work in shifts whereby workers succeed each other at the same work stations according to a certain pattern, including a rotating pattern, and which may be continuous or discontinuous, entailing the need for workers to work at different times over a given period of days or weeks.
Shift worker	Any worker whose work schedule is part of shift work.
Adequate rest	Means that workers have regular rest periods, the duration of which is expressed in units of time and which are sufficiently long and continuous to ensure that, as a result of fatigue or other irregular working patterns, they do not cause injury to themselves, to fellow workers or to others and that they do not damage their health, either in the short term or in the longer term.

Adapted from Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time. Official Journal L 299, 18/11/2003 P. 0009 - 0019 [http://eur-lex.europa.eu ].

**Table 3**  
Summary of the new deal and EWTD legislation.

**The New Deal Contract includes the following key points:**

- Working time should not exceed 56-h of work per week.
- Actual duty hours depend on working pattern implemented (e.g. full shift, partial shift, etc)
- Maximum of 16-h work in a 24-h period
- Eight consecutive hours rest between full shifts
- Natural breaks of 30-min per four-hours worked
- Minimum of 24-h rest every 7-days, or 48-h rest every 14-days.

**EWTD regulations include the following key points:**

- Working time not exceeding 48-h per week, averaged over 26-week period.
- Maximum of 13-h work in a 24-h period
- Eleven consecutive hours of rest per 24-h period.
- Minimum of 24-h rest every 7-days, or 48-h rest every 14-days.
- Twenty-minute break per 6-consecutive hours worked.
- Four weeks paid annual leave.

of work. If the doctor merely has to be contactable on-call, then only that time linked to the actual provision of their duties counts as working time.<sup>34</sup>

The Jaeger ruling related to whether resident on-call time counted as working-time when not actually performing medical duties. The Court judged that on-call time requiring the doctor to be physically present should count as working time even if the doctor was not working (e.g. resting or sleeping). Compensatory rest periods should therefore immediately follow the period worked.<sup>35</sup>

Together these have substantially reduced the previously common practice of resident on-call rotas and moved the profession towards full-shift working and non-resident on-calls.

**3.3. What does not count as EWTD work?**

Your working week does not include breaks when no work is undertaken, such as lunch breaks, normal travel to and from your work place, time when you are on-call away from the workplace and not working (i.e. non-resident on-call), travelling outside of normal working hours, unpaid overtime that you have volunteered for (e.g. staying late to finish work off), and paid or unpaid holiday.

**3.4. Opting out of the EWTD**

If you wish to, you may apply to opt-out of the EWTD working time limits. However, it is important to note that you cannot opt out of the rest requirements (EWTD or New Deal) and that opting out does not exempt you from the 56-h New Deal working time limit.

Opting out does not necessarily result in extra training time. You may find the extra hours worked are taken up by further service commitments. You will need to weigh up carefully whether these will further your clinical experience and training.

If you sign an opt-out you are free to cancel this agreement at any time by giving between one-week and three-months' notice to your Director of Human Resources (depending on the wording of the agreement).

It is important that any opt-out you choose to pursue is of your own volition. Your employer cannot ask or pressurise you to opt out from EWTD limits, and opting out of EWTD limits must not be a requirement for your employment. There is currently no nationally agreed system for opting out of EWTD working time limits in the NHS. Opting out must be agreed with your employer in writing.

**3.5. Remuneration for opting-out**

Any additional work undertaken after opting-out of EWTD limits should be remunerated by your employer. How you are

paid is open to local negotiation. However, it is important to note that your pay banding will not necessarily change should you choose to opt out if your extra hours do not meet the threshold for the next banding level.

Payment can be made through via hourly locum rates as per the nationally agreed locum scale, or through the pay-banding system. The latter approach requires formal monitoring to establish appropriate remuneration; many may find hourly locum pay preferable.

**4. EWTD and medical indemnity**

Trainees have rightly raised serious concerns regarding their medical indemnity position for work undertaken over and above their 48-h compliant rota. Given the propensity of hospital management to distance themselves from any adverse outcomes, trainees are right to be cautious and question what support, if any, the NHS will offer.

Two specific scenarios have been identified:

1. Where clinical workload necessitates staying beyond your allotted hours.
2. Where you attend for training in your own time outside your allotted hours.

The first scenario is likely to be indemnified. However, if this is a recurring scenario then it may be more appropriate for the employer to acknowledge this, re-design the rota, and re-band your post as appropriate.

The second scenario is less clear-cut. While in theory NHS indemnity should still apply, the caveat may be whether the employing organisation knows this 'work' is occurring, and whether the supervising Consultant is prepared to take clinical responsibility for this.

The NHS Litigation Authority has previously been asked to clarify this issue and released the following statement<sup>36</sup>:

*"Any activity carried out by clinicians which would be the subject of an indemnity if carried out during 'allotted' hours will be treated no differently under our schemes because that work was being done outside these hours". Stephen Walker, Chief Executive, NHS Litigation Authority, November 2007*

We asked the Medical Defence Union (MDU) for their opinion and received the following response:

*"...we would need to know in what capacity the surgeons in training are attending cases 'for their own education outside of the EWTD working hours'. If they are merely observing such cases and are not in any way providing clinical care but are just an observer, the question of indemnity would not arise. If, however, they are attending cases as part of the medical team providing care or treatment, we would expect that they are doing so as part of their employment and in that case they will be covered by NHS indemnity and there would be no need to inform the MDU. In the first instance we would advise any doctor who was working outside the EWTD hours to check with the NHS employer for whom he or she is contracted to work these additional hours what the indemnity arrangements are."*

We asked the Medical Protection Society (MPS) for their opinion and received the following response:

*"Clarification has been sought which confirms that the NHSLA (National Health Service Litigation Authority) has reassured Doctors treating NHS patients beyond the limits of their contractual duties that they would be indemnified for claims by the NHSLA. However, it would be wise to discuss the views and options locally if*

working beyond contracted hours is not for service provision, but for educational purposes. Claims which arise from patients receiving NHS hospital care should therefore be covered by Trust indemnity. MPS would assist in matters which arise from clinical work undertaken outside of core contractual hours for non claims matters, such as GMC or disciplinary investigation.

