COMITÉ PERMANENT DES MÉDECINS EUROPÉENS
STANDING COMMITTEE OF EUROPEAN DOCTORS

CPME/AD/Brd/170307/054/EN

At its Board meeting in Warsaw on 17 March 2007, the CPME adopted the following resolution: **CPME / EMSA / PWG joint contribution to the consultation on "Modernising labour law to meet the challenges of the 21st century"** (referring to CPME 2007/054 Final EN)

CPME[1] / EMSA[2] / PWG[3] joint contribution to the consultation on "Modernising labour law to meet the challenges of the 21st century"

We received with interest the Commission's Green Paper 'Modernising labour law to meet the challenges of the 21st century", by which European stakeholders are invited to express their views on a number of questions in the light of the "flexicurity" approach to the European labour market.

The organisation of the working time in Europe needed a public debate and so, the European Commission launched on November 22nd an open consultation on *"Modernising Labour Law to Meet Challenges of the 21st century"*. Within the "Flexicurity" approach, this Green Paper asks Member States, social partners and stakeholders how labour law, at EU and national levels, can help the job market become more flexible while maximizing the security for workers.

We are answering to the questions directly relaying to the obvious issues of the Medical Workforce. We would like to stress that this reply is not considered conclusive and we reserve the right to approach the Commission on other issues of the Green Paper at a later time.

We would like to

- ★ Congratulate the EC for the objective of this Green Paper which is to launch a public debate on how labour law can thrive to support the Lisbon Strategy, by achieving sustainable growth with not only more, but also better jobs.

[1] CPME: Standing Committee of European Doctors represents all medical doctors in the EU which is approximately 2 million physicians. www.cpme.eu
[2] EMSA: European Medical Students' Association www.emsa-europe.org
[3] PWG: Permanent Working Group of European Junior Doctors www.juniordoctors.eu

- ★ Raise awareness of the poor working conditions of certain European professionals, which do not only affect these European workers but also productivity and the quality of European services.

- ★ Point-out the consequences that will arise if the “Flexicurity” approach favours flexibility over the safety of professionals and citizens, encouraging the abolishment of all clauses that safeguard European workers thus undermining the relevance of the European Working Time Directive (EWTD) as a whole.

- ★ Ensure that safety may never be at the price of the employee, namely by forcing him to choose between an insufficient income and the possibility to work over 48h a week.

CPME policy (2004/155Final) adopted in respect of the current proposal for a Directive of the European Parliament and of the Council amending Directive 2003/88/EC concerning certain aspects of the organisation of working time (COM(2004)607) clearly stresses that:

- ★ the **time doctors spend on-call** at the working place should be counted as working time

- ★ a unilateral extension of the **reference period** from 6 months to 12 months should not be possible. The provisions of the European Working Time Directive should therefore not be changed into a more liberal direction. However, we welcome the Commission proposal that the length of the reference period should not be longer than the length of the work contract

- ★ the possibility for **individual opt-out** for doctors in training should be abolished from the Directive

- ★ as far as the Medical Profession is concerned**, compensatory rest** needs to be taken at times immediately following the corresponding periods worked unless otherwise decided by collective agreement

Doctors’ working time not only is a workers’ health and safety matter, but it also concerns the performance of the medical professionals’ duties and responsibilities. Safe care for patients should therefore be bore in mind in the definition of doctors’ working time and working conditions.

In order to improve doctors’ working conditions at the EU level, the following issues are considered necessary:

- ★ **the private and public sector should comply with the same rules – no different rating**
- ★ **effective controls and sanctions in case of violations should be imposed in both sectors**
- ★ **the observance of maximum limits of working time should be guaranteed**

- ★ **adequate time for doctors' training and continuing professional development should be secured**
- ★ **the current definition of working time, as defined by the European Court of Justice, should be respected**

It is necessary to establish a weekly working time limit in order to protect the health and safety of doctors. It is necessary to keep them from working very long hours, as it can lead to doctors becoming physically and mentally over-tired, and therefore unable to care for the patient. Long working hours are not only harmful for the health and safety of workers, but also because exhausted doctors due to long working hours may become a risk for patients. In addition, it makes medical profession unattractive for young students, who prefer to choose other professions with better working conditions. Besides, it is becoming increasingly difficult to balance work and family life.

