Reasonable Working Hours For Junior Doctors: How Much Longer Must They Wait?

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"...Doctors have this wretched thing called a vocation. Bad things vocations. They cause you to perform stupid and unrewarded deeds; and nobody knows this more than young hospital doctors. Only the truly idiotic, the cretinously supine or the hopelessly vocational would endure for a week what hospital doctors do for years".


Is Kevin Myers right? Most European workers have been protected from excessive and dangerous working hours since the introduction of the Working Time Directive in 1993. Yet it appears that junior doctors may have to wait until at least 2010 for a 48 hour week. Virtually all other workers are currently guaranteed a cap on their maximum working week in order to protect their health and safety, yet presently there is no limit whatsoever on the number of hours a junior doctor may be required to work. It appears universally recognised that the excessive demands placed on junior doctors constitute a serious risk, not only to the health of the junior doctors themselves but to their patients as well. How then has this ostensibly unfair and dangerous state of affairs come to pass and is the Irish government doing everything possible to remedy it? As the ultimate employer of all junior doctors, is the State doing its utmost to vindicate their right to a safe system of work, and the rights of the State's citizens (as patients) to a proper and safe system of medical care?

THE WORKING TIME DIRECTIVE–A BRIEF HISTORY

Although primarily founded as an organisation to promote enhanced trade and cooperation between the countries of Europe and their peoples, the European Union (originally the European Economic Community) has long had regard for the rights and entitlements of workers. Article 118A of the EC Treaty (which is the founding document of the Union) requires Member States to:

"Pay particular attention to encouraging improvements, especially in the working environment, as regards the health and safety of workers..."

The Community Charter on the Fundamental Social Rights of Workers contains provisions in relation to working time and holidays. In particular the Charter makes reference to the right of workers to have a suitable weekly rest period and also states that every worker must enjoy satisfactory health and safety conditions in their working environment. The terms of the EU Directive on Working Time (Council Directive 93/104/EC of 23 November, 1993) were based on Article 118A of the Treaty. They have been transposed into Irish law by means of The Organisation of Working Time Act, 1997 and Regulations made under The Safety, Health and Welfare at Work Act, 1989. Under the Directive, Member States were required to implement all its provisions by the 23rd November 1996, but Ireland was late in doing so and the provisions on rest and working hours became effective only from 1st March, 1998. The Act sets out statutory rights for employees in respect of rest, maximum working time and holidays. The key provisions of the Act on minimum rest and maximum working time are shown in Table 1.

The European Commission's original proposal for a Directive on working time covered all economic sectors and activities and indeed the Directive as approved by the Commission and The European Parliament did so. Political intervention by Member States (including Ireland) meant however that a decision was taken at Council level to exclude certain sectors and activities from the scope of the Directive. The final result was that junior doctors (as well as certain other workers, particularly in the transport industry) were not to be protected. Most of these excluded sectors (for example fishing and work at sea such as on oil rigs) were omitted from the protection of the Directive for genuine logistical reasons. Oil rig workers may be confined to a rig for weeks on end when working but then be free for many weeks when not on duty. It was recognised that some sectors required individual attention and would need to be dealt with by specific Directives appropriate to each industry. No

Table 1: Features of the safety, health and welfare at work act

- Maximum average net weekly working time of 48 hours;
- A daily rest break of 11 consecutive hours;
- Rest breaks while at work;
- A weekly rest break of 24 consecutive hours;
- Maximum average night working of 8 hours;
- Maximum hours of work for night workers engaged in work involving special hazards or a heavy physical or mental strain - an absolute limit of 8 hours in a 24 hour period.
such reasons existed however for the exclusion of junior doctors. Countries such as Ireland and the United Kingdom simply argued that their health services were not yet ready to give junior doctors the protections to which other workers were entitled.

The Directive was adopted in a form which gave no protection to junior doctors and which made no reference to future protection.