From a risk management perspective junior doctors should consider the appropriateness of volunteering for extra work if they are tired, despite there being a good training opportunity. They must obviously ensure their own and the patients welfare as a priority. Ultimately, trainees are accountable for the decisions which they make, and they will be expected to always put the interest of the patient first."

It is therefore clear that in the event of any adverse clinical incident occurring, a surgical trainee would be expected to have shown a professional regard for their rest periods, and not put a patient at risk as a result of their own tiredness.

Regardless of indemnity, in the second scenario a trainee may still find themselves in breach of their employment contract by undertaking these additional hours.

#### 4.1. EWTD non-compliance

It is just as important that those wishing to adhere to a 48-h compliant rota are able to do so. Trainees concerned that their EWTD rota is in fact not 48-h compliant over the reference period of 26-weeks should raise this issue with the Director of their Human Resources department and clinical leads. If this concern is valid, the employer has a duty to then reduce working hours through rota amendments such that compliance is met.

A number of sanctions and penalties are available for NHS Trusts that fail to implement or knowingly run non-compliant rotas (excluding those for which derogation has been applied). These include an improvement notice, a prohibition notice, a fine (£5000/employee/week) or imprisonment of the responsible authority.

#### 4.2. EWTD and employment contracts

Trainees may find themselves in breach of their employment contract and/or terms and conditions of service by undertaking additional hours over and above those included in their EWTD-compliant rota.

This is dependant on the definition of 'work' as applied to surgical training and this (as far as we are aware) has not yet been legally defined in *this scenario*. It will also depend on the exact wording of your contract, which may differ from hospital to hospital.

It is therefore vital that trainees wishing to undertake either paid locum work, or additional training beyond their contracted hours are aware of the specific wording of their contract.

Typical contractual statements preventing such work may be worded as follows:

*"You agree not to undertake locum medical or dental work for this or any other employer where such work would cause your contractual hours (or actual hours of work) to breach the controls set out in paragraph 20 of the Terms and Conditions of Service."*

*"Your hours and duties are as defined in the attached job description [for rotations, the job description may differ for each individual post/placement]. You will be available for duty hours which in total will not exceed the duty hours set out for your working pattern in Paragraph 20 of the Terms and Conditions of Service."*

**Table 4**  
Suggested actions to protect training for surgical trainees.

- Be pro-active in seeking out training opportunities during regular working hours. Find out who is operating when and whether you can assist; find out who needs help in clinic.
- For more junior trainees, ensure you gain the most from hospital-based training time by practicing basic surgical skills (including laparoscopy, where appropriate) at home using simple models.
- Explore whether opting out of the EWTD could be suitable for your needs.
- Make sure training opportunities are protected in any revisions of your rota and alert your consultants, educational supervisors, programme directors and NHS Trust if this is not the case.
- Ensure local and regional training (e.g. lectures, simulation sessions) takes place.
- Maximise study-leave benefits and undertake appropriate courses.
- Discuss service provision balance problems with seniors or training programme coordinators to ensure training opportunities in your current post are maximised.
- Ensure your current rota and banding adequately reflects the work you are undertaking.
- Any new rota should be appropriate to the work required and be agreed in consultation with your colleagues and Consultants.
- Record when training occurs out-of-hours.
- Observe good clinical governance and ensure your NHS Trust management and clinical leads are aware of hours and rotas actually being worked.
- Always report patient safety incidents and near-misses to your employer, particularly highlighting where EWTD restrictions or consequences have played a role.
- Keep records of all your correspondence (email, letter, etc) relating to any of these issues, particularly with your employers. If necessary, ensure their verbal instructions or guidance is confirmed in writing.
- Consider writing to your local Member of Parliament (MP) to highlight problems with patient safety, working hours and surgical training arising from the EWTD (e.g. <http://www.writetothem.com/>).

In a worst-case-scenario breach of these contractual obligations may be considered grounds for dismissal. At the very least it is likely your NHS Trust will seek to use this in their defence should any adverse incident occur during hours worked over-and-above your contractual obligations.

We are anecdotally aware of some NHS Trusts who, despite including these clauses in their employment contracts, are then asking medical staff to work additional hours to fill rota-gaps. Such incongruities should be highlighted to the employing NHS Trust.

### 5. What can trainees do to protect training?

Despite the long interim transition period, little has changed in surgical training to compensate for the inevitable reduction in surgical exposure and experience caused by the reduction in working hours. Many surgical trainees are disregarding the legislation and taking their own steps to protect their surgical training. This typically includes attending operating theatre lists on days-off or annual leave, however this cannot address the reduction in non-elective exposure, nor the experiential elements of dealing with ward work, emergency admission and out-patient clinics. We have provided a list of suggested actions to protect training in [Table 4](#).

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The authors are current surgical trainees and former elected Presidents of their respective surgical training associations. The authors have no other relevant financial or personal conflicts of interest to declare in relation to this paper.

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