Review of the Impact of the European Working Time Directive (EWTD) on the Quality of Postgraduate Training

NHS Medical Education England (MEE)

Consultation exercise, 22nd December 2009 – 15th February 2010

i. Background

The quality of medical training is paramount in ensuring that the healthcare workforce are equipped to deliver safe, high quality care to patients today and in the future. This review will provide an objective, independent, evidence based report, including recommendations, specifically focusing on how the 48-hour week impacts the quality of the training of doctors, dentists, pharmacists and healthcare scientists.

The review is being carried out in a number of stages. Currently we are conducting a literature review of the available research and evidence. This will be supported by evidence gathering from relevant parties in oral, written and survey formats. The evidence will be collated to form the draft report and recommendations and a second series of oral hearings will be held in March 2010 (if necessary, as determined by the review team) for further oral debate and review.

The report will include recommendations on the steps that need to be taken to ensure that the training delivered is of high quality. The primary focus of the review will not be on service issues or the implementation of the EWTD but on producing a workforce that is fit to deliver a quality service to patients. The review will complement the work being done by the Postgraduate Medical Education and Training Board (PMETB) as part of their ongoing programme of quality assurance of postgraduate medical education and training. For more information on Medical Education England and the review, please visit http://www.mee.nhs.uk/

This consultation is one aspect of the evidence-gathering process, which includes oral evidence collection and a quantitative survey.

ii. Guidance for submission

Please respond to the questions below. Use as much space as required and attach source documents if applicable. Please give evidence/examples where possible and identify whether your comments are general or linked to a particular profession or specialty within that profession. Respondents may wish to consider these questions in the context of the phased introduction of the EWTD – i.e. the effect of the introduction of the 56 hour working week in August 2004 and the effect of the 48 hour working week in August 2009. If you are returning your response by emailed, please keep it in an unlocked and malleable format (No PDF documents please)

iii. How to submit a response

All responses should be submitted electronically to meewtdreview@dh.gsi.gov.uk under the heading 'MEE EWTD Review - Written Evidence'. If you are unable to submit by email, responses should be sent to:

Carley Doughty

MEE EWTD Review - Written Evidence, Medical Education England
Room 531B, Skipton House, 80 London Road, London SE1 6LH
meewtdreview@dh.gsi.gov.uk

MEE EWTD Review -
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Responses received after the 15th February 2010, either hard copy or electronic, will not be considered.

If you have any queries please contact Carley Doughty on 020 79725791 or Kirsten Miller on 07554 334321.

iv. Report

The review team will consider all evidence submitted, and will produce a final report in April 2010

Medical Education England

1. Details of your response

About you
Mandatory questions are marked with an *

If you are responding on behalf of an organisation	
*Please provide your name:	**Professor Tony Weetman**
*Please provide your job title:	**Chair**
*Please provide the organisation's name:	**Medical Schools Council**

Confidentiality	
*Do you consent for your name or the name of your organisation to appear in the index of responses in the group's final report? Please delete as applicable:	**Yes**
*Do you consent for your response to be quoted in the group's final report? Please delete as applicable:	**Yes**

2. Consultation questions

1.	**How would you define high quality training?** Respondents may wish to consider quality both in terms of training outcomes and the methods of training.

High quality training is the process that allows trainees to acquire the knowledge, skills and attitudes needed to carry out their present role, progress in their chosen career and prepare them for lifelong practice and learning. Training outcomes can be divided into knowledge, skills and attitudes and there are clear methods for assessing all of these domains. Ultimately the outcome of high quality training is a practitioner who is safe to act independently, and with confidence, within a defined field of practise.

High quality work based learning in the Medical Undergraduate and Foundation Year One context recognises the need for increasing levels of experiential learning as trainees progress. This experiential learning must be supported by effective and timely mentoring to ensure *reflection in action* as well as *reflection on action* (Schon 1991). Students should be encouraged and enabled to understand concepts and principles rather than merely reproduce factual knowledge, to adopt independent thought and self-direction in their learning throughout their professional career, and to integrate their learning across systems & disciplines.