**Should the 1993 Directive Have Reduced Junior Doctors’ Hours?**

At the time of adoption of the 1993 Directive, the Commission emphasised the benefits that would accrue from the existence of adequate working time arrangements in all sectors, not only in relation to the health and safety of the workers, but in relation to benefits that the general public at large might enjoy. It stated that this was particularly the case with regard to doctors in training and transport activities where “fatigue brought by excessive hours of work may constitute a direct risk to the welfare and safety of others”.

There appeared to be universal agreement that a genuine and discernible need existed to protect the health and welfare of workers and the public by restricting working hours. No objectively justifiable reasons were advanced for excluding junior doctors from the protections to be afforded others however they were excluded because of political unwillingness to meet the financial costs that would result from the necessary changes.

At the Irish Medical Organisation’s annual general meeting in Killarney in April of 2000, Dr David Madden, a specialist registrar in occupational medicine outlined the many health effects experienced by people working for prolonged periods. These included a reduction in work efficiency, which could be related to “shift lag”; a collection of symptoms including fatigue, lethargy, digestive problems and sleeplessness. In his opinion shifts should not exceed nine hours. At the same meeting the Medical Director of the VHI (Voluntary Health Insurance Board), Dr Bernadette Carr, told delegates that doctors hours were currently “beyond the call of duty”. She suggested that a quality medical service might not be compatible with a background of enormous workload leading to excessive working hours.

In an article on the 5th of May 2000, Dr Muiris Houston, Irish Times Medical Correspondent, posed the following question:

> “Is it right to expect a doctor who is sleep-deprived to think clearly and logically when faced with a patient whose condition has deteriorated rapidly and in whom an accurate diagnosis is essential? Can we really ask doctors to carry out highly technical procedures the day after they have been up all night without a break?”

He said that circumstances had now changed to the point where the system was no longer compatible with either the demands of modern medicine or the lifestyles of young doctors. Being “on call” had changed to being “on duty” in his view. The organisation of modern medicine had changed too much for the old systems to work. As Doctor Muiris Houston put it:

> “Whereas in the past the young apprentice could reasonably expect to be called to the wards once or twice at night, the reality of 21st century medicine is that he or she does not get to bed at all. This means working from 9 a.m. to 5 p.m. the following day without adequate rest, 32 hours of continuous responsibility for the health and lives of others”.

Speaking to the Irish Times on the 11th of May 2000 the Fine Gael spokesman on Health, Mr Alan Shatter, called on the Minister for Health, Mr Martin, to reduce the pressures under which junior doctors worked. He highlighted two examples that he felt illustrated that the hospital services were incapable of properly meeting patients’ needs. In an incident the previous Sunday, at Beaumont Hospital a 29-year-old junior doctor suffered a heart attack at the end of a 36-hour roster and was admitted as a patient to the coronary care unit of the same hospital. In the same week, at St Vincent’s Hospital Dublin, a medical registrar collapsed while on duty.

There has been a suggestion in the media over the years that the necessary reforms have been delayed due to unwillingness on the part of existing Hospital Consultants to support the campaign for change. According to Dr Houston this is not the case:

> “Junior doctors have the full support of their consultants in taking industrial action. Whereas 20 years ago senior doctors might have wrangled their noses and commented: “We worked long hours, why can’t they?” this is not a view you will find today. They see the huge cracks in the system and will testify to the negative impact on both patient care and doctors’ health.”

With so much agreement on the issue how could junior doctors have been excluded complete-ly? The European Commission, Consultants, junior doctors, occupation health specialists and senior health administrators in this country all appear to concur that a reduction in working hours for junior doctors is not just desirable but necessary. Why isn’t it happening? In Ireland, the only obstacle appears to be the Irish Government, which has consistently sought to delay for as long as possible, the introduc- tion of positive changes.