The promotion of the highest standards of medical training and practice for junior doctors (including a high security standard in order to achieve the highest quality guaranteeing patient safety) is vital. At present, doctors in training are excluded from the full protection offered by the Working Time Directive that other EU workers benefit from. Not until August 2009 will Europe's junior doctors benefit from the same protection of their health and safety and the concept of a 48 hour working week. It is pertinent to note that it has taken doctors in training 90 years to achieve this standard which was first adopted by the 1st Convention of the International Labour Organisation in 1919[4].

"The failure of the extraordinary EPSCO council of 7 November 2006 to reach an agreement has highlighted how the provisions of Directive 2003/88 EC and the relevant ECJ jurisprudence remain particularly challenging for certain sectors such as health. The Commission is now reviewing the situation in the light of the stalemate in the Council."

Green Paper Question 11

"How could minimum requirements concerning organization of working time, be modified in order to provide greater flexibility for both employers and employees, while ensuring a high standard of protection of workers' health and safety? What aspects of the organization of working time should be tackled as a matter of priority by the Community?"

The EWTD was adopted in 1993 as a safety measure because of the recognised negative effects on health and safety of excessively long working hours, it is designed to help work-life balance by limiting 'long-hours' which are both stressful and harmful to health. In 1993 the UK negotiated the inclusion of an opt-out clause which allows individual Member States not to apply the 48 hour weekly maximum under certain conditions. Although considered to be an exception, experience has proven that this clause has proven to diminish the Directive's objectives to the extent that safety is now optional.

[4] Hours of Work (Industry) Convention, 1919

When considering the organisation of working time, the Commission has an opportunity to change the conditions under which doctors work. We see the protection afforded by the working time directive as central to improving the safety of patients across the EU and this opportunity must not be passed upon.

The relationship between poor working conditions and error

Comparing doctors in training and other professions
Family life, sexual demography and personal safety

Current health care systems are too reliant on resident doctors in training working extended hours to deliver patient care. There is an expectation for these doctors to work hours far in excess of those worked in other industries. By its nature this places doctors at risk of fatigue and the consequences that arise from this. Thus the system as it exists at present is by its very design jeopardising patient safety. The aircraft industry and road transport industries have for a long time recognised the need to limit hours of duty to ensure public and personal safety. There is a growing acceptance of the concept that errors result largely from the failures of systems, not from individual carelessness or inadequacy. The concept of "latent" errors[5] illustrates that deficiencies in design, organization, maintenance, training, and management will create conditions in which persons are more susceptible to mistakes. For many years the links between excessive hours of work and risk to ones health and safety have been apparent; but there has been recently a growing amount of published research in this field, particularly in relation to the work hours of resident doctors in training. There is now direct evidence that excessive hours of work in residents are associated with disrupted sleep patterns, increased incidence of attentional failures[6], increased incidence of motor vehicle accidents[7] and increased numbers of serious medical errors[8]. Thus excessive hours of work for doctors in training are damaging to the individual doctors health, their individual safety and to the public's health.

Excessive workload and lack of adequate rest will make a person more prone to individual error. Correcting these defects in systems is the most effective way to reduce human errors. This concept is best summed up in the statement:

"We cannot change the human condition, but we can change the conditions under which humans work."

Doctors are no different to other workers and deserve the same level of protection. The EU must make concerted efforts to ensure the EWTD in full is implemented on schedule, with all doctors across the EU benefiting from the introduction of the 48 hour working week. This is vital not only from a health and safety perspective but also to allow us to reconcile the balance between work and family life, particularly with the changing sexual demography of the

[5] Lockley et al, N Engl J Med 2004;351:1829-37.
[6] Barger et al, N Engl J Med 2005;352:125-34.
[7] Landrigan et al, N Engl J Med 2004;351:1838-48.
[8] Reason J, BMJ 2000;320:768-770.

medical workforce. The Commission must clarify what measures it intends to take were a member state to fail to meet it’s obligations to implement the directive on time.

