RUNNING OUT OF TIME

The deadline for implementing European legislation on doctors' working hours is looming, but it remains unclear what the rules will be or the effect they will have on staff and patients, **Tessa Richards** reports

Few pieces of recent legislation have generated as much heat among doctors as the European Working Time Directive. Since its inception in 1993, EU member states have adopted different stances to this law, which applies to all employees. In the health sector, the UK, along with Denmark, has been among the more conscientious about applying it. As a result British doctors have been fully engaged in the much wider debate in Brussels on proposals to change the directive. A decision on whether new draft legislation is approved or falls will be made by the end of the month. The crunch issue for doctors centres on whether the legislation is affecting the quality of patient care and professional training.

The directive was incorporated into British law in 1998. Junior doctors were exempt from it initially, but it was later extended to cover them and the UK agreed to implement it incrementally. The plan was to reduce the working hours of doctors in training to 58 a week by 2003, 56 by 2007, and 48 by August 2009. Over the past year the practical difficulties of devising rotas to meet the 48 hour goal, which includes rigid stipulations about rest periods, have becoming increasingly apparent. So has concern about the effects on patients and junior doctors of achieving full compliance with the law.

Stand off

Over the past four years, national governments and the European parliament have been discussing revisions to a new text of the working time directive drafted by the European Commission. Discussions are tense because MEPs and governments of member states hold polarised views. The main bone of contention relates to two issues.

The first is allowing countries to retain their right to opt-out—Britain is among 15 member states that use an opt-out that allows individual workers the right to work longer than 48 hours if they choose to.

The second is the extent to which time spent on call counts as working time. Judgments by the European Court of Justice suggest that all on-call time spent at the place of work, irrespective of whether it is active or inactive (resting or asleep), should be counted as working time. The court has also ruled that "compensatory rest" should be taken immediately after work shifts.

Last December, the parliament voted to end member states' right to the opt-out and for the Court of Justice rulings to be observed. The European Council wants to retain the opt-out and to allow countries leeway on how much on-call time counts as working time and when rest is taken—a position which clearly offers health authorities more flexibility.

Expectations that these bodies will reach a compromise are fading. A recent conciliation meeting failed to reach agreement on a revised text. If agreement is not reached in their meeting later this month—and few predict it will be—the draft legislation will fall because the legal deadline for settling differences between the two institutions will have expired.

The view from Brussels is that the commission is unhappy about this impasse. If a compromise is not agreed, the status quo will prevail and, theoretically, the commission will be in the invidious position of contemplating legal action against countries that are not fully observing the 1998 directive and court rulings. In practice it will be unwilling to do this and may draft new proposals on on-call time and compensatory rest.

Implementation

Just how many countries are failing to implement the European Working Time Directive is not known. The commission carried out a survey of member states' compliance last year, but the results are not yet available. In the health sector, anecdotal evidence from a BMA survey of representatives of national medical associations suggests that many countries are not in a position to meet the August 2009 deadline. In the UK the picture is mixed. The Department of Health has suggested that six of the 13 strategic health authorities want more time to achieve full compliance, although most trusts maintain they are reaching the 48 hour goal.

Half of the respondents to a questionnaire survey of all specialist registrars in training, college tutors, and regional advisers carried out last December by the Royal College of Physicians, said their hospitals were unprepared for the 48 hour target. A more recent survey carried out by *BMA News* suggested an even greater proportion is unprepared. Compliance is of course hard to define. Trusts try to ensure that junior doctors fill in their hours of work forms accurately, but it's acknowledged that a degree of "fudge" is possible. Senior doctors observe that some trainees voluntarily use their legal option to spend more time at work than they are rostered for (eight hours extra a week is allowed) to gain more hands on clinical experience; a move that many welcome.

But while the issue of compliance is straining the administrative ingenuity of managers to its limits, doctors are exercised by its impact. The BMA has long held the view that implementing the working time directive, which was introduced to protect the health and safety of employees, is unequivocally in the best interests of doctors' work-life balance and patient safety. The Department of Health takes a similar view, and its website provides advice for hospitals who need guidance and support to make their rotas work (www.healthcareworkforce.nhs.uk/workingtimedirective.html).