**Are Doctors in Other European Countries Treated Similarly?**

The situation abroad must be examined in the light of the exclusion of certain types of employ- ees from the Directive. “Doctors in Training” are not protected by its provisions and this term is analo-gous to junior doctors or Non Consultant Hospital Doctors (NCHD’S) in Ireland. In some European countries NCHD’S are however treated as having finished their training and entitled to a cap on their working hours. For example a Registrar in Ireland is regarded as a doctor in training, yet a doctor in Spain, at the same stage in his or her career, is regarded as qualified and entitled to the protection of the Directive. It is estimated that there are over
270,000 junior hospital doctors throughout the EU who come within the definition of "doctor in training". Almost half of these are in Germany, where national legislation on working time already exists. In the absence of any European Directive the Germans have proceeded to protect their own doctors (and patients) with domestic legislation.

In June of 1999 a Joint Steering Group (JSG) on the working hours of NCHD’s was established by agreement between the Department of Health and Children, The Health Services Employers Agency and the Irish Medical Organisation. Their brief from the Government was to report on what changes needed to be made in this country should the 1993 Directive be extended by the E.U. to protect junior doctors. They examined the working hours and conditions of junior doctors in Ireland and compared the situation here with the position abroad. The principal findings of the study with regard to working hours were that NCHD’s in Ireland worked on average 77 hours per week. Anecdotal evidence suggested that it was not unusual for many junior doctors to work in excess of 100 hours in some weeks. Such hours must be looked at in the light of the maximum working hours under the 1993 Directive (referred to in Table 1 above), which are the maximum hours that it is felt safe to ask employees (other than junior doctors) to work.

In Holland junior doctors currently work a 46-hour week averaged over 13 weeks. Twenty-four hour shifts are no longer permitted under domestic legislation. The maximum shift duration is 12 hours and the 46-hour working week incorporates 8 hours for education. There is strict central monitoring of adherence to the 46-hour working week and each hospital is inspected 4 - 6 times per annum to ensure they are complying with the working time rules. Penalties are applied for every breach of the 46-hour working time rules at a rate of 1,500 guilders per person per day and some hospitals have been fined up to 200,000 guilders (approximately IR£7.000) at a time. This reduced working week has resulted (according to the JSG) in a 5-10% increase in available junior doctors, due to doctors being attracted back from nonmedical work by the changes.

Prior to 1981 Denmark had a situation whereby doctors were working on average between 60 - 70 hours a week. Junior doctors decided on strike action on the basis that they should work a 40-hour week, similar to that enjoyed by other workers in that country. The Danish Association of Junior Doctors and the Association of County Councils brokered a deal concerning the organisation of work and the duties of junior doctors. As a result it was agreed that the average weekly working time should be 37 hours; to be averaged over a period of 14 weeks. The average number of hours worked by Junior Doctors in Denmark is currently 41.3 hours per week.

There appears to be a misconception in Ireland that no action can be taken until another EU Directive forces change. This is simply not the case. The EU lays down (by Directive) the minimum standards that must be adhered to by member states. It does not prevent any individual state from adopting a more stringent standard or introducing more generous protections for workers. As can be seen from the above, Germany, The Netherlands and Denmark have all proceeded, in the absence of any compulsion from Brussels to enact domestic provisions which grant junior doctors similar rights to other workers. Why are we so reluctant to do so here?

**EUROPEAN DEVELOPMENTS SINCE THE 1993 DIRECTIVE**

The Commission was opposed to the final form of the 1993 Directive, which did not protect certain categories of workers. It stated that it was satisfied that these amendments to the Directive were not introduced because of any suggestion that health and safety as regards working time for the excluded workers was already sufficiently protected. It was the Commission’s strong view that the basic principles of the Working Time Directive should apply to all workers, and that there was no justification for complete exclusion of any sector.

The Commission felt that the exclusion of certain sectors from the protection of the Directive resulted in a "health and safety problem that must be rectified given that there are workers …who have no protection against risks to their health and safety through having to work excessively long hours".