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The “opt out” and the European Court of Justice (ECJ) rulings

It is our view that the role of EU legislation is to set a benchmark standard by which the health and safety of an individual is protected from the deleterious effects of excessive hours of work and disruptive working patterns. There should be a high standard set at an EU level which can only be liberalised at a national level by the voluntary collective agreement of both the employer and employee. This is a concept that is enshrined in Article 118 of the Treaty of Rome, which calls for the promotion of the right of association and collective bargaining between employers and workers. In any case, there must be absolute upper limits placed on any divergence from a common EU standard of the organisation of working time, otherwise this will cease to have any purpose as a piece of health and safety legislation.

It is our view that main tenants of Directive 2003/88/EC, as clarified by recent ECJ judgements[9,10,11] on the definition of working time must form the basis of any future legislation on the organization of working time. The exception to this is that the “opt out” clause should be abolished from the directive. The Barnard Report into the application of the “opt out” clause in the UK (the member state where the “opt out” has been most widely applied) concluded it has been systematically abused to such an extent that the Commission launched infringement proceedings through the European Court of Justice[12.] The possibility to opt out of the protection provided by Article 6 of the EWTD undermines the basic principle of the Directive. One cannot simply choose to opt out on health and safety laws and it is likely that were the opt-out to remain within the directive it would continue to be abused.

Some employers would argue that abolishing the individual opt out, strengthening the definition of working time and maintaining current provisions on reference periods would not provide them or healthcare systems with enough flexibility, and that some concessions should be given. But while some Member States have during the implementation period prepared for the provisions of the EWTD, others have not. There should not be a levelling down of standards to compensate for inaction on the part of those responsible for their implementation. Such an approach would jeopardise the public health and patient safety and the Commission must not be complicit in such action.

On-Call

Rulings of the ECJ have been very important in setting a standard definition of on-call as they establish that it should be counted as working time.

The SiMAP trial ruled that on-call duty performed by a doctor where he is required to be physically present in the hospital shall be regarded in its totality as working time. The Jaeger case also set a similar decision stating that the working time includes the time where the person concerned is permitted to rest at the place of work during the periods when his services are not required.

[9] ECJ Case C-303/98 (SIMAP).
[10] ECJ Case C-151/02 (Jäger).
[11] ECJ Case C-14/04 (Dellas).
[12] ECJ Case C-484/04 (Commission VS UK).

The European Court of Justice states that the hours of actual presence on the premises, including the inactive part must be counted as working hours. This should be implemented in all member states immediately.

Therefore, all time doctors have to spend (also standby time) at the hospital should be considered as working time.

Adaptation to the provisions in the EWTD must not rely solely on recruiting more medical staff, but also on organising work in a way that consumes fewer on-call hours in hospital. This includes both organising on-call from home where possible and concentrating services where a doctor on-call is necessary. Models for this approach to healthcare have been successfully implemented in many European countries and allow for the delivery of high quality healthcare with greater efficiency in the allocation of resources. Hospitals and healthcare systems should no longer be reliant on large numbers of resident doctors in training to sustain these systems.

It was reported that during an on-call, even when sleep was not disrupted by the service, it seemed often limited and most of all fragmented[13]. The increase in sleep on the night following the on-call is limited to 20 minutes on average in comparison with a normal night, without any obvious improvement in its quality. When the day following an on-call is a normal working day, the motor activity is only reduced in the evening, probably owing to the fact that fatigue and sleepiness are hidden, during the day, by the work demand. Dinges[14] studies shown that many people are not biologically apt for night work and that, even those who cope require up to a 3-day adaptation period to recover from overnight periods of work.

For Minors and Waterhouse[15], a minimum of four-hour sleeping period at night is necessary to maintain the 24-hour synchronization of the body heat.