The delivery of high quality learning and training is dependent on work based training environments that enable learners to meet the outcomes of their programme through working in high quality clinical areas which:

- Are appropriately staffed
- Provide effective clinical and educational supervision including immediate feedback on decisions and actions
- Provide the appropriate case mix and a clinical context to enable students to relate their learning to future practice
- Encourage students to integrate their learning across systems & disciplines.

The quality of training can be assessed in many different ways; by success rates in national assessment processes/ postgraduate examinations, by feedback from trainees and/or trainers, and ultimately from results and outcomes in patient treatments, though granularity of performance data is very difficult to assess.

2.	**What has been the impact of the introduction of the EWTD on the quality of training?** Respondents may wish to consider the impact in terms of quality of the training outcome and quality of the training methods.

There is little evidence yet as to the impact of EWTD on the quality of training outcomes. However both staff and students in medical schools perceive that education and training has suffered. EWTD has resulted in the widespread adoption of shift working, meaning that the contact between trainee and mentor is fragmented. Under EWTD, the opportunities for the trainee to receive

effective feedback are reduced and the trainee's reflection is unsupported and therefore less effective in itself. It is felt that EWTD has contributed to the degradation of the team approach to medicine, in that Trainees no longer belong to a particular team. As a result training is more haphazard, there is less bonding with a team and consequently lower morale.

There is some evidence, all be it mainly anecdotal, that this negative impact is felt by medical students as well as postgraduate trainees. In particular pressurised shift working has meant that junior doctors are finding it harder to teach and mentor medical students who are consequently losing out on this crucial element of their education and training. Also, shift working for junior doctors has knock on effects for students who are experiencing less out of hours work and fewer clinics.

Whilst there has always been a tension between the provision of a basic minimum of care and upholding the highest standards of professionalism, the introduction of the EWTD has made this tension more stark. For example:

- A perceived tendency to see the role as performing a 'job' rather than a vocation - trainees have increasingly tended to work as technicians helping out as and when they are required, rather than as members of an integrated team providing care.
- Postgraduate trainees are finding that service demands and the need to familiarise themselves with patients when they come on shift mean that there is little or no time to teach students.
- Significant concerns about the continuity of care provided and the ability of trainees to follow up patients across shifts. As a consequence there are also concerns about the learning that students and trainees gain from their experience of providing care.
- Some doctors are starting to struggle to complete all of the required competencies in a given training block.

Medical schools report a reduction in confidence amongst students and trainees, which could be a result of a number of the above concerns. Perhaps the most worrying feedback from junior doctors is that although they are very interested in the medical specialities, they are reluctant to become a medical registrar because of the strain under which they have seen registrars working.

It should also be noted that EWTD represents a particular threat to the future of academic medicine. In an effort to achieve EWTD compliant rotas many trainees are being used to fill gaps in rotas with unsocial hours that do not provide the necessary exposure to academic disciplines or develop the key skills that they require for a career in clinical academic medicine. In addition, a lack of regular contact with senior academic role models means that the opportunity for informal mentoring and recruitment has now been lost. In clinical environments where a consultant may meet a junior doctor only once or twice in a six month period it has become virtually impossible to spot the potential stars who need encouragement. The result is that the majority of trainees (excluding those in recognised academic training posts early on in their careers) are less likely to be exposed to academic discipline than previously, with fewer opportunities to gain experience with research and teaching.

A number of schools have explored the impact of EWTD in detail to provide additional evidence of the effect of EWTD on the quality of training:

Sheffield

Of the two 'conjoined' surgical firms within the Sheffield Teaching Hospitals Trust, each timetables one teaching session to be delivered by either a CT1-2 or ST3 or above once a week over 18 weeks. Out of the 36 scheduled teaching sessions that should have been delivered since August 2009 not one session could be delivered as there are no available junior staff. Before the introduction of EWTD about 50% of the timetabled teaching sessions occurred. In the past, these teaching sessions always took place after a business ward round. Now the ward rounds are attended by only the consultant and Foundation doctors.

Shift patterns and the requirement for trainees to cover absence of other juniors combined with the number of training/education sessions that trainees are required to attend, has made it virtually impossible to timetable CT1-2 of other senior trainees to deliver undergraduate teaching. There is anecdotal evidence that this occurs in other medical schools also.

Furthermore, consultants in Sheffield are finding it increasingly difficult to teach medical students other than in an unplanned manner on business ward rounds and clinics.