On the 18th of November 1998 the Commission decided to proceed by amending the 1993 Directive to extend its provisions to junior doctors within seven years. A substantial amount of debate then ensued between the Member States. On one side the Commission (and those states which had already introduced their own protection for junior doctors) pressed for early introduction of the proposed changes. On the other side Member States which had not yet made any moves to protect junior doctors argued that a long lead-in period would be required in order to make the necessary changes in their health services which would allow for reduced junior doctor hours. On the 25th of May 1999 European social affairs ministers voted unanimously, on the basis of a U.K. proposal supported by Ireland, to extend the deadline for member states to reduce junior doctor’s hours to a maximum of 48 per week within 13 years. The European Social Affairs Commissioner (Mr Padraig Flynn) was quick to announce his dismay at the deal in which the Irish Government voted against the stated position of its own Commissioner and referred to it as neither "politically feasible or morally acceptable".

"It is unacceptable that patients can continue to be treated by doctors who are literally exhausted, and in consequence may pose a danger to people’s health. We cannot compromise on the health and safety of doctors and their patients for a further unacceptable period of time".

Mr Flynn made it clear that he would support attempts by the members of the European Council to reduce junior doctor's weekly working hours to a maximum of 48 hours. The Directive sets the overall principle that working time should not exceed an average of 56 hours per week. It gives the Commission the right to amend the Directive, but does not prevent any individual state from adopting a more stringent standard or introducing more generous protections for workers. As can be seen from the above, Germany, The Netherlands and Denmark have all proceeded, in the absence of any compulsion from Brussels to enact domestic provisions which grant junior doctors similar rights to other workers. Why are we so reluctant to do so here?
Parliament (when the proposal next came before them) to reduce this 13-year period. There then followed a process of difficult conciliation between the Parliament and the respective governments in an attempt to reach a compromise.

The fruit of this conciliation process was the European Directive of the 22 June 2000. This Directive, which must yet be transposed into Irish Law, required that the maximum average working hours for NCHD’S be reduced to 48 hours by the year 2010. No limit on hours is to apply until the start of 2005 and from that year to 2007, a 58-hour maximum will apply. For the years 2008 and 2009 a 56-hour maximum will apply before the limit reduces to that applicable to other workers. It would appear then that that change, albeit at a slow pace, is on the way due to the commitment of the European Commission.

Due however to the way in which the Irish Government had transposed the 1993 Directive into Irish law, it appeared that the new Directive would be completely ineffective to protect the rights of junior doctors. Both the Irish and U.K. legislation implementing the earlier Directive had defined working time as any time an employee is “at his or her place of work or at his employers disposal and carrying on or performing the activities or duties of his or her work”. The Irish and British governments had so defined this term in order to exclude from the definition time spent on-call at the employers place of work. By doing so they appeared, either deliberately or inadvertently, to exclude any possibility of junior doctors ever receiving any benefit from the Directive, even when extended to cover them, given that so many of the hours worked by them are on-call hours. A roster that scheduled no more than 48 “shift” hours for a junior doctor, even if he or she was then expected to work another 50 or 60 hours on-call, would not offend the provisions of the legislation. By defining working time in such a way, it appeared that the Irish government had divested junior doctors in this country of any potential rights, which they might have hoped to obtain.

On the 3rd of October 2000 however a decision of the European Court of Justice gave hope to junior doctors. In a case brought against the Spanish health administration by SIMAP, (the union representing health care workers in Valencia), the court found that hours spent on-call in a hospital or health centre should be considered shift work and treated accordingly in calculating pay and hours worked\(^9\). The SIMAP decision overrules the Irish and U.K. definitions and for the first time offers a real hope of meaningful protection from excessive hours for junior doctors in Ireland. It remains to be seen when the new protections will actually arrive.

**WHEN WILL JUNIOR DOCTORS SEE A MEANINGFUL CHANGE IN CONDITIONS?**

Prior to May of 2000, the last NCHD strike in this country had taken place in 1987 and was called for reasons substantially similar to those which had precipitated the strike 13 years later. At that time the then Minister for Health, Dr Rory O’Hanlon said in resisting the demands of the doctors:

“A consultancy manpower study has almost been completed and we can’t change until we learn its findings”\(^9\).

