

---

# REPORT ON BMA EWTD AND TRAINING CONFERENCE

---

HELD AT BMA HOUSE ON 26<sup>TH</sup> FEBRUARY 2010

---

## INTRODUCTION

---

I attended this conference on behalf of trainees in Paediatric Surgery and as a representative of BAPS and the SAC. It was well organized by the BMA and well attended by trainees and trainee representatives (including the BOTA and ASiT chairs), representatives from School of Surgery, Deans and other with an interest in postgraduate medical training. On the whole the focus was on practical solutions and facing up to the reality of EWTD.

The BMA EWTD survey received >1500 responses and was reported in Feb 2010; half of respondents stated that training was adversely affected by EWTD, mainly due to covering gaps in the rota.

The aim of this conference was to review how EWTD is affecting junior doctor training and ensure that training is protected and improved in the new working environment.

---

## KEYNOTE ADDRESS

---

---

PATRICIA HAMILTON, DIRECTOR OF MEDICAL EDUCATION (ENGLAND), DH

---

Dr Hamilton spoke about how training has changed for the better over the last generation. We are now all more 'educationally competent' and improving training is part of improving quality, which ties in with the Darzi review. We need new parameters to determine when we have 'arrived' (in terms of completing training), as it is not just a question of elapsed time.

The EWTD means a working week of 48 hours per week (averaged over 26 weeks). The rest breaks stipulated by the New Deal are not optional. One of the biggest problems with EWTD is gaps in rotas, caused by the reduced granting of visas to international medical graduates.

The Secretary of State requested derogation from the EU for rotas which were not yet compliant, to 52 hrs/wk for 2 years; only 86 rotas have taken up this option.

The quality of training may be affected by reduced exposure to specialist clinics, operating lists, procedures and formal teaching. One of the key problems identified is loss of the 'firm apprenticeship' model. The DH has put £310M into finding solutions, including £50M earmarked for 24/7 specialties such as paediatrics, O&G and anaesthesia.

Possible solutions include:

- Increased hours – but this leads to poor performance
- Increased length of training – but not just more of the same
- Innovation and improvements in training – ideal
- Making service provision less dependent on trainees
- Not every centre needs to be a training centre
- Service reconfiguration needs to take training into account
- Simulation offers an alternative to patient based training

The outcomes we should be looking for are EXCELLENCE in:

- Fitness for purpose
- Patient safety
- Job satisfaction – which includes geographical stability, accommodation and remuneration, reasonable career prospects, flexibility to change career direction, not being overtired or under-occupied and family friendly working
- Value for money (for government)

The key point was that we need to change the way we do things and make sure we assess the quality of what we do.

---

## EUROPEAN UPDATE

---

---

### PETER MAGUIRE, CHAIR OF BMA COUNCIL WORKING GROUP ON EWTD

---

Dr Maguire gave a summary of the current position of EWTD compliance in all EU countries. He pointed out that EWTD is a piece of Health and Safety legislation that covers the whole EU. It was difficult to obtain official figures for compliance in most countries – an official EU document was supposed to be published in 2008, but is not yet published.

The only countries that are definitely compliant are Denmark, Germany and Sweden, but questions have been raised at how fully trained doctors are at the end of this process – an example raised by the president of BOTA being Scandinavian orthopaedic surgeons who came to work at treatment centres in UK and caused scandal.

Denmark – doctors work 37 hours a week, and there are a large number of doctors compared to other countries.

Many countries complain of excess bureaucracy and many doctors in newer EU countries go to work in other countries for better pay and conditions. In many countries doctors are paid for a compliant week but work much longer (including Portugal, Slovak Republic, Estonia, Spain).

Ireland has received a formal letter of notice from the European Commission about its failure to implement EWTD in full for doctors.

The new European commission will take office in early 2010 and has said it will reopen talks on a revision of EWTD, but changes are not expected imminently. The current European Parliament is more right wing than previously, so more likely to revise the legislation, but it will be a slow process.

The BMA supports a maximum average of 48 hours per week, and a retention of the opt-out clause for those truly in control of their working hours.

---

## BREAKOUT GROUP –SURGICAL TRAINING

---

This was a discussion about the particular impact on surgical training of the EWTD. The general feeling among the surgical trainees was that EWTD has had a very negative impact on their training and that training has not changed enough to take reduced hours into account. There was widespread support for service reconfiguration that would take trainees away from centres which cannot delivery quality training and only offer training in selected centres. There was support for the separation of training and service delivery, and the separation of emergency and elective work, although it was accepted that someone needs to do the jobs and clerk the patients. ASiT seem to be working hard to suggest improvements in training. They presented some ideas for change including:

- Training tariffs for trusts
- Formalized weekly training lists
- Teaching clinics
- Specific emergency placements
- More careful selection of trainees
- Mandatory teacher training
- No fault outcome of ARCP
- Relaxation of EWTD

---

## BREAKOUT GROUP – LEARNING FROM FLEXIBLE TRAINING

---

This was a very positive discussion about the way that all trainees can learn from flexible trainees, who have always worked ‘reduced hours’ to maximize training opportunities and improve handover.

Things that flexible trainees have usually done well is to hand over patients well and effectively, and to make the most of the time they are at work, to make the most of training.

Ideas that could be used in all fields included

- Job planning for junior doctors – to maximize time spent in identified training opportunities (e.g. OP clinic, theatre),
- Increased responsibility for their own working patterns, which would improve job satisfaction.
- Providing focused training- which should be trainee led but with discussion with Educational Supervisors.
- Slot sharing in teams was an idea that could be used to recreate the traditional ‘firm’ based structure in the new working environment – so that a few consultants worked together with their junior doctors cross covering. This would improve patient safety as well as training.

It was recognized that handover is increasingly important when doctors work fewer hours, and ideas to improve this were discussed.

---

## SUMMARY

---

David Haslam, Chairman of the BMA GP committee, commented that the care of tomorrow’s patients is as important as the care of today’s patients, so it is very important to get training right. Many ideas and innovations were discussed, and I hope that concrete action will be taken by deaneries and postgraduate schools of education to change the way training is planned and delivered in the era of reduced junior doctor hours. Trainees are keen to work with trainers and deaneries to maximise training opportunities and improve training.

***Clare Rees MD MRCS***  
***National Trainee Representative in Paediatric Surgery***