The position of the Royal College of

Physicians of London is more guarded. The statement on its website says it does not support the introduction of the 48 hour week unless "certain conditions" are met. Foremost among these are that patient care and the quality of training are not compromised.[1] A worrying finding from its 2008 survey was that around two thirds of the trainees and trainers who responded said they thought that implementing the directive would worsen patient care and medical training. Concern was also expressed about the difficulty of finding enough locums to cover gaps in hospital rotas and the quality of care provided by external locums.

Evidence that the quality of medical care is suffering is "inconclusive," says Andrew Goddard, director of medical workforce at the college. "We are scarcely in a position to do a controlled study," he added. "We do, however, feel that it's essential to be alert to any changes in surrogate markers of quality." In the case of patient care, this would be reflected in lapses in safety and the number of complaints made by patients, he suggests. For quality of training, the indicators are the rate of successful applicants for certificates of completion of specialist training and sickness rates among junior doctors.

Surgeons are pushing hardest for revisions. The Royal College of Surgeons of London believes that a 48 hour working week for surgeons is neither achievable nor desirable.[2] Its survey of surgeons in training suggested that the move to shift work to comply with the directive has already increased the number of medical errors, adversely affected training, and increased fatigue among junior doctors. It also found that some trusts re-employ their junior staff as locums to plug gaps in their rotas. The college maintains that 65 hours is the optimum number for working hours for surgeons in training.

Maximum working hours[3]
Denmark: 37
France: 52.5
New Zealand: 72
UK: 56-64
US: 80
Australia: No limit

Amid these conflicting views some senior doctors, including those in the Department of Health, admit that although the UK has had a long time to implement the directive, competing priorities have seen it "sleep walk" towards the August 2009 deadline. The profession as a whole, they suggest, has underestimated the scale of the requisite organisational change and the implications for medical staffing.

Irrespective of whether agreement to amend the directive is reached in Brussels in the next couple of weeks there is no turning back for the profession. Medical training in the UK has shifted from an apprenticeship model to a shift work one in which service commitments for consultants are increased. Patients are likely to welcome this but it certainly requires an expansion in the number of consultants. Many claim to be working harder than ever. Although consultants are covered by the directive, in practice they have a degree of autonomy and can work longer hours by using the opt-out. (General practitioners' are considered to be self employed and exempt from the directive.)

Talking to senior doctors is revealing. Some are quick to proffer the view that, paradoxically, life for their juniors has become more stressful as their hours have come down from 56 to 48. When they are on call they cover more patients and are unfamiliar with the history of most of them. Ties with consultants are weaker and mentorship reduced. Consultants are also concerned about loss of continuity of care, a cause of medical error. Some juniors say that their training is being neglected in the drive to cut hours.

The reality is that no one knows what an optimum training schedule for doctors looks like. In the US, junior doctors work up to 80 hours a week, but debate on the risks associated with these long hours is growing. Currently the Institute of Medicine has sanctioned an 80 hour week but with certain provisions.[3] Given the US position and the varied situation in Europe there has to be scope for mutual learning on best practice as doctors' hours are reduced. There is also force in the argument that the UK should assess the impact of the reduction of junior doctors' hours to 48.[4] Legislation that was never designed to regulate the way hospitals function and doctors work and train cannot be assumed to be beneficial in the absence of evidence to show that this is the case.

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Humanitarianism on trial in Sudan

The expulsion of international aid groups from Sudan has highlighted the difficult balancing act between upholding human rights and supporting vulnerable populations, as **Peter Moszynski** reports

The expulsion of 13 international aid groups and dissolution of Sudan's three largest indigenous organisations at the beginning of March, in retaliation for the international criminal court's (ICC) indictment of President Omar al Bashir for crimes against humanity, has devastated the world's largest humanitarian operation. It also raises the question why some of the world's most respected relief agencies are accused of being agents of neocolonialism, and poses a dilemma for medical workers attempting to help non-combatants in the middle of civil conflict: should they speak out when they witness the effects of mass rape and ethnic cleansing or should they remain silent in the name of humanitarian neutrality and impartiality?