From the subjective point of view, all the parameters (daytime quality, irritability, sleepiness, concentration, fatigue and mood) are being altered on the day following the on-call. The poor quality of the overnight on-call, as shown in the wake-sleep diary, coincides with data collected amongst engineers on stand-by that expect to be woken up. On the second day post on-call, despite a night when sleep is recovered, fatigue is still present and mood as well as concentration is still deteriorated. Those persistent negative effects suggest that the recovery has been incomplete as demonstrated above. The return to normal cognitive functions only occurs after 2 nights of rest recovery. This study stresses the role played by a sufficient post on-call rest in order to protect patients' safety as well as physicians' health. The introduction of this rest requires the implementation of a restructuring within hospital units.[16]

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[13] Gaba DM, Howard SK. Fatigue among clinicians and the safety of patients. N Engl J Med 2002;347:1249-1255

[14] 26. Dinges DF. The nature of sleepiness: causes, contexts and consequences. In: Albert Stunkard & Andrew Baum editors. Perspectives in behavioral medicine: eating, sleeping and sex, Hillsdale, NJ: Lawrence Erlbaum Associates, 1989: 147–179.

[15] Minors DS, Waterhouse JM. Circadian rhythms and the human. Bristol, UK:Wright PSG, 1981.

[16] Torsvall L, Akerstedt T. Disturbed sleep while being on-call; an EEG study of ships'engineers. Sleep 1988; 11: 35–38.

Training in the medical profession

Training cannot be separated from working time in the medical professions; it has a particular way of teaching, where junior doctors obtain their knowledge from practicing within a team that is responsible for their tutoring/education. The time they are learning cannot be separated from the time they are working, since both happen simultaneously, on a bed-side case-by-case manner. In fact, the new EWTD serves as a perfect opportunity to review and optimise medical training, removing the limitations we have today.

Considering, as for now, the medical training part, it is first important to notice the two features, which are implied in: the theory and the practice. Indeed, if the theoretical part is easier and easier accessible to the future healthcare professionals, thanks to the modern age we are living in, and does not imply to be at the Hospital, it goes without saying that practice cannot be taught at home. On-call time must therefore be added as well. As a matter of fact, most Junior Doctors, get a different type of training during their on-call time duty, which must be considered as an important feature of their training. Moreover, this kind of training has to be considered as working time as well.

The relationship between this week time and the entire length of the training time is a major concern for junior doctors. If decreasing the week time implies an increase of the total length of specialization, the consequences on the medical workforce could be really damaging for the patient safety and good care; hence, increasing the length of medical studies could be a factor of students' attrition for medical studies. As far as it is possible to anticipate, these consequences still remain unclear. Therefore, we propose to optimize this medical training time, in order to provide the best medical training in an appropriate length of years, while respecting a 48 hours week working time, including the on-call time duties. That would require a stronger pedagogic project at the Hospital, a greater communication between junior and senior doctors, in order to promote and facilitate the knowledge and experience transmission.

"Compensatory" rest

The term *compensatory rest*, contemplated in the EWTD, that establishes a mandatory rest period after overtime work, may be misleading, since it may be understood that this time is merely a compensation of the rest time that was made use of during the overwork. The fact is that a rest period following a long episode of activity is rather an indisputable necessity for safety reasons instead of a sheer compensation. Sleep, set like clockwork, regularly occurs in two periods, over a 24-hour timeframe, by night and between 13:00 and 15:00[17].
A disruption of this cycle has diminished appetencies in the following days as a consequence. Studies on pilots crossing 6 time zones while flying have revealed that the ability to perform simple tasks is recovered only within 3 days and that more complex tasks require more than 5 days to be recovered[18]. Most accidents in the automotive industry occur during or right

[17] FEMS document on Working time & medical on calls (F04/22 EN)
[18] Klein K, Bruner H, Gunther E. Psycholgical and physiological changes caused by desynchronisation following transzonal air travel. In: Colquhoun WP, eds. Aspects of Human Efficiency: Diurnal rhythm and loss of sleep. London: English Universities Press, 1972.

after a working night[19]. Even more so, Dawson and Reid concluded that the psychomotor performance of an individual after a 24 hour period of wake is the same as that of an individual with a blood-alcohol level of 1 g/l [20].

