European working time directive

# The European working time directive

**P Nucci**

## An Italian ophthalmologist's view

The European working time directive (EWTD), written by the Council of the European Union (93/104/EC) to protect the health and safety of workers in the European Union, is an excellent opportunity for the British NHS to modernise its services. It lays down minimum and maximum requirements regarding working hours, breaks, annual leaves, and schedules/arrangements for night workers. The directive was enacted in 1998 in Great Britain as the working time regulations. Since 2004, this health and safety legislation has been extended to doctors in training who have traditionally worked long hours and overtime and who are essential to any health system in providing complete medical coverage to patients. These regulations are directed at employers, building on the progress already made through the ''new deal.'' They are part of a broader plan, which includes existing initiatives such as *Improving Working Lives* and the *Changing Workforce Programme*, to improve the work/life balance of NHS employees.

For numerous reasons, in Italy there is little awareness of these European directives. Although it is fully recognised that doctors in training are often inappropriately employed at a clinical level their experience and training should not allow their workload rarely exceeds 58 hours per week. I recently compiled a survey for our scientific community (SOU, Società Oftalmologi Universitari) that identified the major grievances of doctors in training: hardship related to the hourly workload was, in eighth place, a long way from the first three grievances of overall inadequate surgical training, a routine and non-educational use of their time and energy, owing primarily to their employment in overflowing and ungratifying outpatient services, and inadequacy of even their classroom preparation.

The most obvious reason that the workload is not a problem for Italian doctors in training in ophthalmology is that it does not exceed 40 hours. Additionally, the problem of making up hours after being on call is no longer relevant in ophthalmology since this type of service is utilised less than in other departments. The overtime put in by junior doctors reflects more their personal availability aimed at convincing their tutors or physicians in charge of their competence, prompted by career ambition or simply by a desire for greater opportunity in training.

The second reason that these directives do not have an impact is the tendency for Italians at various levels to not perceive European legislation as binding. The national health system and the university are notorious sectors in which the disaccord is so great that there is almost the perception of immunity from legislation, associated with the complex and anarchic condition that defines both organisations. The notion is rife that the equilibrium they have achieved, like a house of cards, cannot and must not be disturbed by a Europe that presumes much but does not give in return. The plethora of physicians in Italy, the resistance to a handover from generation to generation, the positions of untouchable privilege in a still medievally managed university all contribute to the deaf ear given to European dictates.

The fact that the EWTD will indeed challenge the entire hospital-university system, critically analysing how training is delivered in Italy, is another reason for concern in the minds of many university professors and hospital administrators. This challenge heralds the fear of a complex upheaval of training systems and methods, perhaps without resulting in a better trained physician, yet surely with much more work for those in charge of training. Nevertheless, I strongly believe that a better managed, better structured and more in-depth training programme will lead to a more meaningful and focused training of physicians. This is exactly what is required in addressing the EWTD.

Although the EWTD was conceived as a means of improving working lives and patients' safety, I would suggest an additional directive that goes further, requiring junior doctors to give an anonymous evaluation of the quality of their work time in their training environment.

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Surgery

# Wrong site surgery

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## A great deal of work needs to be done to reduce and potentially eliminate this most basic of errors

Wrong site surgery (WSS) is likely to be as old as surgery itself. Within ophthalmology Traquair, in 1947, described the ''important and very pertinent disaster of wrong site surgery where enucleations of the wrong eye have been performed.''[1] Although among the pantheon of medical errors it is relatively rare, the consequences can be disastrous—for example, removing the wrong eye when its fellow is blind. Because of the potentially serious nature of this error, a number of organisations have focused their efforts in reducing the occurrence. Unusually, in the field of medical error, WSS errors are thought to be entirely preventable. This has led to the adoption of a number of broadly similar protocols and guidelines to try to remove this most devastating of mistakes.

### WHAT IS WRONG SITE SURGERY?

Wrong site surgery can be simply defined as ''the performance of an operation or surgical procedure on the wrong part of the body.''[2] Within this particular definition there are a number of subcategories:

- Incorrect side (for example, left eye rather than right), which can obviously only occur with paired structures such as kidneys, ovaries, or eyes