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European Working Time Directive (EWTD): Countdown to August 2009

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Background

The European Working Time Directive (EWTD), Directive No 93/104/EC, was introduced on 23rd November 1993 and was incorporated into United Kingdom Law by the Working Time Regulations, 1998/1833, on 1st October 1998.

The original 1993 EWTD is concerned with the health and safety of workers within the European Union. With regard to the organisation of working time, it lays down a number of basic principles concerning the maximum weekly hours an employee is required to work, daily rest time, breaks, weekly rest time, annual holidays and the duration of night work for night shift workers.

As of August 1st 2009 the European Working Time Directive (in force for doctors since 1998, other than those in training) will apply in full to trainee doctors. This will introduce a maximum 48 hour working week for these doctors. The Directive also provides for other measures to include one rest day per week (24 hours per 7 days which can be aggregated to 48 hours rest per 14 day working period), a maximum working duty period of 13 hours allowing for 11 hours rest period per day and a 20 minute break per 6 hours worked. This requirement for an 11 hour break per day has led to widespread shift working in the NHS for doctors resident within the hospital. The daily rest requirement has provided the biggest challenge for healthcare providers.

What is a directive?

A Directive is one of five different legislative acts that can be adopted by the European Parliament or Council. Directives, as defined by Article 249 of The Treaty of Rome (1957), are not binding generally – they are only relevant to those persons to whom the directive is addressed. Importantly, not only are they not binding generally, they are binding only "as to the result to be achieved" – i.e. a Directive lays down an objective but allows the government of each member state to achieve the required objectives by the means it regards as most suitable.

Two cases adjudicated upon by the European Court of Justice (SiMAP and Jaeger) have resulted in European case law decreeing that all hours spent on hospital or healthcare premises are working hours, whether the doctor is active or not working (resting on the premises at the disposal of the employer). This is fully supported by BMA policy but is a decision opposed by many EU National Governments and therefore the EU Council of Ministers. It should be noted that the EWTD has probably been fully implemented in only 25 of 27 EU member states at present. A position paper

on the current implementation status of the Directive on a country by country basis was due towards the end of 2008; however this information has been extremely difficult to collate. This information is expected to be formally published during April 2009. The European Commission has however commenced infringement proceedings against Greece for their failure to implement the Directive for doctors working in their public health service. Their drive in these proceedings is that the Directive is "Health and Safety" legislation, designed to protect the welfare of employees. It is anticipated that infringement proceedings against other member states is imminent.

Within the Directive a provision was made for an interim maximal average working week of 52 hours, applied for by specific derogation, where there are "difficulties in meeting the working time provisions" in the healthcare sector by August 2009. If applied, this derogation would last until 2011. Subsequently, application can be made for a final derogation to apply this limit of 52 hours until 2012 if necessary, when the 48 hour maximum working week will definitively be applicable to all doctors. Current thinking amongst some stakeholders (including the Departments of Health and some Royal College members) is that a derogation applying the 52 hour maximal working week will allow some more time for minds to be focused on "Managed Reconfiguration" and change to the way services are provided in the NHS.

Latest position and recent developments

European Parliamentary debate

On 17 December 2008 the European Parliament voted to amend the EWTD in the following key ways:

- all time spent on-call, including inactive time, should be counted as working time. However, by agreement, member states can decide to weight inactive on-call time differently.
- phasing out of the opt-out within 3 years.

Dr Maguire and BMA colleagues lobby the European Parliament in December 2008

Since the decision of the Parliament is, in part, contrary to the position of the Council of Employment Ministers, a process of conciliation must now follow with the aim of reaching an agreement that will be acceptable to both parties. This will take place under the auspices of the Czech presidency of the European Union. The Czech presidency has four months to respond officially to the Parliament's decision and start the conciliation process. There are very significant entrenched opposing positions between the Council and the MEPs. A meeting was scheduled between the MEP Rapporteur on EWTD and the European Commission in late February 2009 to attempt to agree some common ground. In the background there is time pressure to reach agreement in advance of the European Parliamentary elections in June 2009 otherwise the current conciliation process will fall and the status quo will continue to apply, including the provisions of SiMAP and Jaeger case law. On current assumptions a final decision could be available by May 2009. Member states then would have up to three years to implement any new legislation.

UK position

Latest data from NHS Employers indicates that around 50% of junior doctors in England are still in Band 2 posts, which would be non-compliant with the 48hr limit in August 2009. Whilst employers in England appear largely content to proceed with the existing implementation timescale, the Royal College of Surgeons of England is pressurising the government

to adopt some kind of opt-out that would allow surgical trainees throughout the UK to work a maximum of 65 hours per week. In addition, the Royal College of Physicians of London and certain other medical royal colleges have lobbied government to utilise the 52-hr derogation (described below) for some acute emergency specialties. It is known that the UK government has applied for a derogation as outlined. A two-stage process has been suggested; initial application for a wide derogation for acute specialities (acute surgery, acute medicine, paediatrics, obstetrics and critical care), followed by approval of derogation at a national level for individual rotas. The timescale for approval of a derogation from the European Commission (if any) is by the end of May 2009. It should be noted that individual employees (including doctors in training) can "opt out" of derogation, even if it has been agreed for their rota, and only work the 48 hour maximum.

What is a derogation?

This is a special provision in a Directive that allows it to be applied to particular groups of people or organisations in different ways. A derogation is not an exemption. It usually just permits greater flexibility in the application of the law to take into account special circumstances.

The EWTD has been looming over the NHS for over 10 years. The full impact of the directive is only a short number of weeks away. Whilst some areas of the NHS are ready for the impact of the directive, much work remains to be done in other areas to prepare for full compliance by August 1st 2009. Meanwhile urgent debate is ongoing within the EU considering revision of the Directive.

The future of training?

As early as 2004, long before the full reduction in hours to 48 hrs a week, Sim et al found a 20% reduction in the number of anaesthetic cases being performed by junior anaesthetists following the introduction of a full shift system. The GAT Annual Training Survey has repeatedly found that over 50% of trainees wish for training to be extended to compensate for the reduction in the number of working hours.

So, a longer training time before achieving CCT or to continue the status quo accepting that our trainees are now better trained within the reduced hours framework with competence prevailing over experience and excellence? Or the NHS Employers way forward of a junior consultant post with resident on call?

TWENTY TUNES NOT TO PLAY IN THE PRESENCE OF PATIENTS

Whilst acknowledging that this Top Twenty is not entirely original, we have been working hard to compile a list of the least appropriate tunes to play in the presence of patients in theatre / ICU / pain clinic. This is our best effort; further contributions would be most welcome.

Perhaps number 20 could become the signature tune of Safe Surgery Saves Lives?

1. Another one bites the dust – Queen
2. The first cut is the deepest – Cat Stevens
3. Girlfriend in a coma – The Smiths
4. The drugs don't work – The Verve
5. Comfortably numb – Pink Floyd
6. Spirit in the sky – Doctor and the Medics
7. Wake me up before you go-go – Wham
8. Every breath you take – The Police
9. Take me down to the infirmary – Cracker
10. The medication is wearing off – Eels
11. Sister morphine – Rolling Stones
12. Stairway to heaven – Led Zeppelin
13. When under ether – PJ Harvey
14. I wanna be sedated – The Ramones
15. Heart attack – Olivia Newton John
16. Miracle drug – U2
17. I ain't goin' out like that – Cypress Hill
18. Bedside manners are extra - Greenslade
19. Needles and pins – The Searchers (a good pain clinic one)
20. An orgy of flying limbs and gore – General Surgery (yes – this one IS real)

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