As stated before, any rest that may be done during on-call time is not effective. After a sleepless night, some individuals' feel very tired in the morning but do not however feel like going to bed; this is what is known as the circadian effect and has only to do with the fact that the body has it's own vigil-sleep hormonal cycle, that although inhibits slightly the will to go to bed, does not enhance the ability to act, but instead merely misleads the body in a false feeling of alertness. The minimum required to maintain alertness and adequate cognitive functions is estimated to be 5 hours[21.]

For these reasons, compensatory rest for work that has interfered with the rule of 11 hours rest per 24 hours or 35 hours weekly rest must be given immediately following the corresponding period of overwork, for safety reasons. Such shall be mandatory on the day following the overworked period, unless decided otherwise by a collective agreement. If such an agreement as the latter may ever exist in any MS, in no case shall it be allowed to prolong the compensatory rest beyond 72 hours, nor shall overwork be permitted again until the compensatory rest has been taken, since a prolongation beyond this time frame incurs serious risks for the worker and the citizens that interact with them during this period.

Reference periods

The reference period for calculating the average working time should be 4 months, extendable to 6 months by collective agreement. Any unilateral extension of the reference period or an extension beyond 6 months should not be possible. The provisions of the EWTD concerning reference periods should therefore not be changed into a more liberal direction and should also have consider that no reference period should not be longer than the length of the work contract.

The attractiveness of the medical profession and sustainability

In many countries, the medical profession has lost some its attraction to the best qualified students. The principal reasons for this are the intimidating working conditions and in particular the traditional long-hours culture. Young people prefer the choice of other professions where they feel they have more autonomy and the possibility to combine work with family life. It is likely that, were the working hours made more attractive, more students would choose the medical profession than presently do so. It is also likely that female doctors with small children would be more likely to return to work. Thus, we see the protection afforded within the Working Time Directive as essential to the long term sustainability of a high calibre medical workforce. Any amendments to this directive must look to these longer term goals than to a *quick-fix* or *short-termism*. The lack of doctors – junior and senior as well – is

[19] Horne J, Reyner L. Vehicle accidents related to sleep: a review. Occ Enrion Med 1999;56:289-294.
[20] Dawson D, Reid K. Fatigue, alcohol and performance impairment. Nature 1997;388:235.
[21] Hartmann E, Baekeland F, Zwilling G, Hoy P. Sleep need: how much sleep and what kind? Am J Psychiatr 1971;127:41–48.

and will not be acceptable at national or EU level. The increase of the medical studies length could participate to create such an undesirable situation. Moreover, such a potential increase will have a financial cost.

Conclusions

To conclude our response to question 11 of the before mentioned Green Paper, we believe that flexibility can be achieved without harming security irreversibly if the following is implemented:

Individual Opt out

As for working time, a maximum 48 hour week must be established. The possibility to opt out as an individual must be abolished from the Directive.

Rulings of the ECJ

The ECJ states that all hours of actual presence on the premises, including the inactive part must be counted as working hours. This should be implemented in all member states immediately.

Working time

As ruled by the ECJ, all periods of time of which a professional is either actively working or should be available to do so if needed must be counted as working time.

Training

Training of junior doctors must not be considered out of working time, nor should it be prolonged if this directive is applied, since training is a reality during the whole working time.

Compensatory rest

Compensatory rest should be mandatory in the day following an overwork period, unless decided otherwise by collective agreement. If such an agreement ever exists, compensatory rest should be mandatory no later then 72 hours after the overwork period and no other period of overwork should exist until this rest has been concluded.

Reference period

Unless agreed otherwise by collective agreement, reference periods shall not exceed 6 months. In no case should any reference period be longer then the worker’s contract.