

The obvious solution to training is to extend the working day; simple. Who will supervise? Most consultants are already working up to their legal maximum, 48 hours, or 12 "programmed activities" (PAs). Why not appoint more? At present the evidence is that new appointments in ophthalmology have plummeted, as the new financial structure of our NHS unfolds. Even replacement posts are being advertised as short term posts as trusts face considerable financial uncertainty. The support structure is just not in place, with most non-medical staff constrained by a 37 hour working week, and no money to appoint new staff, even if they were available.

Consultants have to shoulder an added burden because their junior support for that day has run out of hours. In this respect, ophthalmology has not, so far, come out of this too badly, but things are about to change: next year the EWTD will define the maximum average working week as 56 hours. It is probable that most units will cope with this. The adjustments to departmental working practices, already made, will be relatively minor. It will mean each doctor in training working 2 hours less, on average, per week. There is likely to be some rationalisation of emergency services between adjacent acute units. However, the crunch will come in August 2009, when the average working week must be reduced to 48 hours.

The first and major casualty in ophthalmology will be the on-call services. A Royal College of Ophthalmologists survey carried out in 2004 indicated that in August 2007, when the 56 hour limit comes in, some 25% of departments will no longer have sufficient resources to provide 24 hour cover. In August 2009, 50% of all UK eye departments will be unable to fulfil the EWTD without abolishing after-hours work, and abandoning all hope of providing continuing cover for their locality.

Rationalisation of services, on a sub-regional basis, will be a necessity if doctors in training are to have a reasonable working week, when the trainers are available (and the patients). It will of necessity be a shorter working week, it might drive doctors out of surgical training.<sup>5</sup> Even in major cities, it is probable that some rationalisation of out of hours services will become necessary, however uncomfortable and politically difficult that may be.

The aims of the EWTD are laudable. The effect has been damaging, especially to training, and to some extent to continuity of patient care, perhaps not so much in ophthalmology. It does not appear to have the desired effect of enhancing working lives of doctors, nor of improving patient care, in general.<sup>6</sup> A proposal for a new directive of the European Parliament is pending, specifically with regard to definitions of "on call

time," and "inactive on-call," and new provisions regarding the "opt-out." Submissions were sent in October 2004. It is not known when the European Parliament will reach a decision. There is clearly an urgent need for there to be changes to the definition of work when a resident is on call and for there to be a relaxation of the opt-out rules. Modernising Medical Careers envisages that all UK graduates will enter some form of formal higher medical training. They will all be subject to the EWTD. They cannot opt out at present. We are sitting on a bomb that is ticking. The explosion will occur in 2009. It is essential that eye departments start to plan now!

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## European working time directive

# European working time directive

S Omland

## A Norwegian perspective

Working time limits in the Nordic countries, with their long, social democratic traditions and strong labour unions, are among the world's lowest.

As early as 1919 the Norwegian parliament passed a statute enacting a limit of 8 hours' work a day for a maximum of 6 days a week. The general Norwegian working week has later been reduced to 5 days, with Saturdays and Sundays free.

Exempt from these limitations have been professions demanding 24 hour reaction capability, such as hospital doctors, who for many years had

virtually unlimited working hours, very much like in the present British system.

More restrictive rules have gradually been established, and the Norwegian hospital doctor's general working week is now limited to 38 hours. Doctors consenting to work up to 50 hours a week are, however, allowed to do so. Maximum continuous on-call duty is limited to 19 hours.

The exemption from the 38 hour limit has had the effect that most hospital doctors work substantially more hours, many as much as 50 hours a week, and tacitly, a few even longer. A particularly

exhausting constellation in the Norwegian system is the combination of an ordinary working day, tied directly to on-call night duty passing over into the first part of the next working day.

A system demanding and expecting top intellectual and professional performance, from a doctor becoming more and more tired, has been the most weighty argument for the introduction of shorter, but hopefully more efficient, working hours in Norwegian hospitals.

Among foreign colleagues I have met quite a variety of views of Norwegian working time rules, ranging from the supercilious to the envious. One British colleague, obviously having noticed our short working hours, politely remarked that it must be rather difficult to become a good doctor in a land where so little working time is devoted to the execution of one's profession.

Another Briton, with whom I worked for some time in Oslo, expressed in a more direct way that the least positive aspect of working as a hospital doctor in Norway, was the short working hours.

The first time I came to Moorfields and observed British hospital doctors' very long working days, evenings, and weeks, I really grasped the full meaning of these remarks.