In April of 2000, the language used by Mr Micheal Martin (the current Minister for Health) in a press release was uncannily similar when faced with an all-out strike by junior doctors the following month:

“The minister is committed to achieving [the extension of the protection of the 1993 Directive to junior doctors] in 9 years. Much of the preparatory work is already in hand. PA Management Consultants are undertaking a study of NCHD’s hours at eight hospitals”\(^10\).

In a further press release later that month the Minister again confirmed his commitment to reduce NCHD’S hours in line with the then imminent 2000 Directive and added:

“Working on achieving the very ambitious targets contained in the Directive would need to start almost immediately”\(^11\).

These assurances must however be looked at in light of the facts. In the 13 years between the two junior doctor’s strikes no provision was introduced by the Irish government to reduce the hours of junior doctors. The Irish government was supposed to have implemented the initial 1993 Working Time Directive by the 23rd of November 1996 but workers in Ireland only began to see the benefits of the Directive in March of 1998. When the Irish government did eventually transpose the Directive, they did so in such a way that sought to exclude from the protection of the legislation hours spent on-call. The strike called for May 2000 was called off on the basis of a deal which increased the rates of pay for overtime but which has done nothing to compel the reduction in junior doctor working hours. While an abundance of press releases were issued from the Ministers office concerning NCHD’S hours in the lead up to last years strike there has been an ominous silence in the ten months since. An acknowledgement by the Minister in April last year that work would have to begin almost immediately to achieve the European target also, implicitly, accepted that this work had not yet started at that date. Given that The European Commission had sought to introduce such protections from the early 1990’s and given that other European countries had already introduced and implemented even more favourable regimes, it appears an amazing and damning admission that in April of 2000 the necessary work had yet to start in Ireland. Perhaps it is not so surprising when viewed in light of the fact that Ireland has consistently voted at European level (with the U.K.) to delay improvements in doctors conditions for as long as physically possible and also in light of the fact that the 2000 Directive has not been transposed into Irish law. Will it be as delayed as long or even longer than, the 1993 Directive?
CONCLUSION

Regardless of the attitude of the Government it does appear that, at last, there is light at the end of the tunnel for junior doctors. The 2000 Directive and the SIMAP case should eventually mean an improvement in conditions, thanks to the tenacity of the European Commission. Exactly how long the Government will delay these improvements remains to be seen but it is disquieting that the Government appears unwilling to move until forced to do so by Brussels.

As matters stand in 2000 there is no provision in place, which currently protects the health, and safety of either doctors or patients from the adverse affects of the excessive hours NCHD’S are required to work. At a time of unprecedented national budget surplus the question as to whether (ethically or morally) there should be such a provision is a separate matter. As Dr Bernadette Carr (medical Director of the VHI) put it:

“It should be a matter of National embarrassment that the initiative for reducing working hours comes through the European Union Directive rather than through the collective will of all the partners in the Irish Health Services” 3.

The reasons for the reluctance of the Irish Government to reduce junior doctors hours are far from clear. The Government claims that the will is there to introduce change, and clearly the finance is available, but no progress has been made. A substantial amount of time and money has been spent on discussion groups, review groups and management consultants, yet was any of this really necessary? No one is asking the Irish Government to reinvent the wheel; other countries have already introduced the required changes successfully and numerous models exist abroad which could be implemented here.

The failure to make the necessary changes led to a crisis in staffing levels in some hospitals last July, particularly due to a shortage of anaesthetists. Junior doctors, tired of waiting for the long promised changes, have been voting with their feet and taking up positions abroad in unprecedented numbers. The response of the Government to this was not to move to improve conditions in Irish hospitals urgently, but to mount a recruitment drive in India and Pakistan, seeking between 50 and 60 anaesthetists. Is it morally defensible for a Nation such as this to send a group to recruit junior doctors from developing countries (where they are undoubtedly needed), when the reason for the shortage here is that we are unwilling to treat our own doctors in a manner which would encourage them to stay in this country?

As the situation stands, the necessary changes are not going to be introduced in the immediate future, and it seems clear that junior doctors, and potentially their patients, will be the ones to pay the price.

REFERENCES

2. The Irish Times, April 14th 2000.