editorial

Psychiatric Bulletin (2005), **29**, 161–163

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The European Working Time Directive

The 'European Working Time Directive' (EWTD) is health and safety legislation adopted by the European Commission in May 2000 (Council Directive, 1993). From August 2004, National Health Service organisations have been required to ensure that their employment of junior doctors complies with it (Department of Health, 2002). The key points of the directive are that workers must have 11 h rest in every 24 h, a minimum 20-min break when their shift exceeds 6 h, a minimum 24-h rest in every 7 days or minimum 48-h rest in every 14 days, a minimum 4 weeks' annual leave and a maximum of 8 h work in every 24 h for night workers. The implementation of the EWTD will have a significant impact on the operation of mental health services. The process also poses significant questions concerning the education and training of the future medical workforce which may become difficult to plan and deliver.

It is almost impossible to underestimate the breadth of the impact that the EWTD will have upon training and service. It is noteworthy that non-delivery of EWTD remains a major problem in some European countries, for example The Netherlands (Sprangers, 2002) where education and training within the concept of the working week was excluded. This is not the position in the UK.

Potential problems

Many of the potential problems have been raised within the College:

The impact of service delivery changes on education

Changes in service delivery must ensure that juniors do not simply move from one task to another with little feedback and little constructive learning. The basis of learning to become a doctor must be rooted in being a doctor. In addition, exposure to a continual series of patient 'sound bites' may be unrealistic as preparation for practice as a consultant, and it is likely that this is not the style of work that would have attracted individuals to psychiatry in the first instance.

Supervision

Educational supervision is the key building block in facilitating learning for trainees. The 1 h per week allows a broad canvas of academic development around patient-based themes to occur, as well as more broad-based progress in many areas of non-clinical competence. The stability of the 'hour' spent in the same place at the same time each week is clearly threatened by shift patterns, periods of compensatory rest, etc., which may well not allow the trainee and educational supervisor (consultant) to be physically present in the workplace at the same time. In addition, the clinical supervision needs of a trainee will need addressing, for example, when working a 'week of nights'.

The bulk of current teaching is delivered by a classroom-based method, including local MRCPsych courses, as well as weekly in-house programmes of case conferences and journal clubs. While rotas may be constructed to facilitate attendance to the maximum, it will be difficult for trainees to attend on a regular basis.

Clinical experience

In any clinical training system there must be adequate time for trainees to gain sufficient clinical experience, both of routine and emergency work. With operationalisation of crisis resolution and home treatment teams in adult psychiatry, the latter is likely to change dramatically.

Sub-specialty experience

To date, the custom and practice in key sub-specialties has been that time spent is not eroded by trainees working to provide a more general service during the day. It is possible that shift working and periods of compensatory rest will effect further erosions of time committed to sub-specialties.

'Acting up/acting down'

Trainees work at different levels according to experience and according to their educational needs. This will continue to be appropriate in a majority of instances but not in others, particularly as there may be fewer doctors around in any given system at any particular time. The

https://doi.org/10.1192/pb.29.5.161 Published online by Cambridge University Press

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direction of 'Hospital at Night' (NHS Modernisation Agency, 2003) for acute hospitals suggests a move toward teams including doctors of differing grade working together according to level of competence rather than any preordained set of duties.

Too many rotas?

Many current systems have rotas devised for a number of different activities, in addition to on-call, e.g. electro-convulsive therapy. These multiple rotas will be difficult to sustain.

Service planning/operational policies

Service planning and operational policies must obviously work from the patient outwards but many will require urgent review if they are not to compromise EWTD compliance. An example may be that of a missing patient or violent incident where notification but no action is required of a doctor.

Improving working lives

The challenge of maintaining appropriate work/life balance and of maintaining the right opportunities for those with particular needs, for example, flexible trainees, must be maintained.

Principles

There are three basic principles. The first is obviously that this is the law and it cannot be ignored. The second is that there are no magic answers or universal solutions, and the third is that there must be no 'sacred cows'; all potential solutions need to be tried and tested.

Possible solutions

Estimates vary, with some authors suggesting a reduction of as much as 79% of 'routine' working time available (Chesser *et al*, 2002). Services will need to adopt a wide variety of strategies to overcome the challenge of a reduction in working time. Solutions will be predicated upon changes in the role and function of consultants. Rotas for out-of-hours work need examination and many small and sub-specialty rotas will be unsustainable. The impact for training include the following:

The learning plan

The introduction of new shift patterns will radically alter the opportunities for teaching and learning through face-to-face contact. The task will be to clearly identify and document what can and will be achieved through relatively independent learning, and how to optimise the limited contact that there will be between trainers and trainees. In examining the thinking and proposals from the conference of medical postgraduate deans ad hoc working group it is suggested that a plan based around three components, patient-based teaching, classroom-based teaching, and learner-based teaching, should be constructed. Patient-based teaching would include ward rounds, topic-based bedside teaching, out-patient clinic, case conference and special experience, including multi-professional opportunities and psychotherapy training, as well as audit meetings and other clinical governance activities. Classroom-based learning would include formal teaching sessions such as MRCPsych lecture courses and journal clubs. Learner-based learning would include educational one-to-one meetings (educational supervision), formal study time and informal study away from work.