Although the international arrest warrant against President al Bashir is the first against a sitting head of state, the indictment had long been expected. The court had been mandated to investigate allegations of crimes in Darfur by the UN security council five years ago, following an international inquiry that found evidence of war crimes and crimes against humanity and recommended the case should be referred to the international court.

Human effects

The expelled charities—whose entire assets were seized by the state—were responsible for over half of Darfur's aid programme, and their departure could leave millions of refugees without assistance. As the UN and the remaining relief groups (both international and newly established Sudanese organisations) rush to fill the void before the forthcoming rainy season makes access all but impossible, there are growing concerns about the effects.

Oxfam representative Alun McDonald said: "In Darfur there are already clear signs of impact. In some camps, there is a real danger that mechanised water pumps will stop working due to lack of fuel and technical maintenance. In Kalma camp this has already happened—boreholes have stopped pumping water."

KEY EVENTS IN SUDAN

1916: Independent Sultanate of Darfur annexed to Sudan by Britain

1992-96: Osama bin Laden and al Qaida based in Sudan

1998: US cruise missile strike destroys al Shifa drug factory in Khartoum

1990-2005: Operation Lifeline Sudan eventually becomes world's largest humanitarian airlift

2002: Nuba Mountains ceasefire starts three year peace process

2002: Uprising of non-Arab tribes in western region of Darfur, complaining of exclusion from peace process, marginalisation, and forced displacement

2003: Formal outbreak of war in Darfur. Khartoum recruits Arab militias to fight Darfuri insurgents

2004: UN commission of inquiry into war crimes in Darfur

2005: Comprehensive peace agreement reached. It excludes Darfur. United Nations Mission in Sudan established to oversee the peace agreement and African Union Mission in Sudan (AMIS) is deployed as peacekeeper to Darfur

2007: International criminal court issues arrest warrant against humanitarian affairs minister Ahmed Mohammed Haroun

2008: United Nations African Union Mission takes over from AMIS in Darfur

2009: International criminal court issues arrest warrant for President al Bashir on 4 March. Two days later Sudan announces expulsion of non-governmental organisations

2010: Democratic elections are due to take place in February as stipulated by peace deal

2011: Referendums on independence for Southern Sudan and Abyei, "popular consultation" on independence for South Kordofan and Southern Blue Nile

With the rains about to start, along with the traditional pre-harvest "hunger gap," he believes things will rapidly deteriorate: "The rainy season usually brings an increased risk of cholera, malaria, diarrhoea, and other water borne diseases. This year a lot of the health and medical programmes that would deal with this have closed down."

Not only do the expulsions endanger relief operations in Darfur, they also affect the rest of northern Sudan and could undermine reconstruction in the war shattered south, unravelling the entire peace process. Sudan accounts for over a third of international humanitarian expenditure, as well as hosting two separate peacekeeping missions. In all, 7610 aid workers—308 foreign workers and 7302 nationals—have been directly affected in northern Sudan (including Darfur), where the expelled agencies accounted for 40% of aid workers, delivering more than half the total amount of aid, including health care, water, sanitation, and food distribution.

Frank Donaghue, chief executive of Physicians for Human Rights, said: "Besides the obvious short-term implications of more than a million people left without access to food, water and medical assistance, another critical, immediate consequence is that there will be no outsiders there to bear witness to human rights violations on the ground."

Ahmed Mohammed Haroun, state minister for humanitarian affairs (despite having been indicted two years ago for crimes against humanity) claimed that the expelled groups had "proved that they are doing little humanitarian work and a lot of intelligence activity that is harmful to Sudan's national security."

He accused relief agencies of "fabricating reports on Sudan's situation, making up evidence and figures to supply the international criminal court." He also claimed they were

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Touchdown: World Food Programme aid flight in Old Fangak, South Sudan

"creating a split in Darfur's social fabric and providing military, information, and logistical support to Darfur rebel groups."

Oxfam, one of the expelled agencies, said: "We have been very clear with the government that we have no cooperation or links with the international criminal court investigation, and that we do not agree with the government's allegations. Yes we have spoken out to raise concerns about the humanitarian situation, but we see that as being a part of our humanitarian mandate."