In spite of the international medical profession's scepticism about the working hours of Scandinavian doctors, foreign industrial labour organisations have for a long time considered our working conditions, and especially the region's opportunity for women to be able to go to work, as a model to strive for.

General working time limits in the European Union have gradually approached Scandinavian levels. This is reflected in the present European Working Time Directive (EWTd), which in its latest edition, states that after a maximum transitional period of 7 years, a defined upper working time limit for health personnel of 48 hours a week is to be established. Even if the EWTd thus leads to a substantial reduction in working time, the directive's rules are still not as liberal as in Norway.

Norway is not a member of the European Union, but because of its

affiliation to the union Norway is obliged to follow the union's rules. In reality, the EWTd supersedes the Norwegian national regulations, compelling Norway to harmonise its working time rules in accordance with the European Union's.

It is not surprising that British ophthalmology will judge the consequences of the new directive as negative. When the "Scandinavianisation" of British working days and weeks eventually has been completed, my prediction is that the present intensive on the job training of British hospital doctors will gradually give way to a system where the doctor will spend more time with the family and also have an opportunity for increased leisure time. The proportion of female hospital doctors will increase. As for the time to acquire medical specialist proficiency of current British standards, this will undoubtedly increase.

Introducing new rules in society can represent somewhat of a trap, especially challenging to eager blinkered bureaucrats whose deepest wish is to exercise power over performers of enviable

occupations like doctors, or for that matter, fighter pilots.

Therefore, a word of caution: do not fall into the trap that befell Norwegian defence bureaucrats when they introduced new working time rules for the Norwegian military some years ago. Quite a few unbelieving eyebrows must have been raised under foreign flying helmets when Norwegian fighter pilots in a joint exercise with other NATO pilots over Norwegian territory, suddenly broke off from their formations with the following radio telephone message: "Sorry, new Norwegian working time rules force us to land so that we can reach our office desk to have lunch in the allotted time."

Anyway, my dear British friends, I wish you the best of luck in your forthcoming effort to implement the Scandinavian way of a hospital doctor's life!

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## Medical Defence Union

# Over 120 years of defending ophthalmologists

C Tomkins

Hundreds of ophthalmologists every year turn to us for advice and assistance

The UK medicolegal climate has changed dramatically over the past 120 years. Ophthalmologists now are subject to far greater scrutiny than ever before. We call it multiple jeopardy. From just one single incident ophthalmologists can be held accountable and have their professional conduct scrutinised in numerous ways: by the civil and criminal courts and coroners, by their employers, the National Clinical Assessment Service, and the regulatory body, the General Medical Council (GMC); through the NHS or independent sector complaints procedures and the healthcare regulator, the Healthcare Commission. The editor of the *BJO* suggested a title of "insuring ophthalmologists" for this article and, in that context, since 2000, the Medical Defence Union (MDU) has provided MDU members with an indemnity insurance policy

for clinical negligence claims. However, as well as claims, hundreds of ophthalmologists every year turn to us for advice and assistance with many other equally important medicolegal matters, which I will touch on too.

## INSURANCE—THE CURRENT POSITION

Many doctors do not realise that just under half of the United Kingdom's practising doctors do not have professional indemnity insurance. MDU members have been provided with individual insurance contracts since 2000, a move not yet taken by the other UK defence organisations, whose members are indemnified on a purely discretionary basis.

This may seem strange, given the global medicolegal climate and the dramatic increase in negligence claims

worldwide over the past 20 years. Many readers may not even know what discretionary indemnity is. Historically it was widely used as a means of indemnifying doctors, but has caused problems in many countries. Insurance is now mandatory in many EU states, most of the United States, and Australia. Unlike insurance, discretion gives doctors only the right to ask for assistance but not to receive it. We don't believe that discretionary indemnity alone provides sufficient certainty for doctors, or patients, when medical treatment goes wrong. Only insurance provides a contractual guarantee of defence, subject to the terms of the policy.

The UK Department of Health has recently conducted a consultation on a change in legislation to make indemnity mandatory for all doctors. We have suggested that the United Kingdom should get into step with other countries and that, in the interests of doctors and their patients, only insurance will do.

## OPHTHALMIC CLAIMS

So what types of ophthalmic claims are we insuring? Looking at medical negligence claims against our members operating in independent practice (since NHS indemnity was introduced in 1990 the MDU has not indemnified NHS hospital claims), the specialty ranks around mid-range in terms of the likelihood of being sued. Our ophthalmic