Junior doctors' working hours: can 56 go into 48?

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A week is a long time, especially if you run a business that operates 24 hours a day, 52 weeks a year. Well, to be precise there are 168 hours in every week. The European Working Time Directive (EWTD) already demands that every junior doctor works no more than an average of 56 hours per week, but on 1 August 2009 the average working week must fall to less than 48 hours.

It can be argued that in many hospitals the medical service is already compromised by the rules of the EWTD, yet in only 16 months each junior doctor must work eight hours less every single week – viewed simply, that is one less weekday daytime shift each week. How can this be achieved? Is there 'slack' in the timetables of most junior doctors? Well, I think not.

What do junior doctors do?

First and foremost junior doctors provide clinical care for patients, lauded by the Tooke Inquiry, in the daytime, evenings, overnight and at weekends. At the same time, they are also being actively trained – mostly in the daytime Monday to Friday, sometimes during the evening, and virtually never overnight or at weekends.

With this in mind, where can the rota planners save the eight hours every week? A quick answer is not at night. The latest Royal College of Physicians' survey of acute hospitals in the UK reveals that the most common staffing to cover admissions and medical inpatient beds at 2 am continues to be one specialist registrar and two more junior trainees; to remove one doctor from that team is quite impossible. The staffing during the daytime at weekends is slightly better (well, by one more junior), but the weekend is already a priority for more active medical input and clinical care, not less. And it is the same in weekday evenings – already there is wholly appropriate pressure to provide much more active management of patients through an extended working day, so there is no chance of reducing the already depleted evening team.

Virtually all the savings in the hours to be worked will have to occur by reducing the number of junior doctors available during the daytime, from Monday to Friday.

What will happen with less junior doctors during weekdays?

The biggest pressure will fall disproportionately on training, because the juniors will be pulled out of the shifts when they receive most of their active teaching. But it is not just the loss of exposure to formal teaching; it is also losing continuity of exposure to each patient's illness. One less day in the hospital every week means it will be virtually impossible for a junior doctor to watch (and learn about) the progress of an illness. This is not just a vital educational experience but it may also be lifesaving for the patient. Seeing a patient once or twice before handover to the next doctor, who then does the same after a short period, means it is difficult to detect a subtle deterioration in a patient's condition. It is the clinical assessment that a patient is not quite as well as the day before, or the day before that, which may alert to an undiagnosed setback. Patients have reason to be worried by seeing a different doctor at virtually every bedside visit, and the EWTD will increase this problem substantially. Even medical records of exceptional quality (which must help some aspects of continuity of care) cannot replace the clinical and educational loss of exposure. There is no robust evidence concerning patients' attitudes to the effects of the EWTD on their inpatient care, but it is unlikely they want to trade continuity of care for slightly fresher doctors.

A cautionary tale

One hospital in England did introduce a 48-hour average working week for the juniors working in an acute unit in 2007; this experiment was observed closely and, as explained above, all the savings were made during the weekday shifts. No extra doctors were added to the rota, and all dropped from a 56-hour to a 48-hour week. Not only was continuity of care a problem, there was also an even bigger breakdown – there were not enough doctors left to get the clinical jobs done during the daytime. Fewer investigations were ordered, less patients examined, poorer continuity notes written, fewer relatives seen, and slower discharge drugs or letters. This should not only be flagged as a risk to patient safety (paradoxically caused by health and safety legislation), but

also it will inevitably cripple the efficiency of a trust – at least the latter will mean it might not be ignored by managers.

The biggest worry

The design of new rosters for August 2009 is difficult because of the rules of the EWTD, and the even more stringent New Deal. Nevertheless, it is possible to construct a legal rota to cover a post 24/7 using perhaps only seven or eight junior doctors. However, that rota is completely unacceptable in that it will mean doctors are working disproportionately many more hours during the evening, nights and weekends. This may be acceptable for a career policeman or fireman, but it is not acceptable for training posts.

Yasmin Ahmed-Brown has calculated that with 10 doctors in a cell on a rota, with full cover for leave, they would have been present for 100 weekday shifts in six months when working the old 'on-call in hospital' pre-EWTD system. When working full-shifts in a 56-hour week they are present for 84 weekday shifts over a six-month cycle; this is obviously why there seem to be fewer juniors around these days.[1] The same 10 doctors working a 48-hour week will be present for only 74 weekdays in six months. To hold the present line of about 84 weekday shifts will require 12 to 13 doctors in each cell.

Are there juniors to fill these posts?

At the moment in England there are about 15,000 junior doctors in trust posts and about 34,000 in training posts. Many of those trust posts have been established to achieve EWTD 56-hour compliance. The number of training posts in hospital medicine will need to increase from 34,000 to 46,000 over the next five years to avoid declaring these doctors and present medical students redundant. In the long term, they are the asset that will provide the specialist-delivered NHS of the future. In the short term, however, they could be used to raise the size of cells in rotas to more acceptable numbers.

What about the Europeans?

The British are always paranoid that Europe makes the rules which we obey, but Europe ignores. Certainly my enquiries among gastroenterologists suggests that only Sweden, Denmark and Britain comply with the EWTD.

The European Ombudsman has recently made an adverse recommendation against the commission for its unwillingness to answer complaints from a German doctor about the flouting of EWTD rules by the employers of junior doctors in Germany. The commission's press office issued a complacent but true statement that, 'almost all Member States seem to be in breach of the court rulings', but there is deadlock about how to resolve the problem.[2]

Most hope that there may in the future be three ways of working. Being on call in the hospital would be the third way of working and this could allow some doctors to remain available in hospital, but sleeping and not consuming any of the valuable 48 hours for work and training each week. As it happens, this will not help those specialties, for example acute or intensive medicine, which require doctors to be awake and working all night, but it could help less intense specialist medical units and the craft surgical specialties.

What should you do?

You should take a great interest in the solutions and rotas for your juniors on 1 August 2009 that are being proposed in your trust. There is pressure to introduce 48-hour rotas in advance of that date. Remember it is possible to create legal rotas that are appalling for both continuity of patient care and training. But such rotas can also have a devastating adverse effect on the efficiency of inpatient services; lengthening of the average length of stay has a dramatically negative effect on a business's bottom line, and short-term savings on junior doctors' pay may cost a trust a great deal of lost efficiency.

References

1 Ahmed-Brown Y, Black M. The European Working Time Directive 2009. *Br J Health Care Manag* 2006;12:373–6.

2 *Special report from the European Ombudsman to the European Parliament following the draft recommendation to the European Commission in complaint 3453/2005/GG*. Strasburg: European Ombudsman, 2007.