Southampton

Research within the School of Medicine in Southampton shows that it is difficult to isolate the effect of the EWTD from other changes in the NHS, especially the changes following the Calman Report, and particularly MMC. The combined impact of these has led to the relative 'absence' of junior doctors from the clinical context and has resulted in the loss of an important access point/ guide/ mentor/ teacher for medical students, affecting both formal and informal teaching and training. As a result, undergraduate students are increasingly disenfranchised from the clinical context.

Another hugely important issue is the increasing specialisation within disciplines. Undergraduate student placements have become shortened and students' attachments need to be carefully planned to ensure that students continue to benefit from a broad exposure. Given that clinical teachers are increasingly working in highly specialised areas, students have to establish teaching relationships with a broader range of individuals.

The combined result of these changes is an overall loss of close working relationships between teachers and students. For institutions, it is more difficult to ensure - and to track - student progress.

This research also highlighted a number of other important changes impacting on medical student learning, including:

- Changing regulatory framework
- Increasingly diverse providers
- Capacity in some specialities
- Replacement of time students spend in patient contact, with other activities
- Performance management and de-professionalisation
- Increased pressure on doctors time to deliver service targets
- Financial constraints

Birmingham

Birmingham Medical School investigated the perceived impact of the European Working Time Directive on

final year medical students' training using a questionnaire. The entire final year cohort, of 404 students, was asked to complete the questionnaire by email, with a 33% response rate. It should be noted that it is still very early to gauge the impact on students' education and training.

Of the 134 final year students who responded to the survey, 23% thought that their teaching had reduced in quantity since the EWTD was implemented. 39% of respondents felt that it was harder to get teaching time with clinicians, particularly with Foundation Doctors (see table below). 28% of respondents thought that the implementation of the EWTD had adversely affected their training to some degree.

Students were asked: *Are you finding it harder to pin down doctors for teaching?* The table below shows a summary of their responses

Answer Options	Response Percent	Response Count
Yes - Harder to get Consultants	0.0%	0
Yes - Harder to get Registrars	3.8%	5
Yes - Harder to get Junior Doctors	20.5%	27
Yes - Harder to get all Doctors	15.2%	20
No	60.6%	80
answered question		**132**

Several respondents commented that the time in teaching may not have been affected, but the quality of their attachment had been. The reduction in junior doctors' hours had led to further fragmentation of the team structure with the result that students find it difficult to build relationships with doctors. Doctors do not feel encouraged to teach the students, and are unable to give meaningful feedback as they have not seen them consistently over the attachment. For example students at Birmingham have commented that:

'There has been a loss of continuation in who you see on the wards. You spend time getting to know a junior doctor and shadowing them, getting greater responsibility, to find they've gone to nights or time off and you have to start that relationship all over again with a new dr. Not very useful when you have only a short time on the wards for a rotation.'

'Much more difficult to build relationships with junior doctors, for example in A&E, when you may see them once or twice only, and when you're only in a certain hospital for 2 weeks in your entire student career.'

'…This also made it harder for me to get to know the staff, and for them to evaluate my progress as a student.'

Many students commented that they felt the impact of the EWTD would be more pronounced when they entered their foundation years, with a number of respondents voicing strong concerns about actual working hours and pressure from seniors to disregard the rules. There is a degree of anxiety about the impact the EWTD will have on students as they become junior doctors. Many students felt that the EWTD would adversely impact on the amount of clinical experience they will accrue as junior doctors. Some students voiced concerns about the potential impact on the quality of patient care, and of over-stretched doctors trying to achieve the same quantity and quality of work within the time constraints.

St Georges

St Georges reported a worrying trend for juniors to comment that whilst they are very interested in the medical specialities they do not want to become a medical registrar because of the strain they have seen registrars working under. Also trainers at St Georges are becoming increasingly frustrated as they are torn between providing high quality training and responding to increasing service demands, including covering for absent juniors. This has led some trainers to opt out and choosing to no longer act as educational supervisors.

Leeds

In Leeds students have reported considerable difficulties in accessing out of hours experience as a result of shift systems. Students find it difficult to contact junior staff on night shifts whom they have not met during the day. Furthermore postgraduate trainees have reported that they are too busy familiarising themselves with patients when they come on shift to teach students.