Nobel peace laureate Jody Williams, who led a high level inquiry into Darfur for the UN Human Rights Council, says "Darfur became the world's largest humanitarian operation not because aid workers were eager to go there, nor because of some kind of neocolonialist agenda to steal Sudan's oil, but because of a government orchestrated campaign of ethnic cleansing that displaced almost half of the population. President Omar al Bashir may be understandably keen to avoid being held to account for his crimes, but expelling organisations seeking to assist the refugees only worsens the situation and underscores his guilt."

Professor Williams insists: "While it is obviously urgent to try to continue to secure the welfare of displaced Darfuris, the international community must make it clear that it will not submit to such blackmail; nor will it allow either civilians or aid workers to be used as human shields to thwart the needs of justice and the responsibility to protect."

Aid workers, peacekeepers, and relief convoys have frequently been attacked; refugee camps and aid compounds are often raided by the security forces; and carjackings have become routine. According to the UN Office for Coordination of Humanitarian Affairs, humanitarian agencies lost 277 vehicles and had 192 armed break-ins during 2008. They lost 354 vehicles, 1035 radios, 684 computers, and 190 generators during 4-25 March.

Professor Williams warned that the continuing problems in Darfur were directly undermining peace and reconstruction efforts in the semi-autonomous south, which has become a reservoir for most of the world's neglected diseases, including roundworm, whipworm (trichuriasis), hookworm, schistosomiasis, lymphatic filariasis, trachoma, leishmaniasis, leprosy, African trypanosomiasis, Guinea worm disease, and Buruli ulcer. Only one in four people in the region has access to medical care.

Should medical workers speak out when they witness the effects of mass rape and ethnic cleansing?

Urging Khartoum to rescind the expulsion orders, UN secretary general Ban Ki-moon told last month's Arab League summit: "Relief efforts should not become politicised . . . People in need must be helped irrespective of political differences. At the same time, peace and justice are core principles of the United Nations. We must all be committed to both."

Obstruction

The recent clampdown is not unprecedented: during the civil war in the south and Nuba Mountains during 1983-2005, denial of access to aid was routine and medical groups clandestinely operating in rebel held areas were often attacked by government forces.

As the Darfur crisis developed, so did government obstruction. When in 2005 Médicins Sans Frontières-Holland reported on the number of victims of sexual violence it was treating in Darfur, its head of mission, Paul Foreman, was arrested and charged with crimes against the state and eventually deported. In August 2006 Slovenian presidential envoy Tomo Kriznar was tried and convicted of espionage and only pardoned after an international outcry. In October, UN special representative for Sudan, Jan Pronk, was expelled for writing about the military situation in Darfur.

In December 2006 the largest agency then working in Darfur, the Norwegian Refugee Council was expelled. Its secretary general, Tom Archer, warned: "The international community cannot continue to mince words, pretending that the hostage-taking of humanitarian operations in Darfur is not happening on its watch." He insisted that it was time for the international community "to break its code of silence and act."

Despite numerous such problems the relief operation continued, although most agencies had learnt to be very careful about how they described the situation on the ground because the smallest transgression from the reporting restrictions imposed by the Humanitarian Aid Commission would often result in the denial of operating licences and travel and work permits.

Médecins Sans Frontières, an organisation founded with the specific intention of bearing witness while working in humanitarian crises, warns that there are risks when speaking out on behalf of the victims. International president, Christophe Fournier, stresses, "Delivering lifesaving assistance to civilians and non-combatants requires constant negotiation with local authorities as well as warring parties, who might be responsible for war crimes. Independence from the international criminal court is not enough to avoid being blocked from providing lifesaving humanitarian aid. International pressure seeking to punish indicted Sudanese officials has led to relief efforts being cut in half, threatening the lives of millions of people."

Most agencies still in Sudan are currently extremely tight-lipped about the situation, attempting to be diplomatic while trying to salvage the humanitarian operation, but with Khartoum now threatening to expel all international non-governmental organisations, many privately believe that maintaining a code of silence could prove counterproductive.

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