Patient-based activities

The core of learning will be patient-based. The requirement will be a systematic rather than an apprenticeship model, with formal documentation such as a logbook or portfolio of both the situation (for example an out-patient clinic) and the learning that has occurred. Individual patient interviews will be enhanced by, for example, demonstration, observed interview, video with reflective analysis and problem-based learning. For each situation a series of prompts can be drawn up and a grid concluded of completed activities.

Classroom-based activities

One of the most basic challenges which prompted this discussion paper was the consideration of formal teaching sessions. Shift patterns will mean that trainees will spend less time at formal classroom-based teaching sessions. There will be a need, therefore, to consider these in different ways (see below). Rather than focus on attendance, participation may be recorded by trainees completing their learning diary against the agreed plan, and this diary being monitored and reviewed during educational supervision and at trainee appraisals. This can improve a simple mathematical expression such as X% attendance required. External auditors such as the Royal College of Psychiatrists accreditation teams can then review individual and/or aggregated data.

Learner-based activities

Once more the emphasis is going to be on the trainee to complete a diary of experience which must be reviewed against the plan agreed with the educational supervisor and tutor. For example, weekly education and supervision can be documented in terms of its occurrence, content and study time; reading books and journals and partaking in distance learning or e-learning can be recorded in a similar fashion.

Learning contract and learning diary

These would be completed and would thus document both learning opportunities and their uptake for each individual. Visiting teams could review aggregated data and make a judgement on the availability of appropriate resources, e.g. distance learning materials, e-library connections and their real-time use.

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Educational supervision

It may be necessary to consider new ways of providing educational supervision. It could be that we need to move to a system where a consultant may act as educational supervisor for a number of different trainees within an organisation with dedicated time provided in the job plan by an employing trust, as is being done for the foundation year. This, of course, does not mean supervising a number of individuals at the same time. However, it would mean that an individual would supervise and facilitate the learning for trainees on a longer basis. This would in no way obviate the consultant trainer's task in providing direct day-to-day clinical supervision for the individual trainee. This is a model that works well in some medical technical specialties but perhaps not so well for specialties such as psychiatry.

Another possibility would be to move away from face-to-face supervision on a weekly basis towards a pattern where the timing remains weekly but the method of communication may be via the telephone or even e-mail.

Clinical supervision is separately considered in the current *Basic Specialist Training Handbook* (Royal College of Psychiatrists, 2003). This highlights the requirement to provide close supervision of work at all times; for example, it states that ward rounds or out-patient clinics should not routinely be conducted by the trainee alone.

Classroom-based teaching

The two main components to consider are the local in-house programme and the MRCPsych lecture course. The former is probably less threatened in that it may increasingly perform a vital and fundamental role in continuing professional development for lifelong learning for all medical staff. The MRCPsych lecture course presents the opportunity for a more radical piece of thinking. EWTD and 'Modernising Medical Careers' (Department of Health, 2003) indicate a move towards a more modular but continued and incremental style of learning for trainees. The MRCPsych lecture course may need to be delivered as a distance learning event, where trainees are able to take their assessments on completion of given modules and move on. The distance learning course could be supplemented by a series of residential courses and may even provide electives around its core. Thus all trainees could access the highest quality teaching and learning materials at the same time; moving to a modular student-based curriculum would allow the more able to progress more speedily.

Clinical experience

A documented learning plan and diary along with a systematic approach will be a possible step forward. Thus, rather than simply having to clock-up so many hours on call, as it were, the trainee would need to demonstrate that they have acquired the right range of experience and learnt from it, whether this happens at night or during the day. The clear downside to this is converting trainees into 'stamp collectors', as it were, whereby the emphasis shifts too far to ticking off in an individual's diary that they have seen condition *x* or performed task *y*, rather than attaining any real breadth or depth to the learning.

For psychotherapy the efficient use of time and the most energetic organisation and leadership will be needed. The requirement to plan regular timeslots over long periods of time may mean that there will be greater planning of individual rotations. The model, frequently used in other medical specialties, means that a trainee is allocated posts for 2–3 years ahead and thus knows their timetables and commitments well in advance, allowing a greater degree of control over the future. Clearly, on the other hand this style removes the opportunity for trainees to choose posts as their interests and enthusiasms develop.

'Acting up/acting down'

There will be a need to ensure that everyone is working to their appropriate level of competence and achievements. In order to progress and learn successfully, it is also important that trainees do not spend all their time doing the same things, thus at a higher level of training continuing to work just as they were when first starting in psychiatry. To this end, job and learning specifications will need to be clear and systems will need to be in place that do not routinely require working at inappropriate tasks.

Conclusions

Implementation of the EWTD is a key driver for change in the education of clinicians. It presents certain questions, many challenging the way we do things now. The current methods of delivery of teaching and learning will have to alter. The College, for its part, is currently rewriting the *Basic Specialist Training Handbook* and the Specialist Training Committee is monitoring ideas and developments. Models will require experimentation and these are to be encouraged and publicised. It is a cliché but in this instance 'no one size fits all'.

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https://doi.org/10.1192/pb.29.5.161 Published online by Cambridge University Press