3.	**How have those working in the healthcare 'system' (e.g. employers, trainers, service and training commissioners and providers) responded since the introduction of the EWTD?** Respondents should consider changes related to training which: • Resulted directly from EWTD • Resulted indirectly from EWTD • Are potentially unrelated but nevertheless are perceived to impact on the quality of training.

It is important to recognise that there have been many other changes over the last few years such as the New Deal, and it is very difficult to tease out the exact impact of EWTD. Most significantly, in response to the EWTD and other changes, has been the introduction of shift working. The negative effects of shift working are outlined in our answer to question two. Attempts have been made to offset the negative effects of the loss of experiential learning by the introduction of formal teaching sessions, such as a greater role for simulation in the teaching of clinical skills. While these are important they are not an effective substitute in the development of skills and judgement.

UK Trusts appear to be looking to reduce their reliance on junior medical staff to deliver care - and to switch to a more trained-doctor service. There are definite contrasts between the home nations as to how this will be affected, but it is seen that the use of a trained doctor cohort will increase patient safety and drive up quality of care for patients. Demography suggests that the training capacity may well have to reduce as a result of this.

Furthermore, the coincidental change in the regulations on immigration by the Borders Agency, along with a less flexible (though arguably fairer & more criterion based) national recruitment method, has meant that the UK has a shortfall in its junior medical staffing requirements. There is evidence from postgraduate deaneries that gaps in rotas, rather than EWTD alone, are causing a lack of training delivery in some units and in some specialties. Any attempt to minimise the negative effects of EWTD needs to take into account other factors causing gaps in rotas affecting quality of training.	
4.	**What lessons can be learned from national and international experience about the delivery of high quality training within time constraints?** Respondents may wish to present evidence on lessons learned from both positive and negative experiences, or from the experiences of colleagues and partners in other parts of the country or the world.
The Medical Schools Council recognises the need for some significant changes in the way Medical Schools help trainees to practice and learn medicine. The Medical Schools Council believes that the following are the main lessons to be learnt so far from the introduction of EWTD: • We urgently need a replacement for the apprenticeship style of the "firm". The use of documentation is not an effective substitute. For example, mentorship may need to be developed at a level other than in the traditional firm structure. • We need to see a move to having greater working under close supervision by trainers who are supported to do this. • We need to develop in our graduating students the ability to maintain high standards of professionalism within the time and service constraints imposed by EWTD – for example by making effective use of handovers, high standards of team working and maintaining commitment. • We need to promote and protect excellence, rather than the current goal of achieving competence within the time constraints of the EWTD. • In some craft specialties we believe that we will need to accept longer training and greater use of alternative experience (e.g. work abroad).	

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3. Publications to be considered as evidence

Please list any published articles or research papers that you would like the group to consider as evidence. Please note that where the referenced article appears on a password-protected site, a copy should be submitted alongside your response. Given the limited timeframe of this consultation, if you are unable to provide a valid web-link, electronic or hard copy for all other articles/papers, your suggestion may not be considered.

In terms of articles published in this area, the articles published by Roy Pounder are probably the best known in this field. Some models of good practice can be found in the healthcare workforce e-resource (http://www.healthcareworkforce.nhs.uk/resourcelibrary.html), with many examples cited. Medical schools themselves are also engaged in relevant research, for example:

- Warwick University are currently undertaking some work in this field, but it is at an early stage.
- A GMC-funded literature review is currently conducted by researchers at Peninsula University which may be of interest.
- Southampton Medical School would be happy to share the results of the education research currently being undertaken - the "demise of the firm project", which is being overseen by - Dr Faith Hill and led by Dr Anja Timm (a.timm@southampton.ac.uk).

Article/ paper title	**Author(s)**	**Source journal**	**Web-link**	*
Skills for Health (2009) Junior Doctors in the NHS: Preparing medical students for employment and postgraduate training.		NA	http://www.skillsforhealth.org.uk/~/media/Resource-Library/PDF/Tomorrows-Doctors-2009.ashx	

***Have you submitted a hard copy? (Applicable only where web-link is not provided)**

MEE EWTD Review - Written Evidence, Medical Education England
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4. Confidentiality of information

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory code of practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you would explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department of Health.

Medical Education England will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.