In this issue of the European Journal of Cardio-thoracic Surgery, Lim and Tsui [1] on behalf of the Registrars and Consultant Cardiac Surgeons of Papworth Hospital refer to the impact of the European Working Time Directive (EWTD) on exposure to operative cardiac surgical training. They have performed a cohort study to determine the factors that influenced operative surgical training. In summary, out of 3312 cardiac surgical operations that were performed over a 2-year period, the proportion of cases performed by trainees was 39% and 40% in each of the 2 years before and after the EWTD was introduced. Using logistic regression analysis, which is a tool that our beloved Papworth colleagues know very well, they reach the conclusion that with a successful institution specific training module and a commitment to training, exposure to operative surgical training can be sustained despite shortening of working hours.

This is an institutional experience that is very well presented by the authors. The question is: Will this be a good example for everybody? It is difficult to say. There are too many differences among public and private institutions, including the case load, and also among accredited teaching institutions and those with no teaching programme. There are also too many differences among European countries. The interest of this paper is that it addresses a very important point for our immediate future as a Specialty and perhaps we should be more aggressive in reminding what our role is to policy makers.

Number one and a big problem. A full-shift pattern was introduced for registrars at their Institution. It was introduced by the administration of the Hospital but the authors do not confirm to us if there was a previous discussion with the surgeons or if, simply, the senior surgeons or the Head of the Department had to agree without discussion. To conclude, first, the Hospital administration does not care about teaching or learning, it does not even care about what happens to the trainees as long as there is no noise and everybody agrees. Good for Europe or, at least, for the UK! It is strongly recommended to carefully read the ‘Compendium of solutions to implementing the Working Time Directive for Doctors in Training from August 2004’ [2] that can easily be accessed on-line. You will enjoy it! It is like going back to the days of past dictatorships in Europe. Just an example: ‘Effective monitoring and recording of the hours worked by doctors in training is a crucial prerequisite for identifying areas of non-compliance and developing arrangements to tackle them’. It was believed that ‘tackle’ was a good term only in rugby and perhaps Jonny Wilkinson could give us more information on this… In any case this is a model which is being reproduced or shared across Europe, too.

Second, Table 1 shows the shift pattern and focuses on night shift. This is interesting and goes back to the concept of industrial factory. In addition, the concept of ‘Hospital at Night’ has been addressed and it is a project that aims to mitigate the effects of full-shift working brought about by the implementation of the EWTD. This can also be reviewed online [3,4]. A nice piece to read that ends up with something like ‘… that means concentrating more on what the patient needs and less on what individual doctors perceive as their role’. We doctors, we surgeons, know very well our professional role and the patients’ needs more than anyone else. We do not need anybody to remind us what our role is and perhaps we should be more aggressive in reminding what their role is to policy makers.

Another interesting issue is that the average number of days a trainee was allocated to theatre was approximately 16 per month and 11 after the introduction of the ETWD. Furthermore, the authors confirm that they did not take into account the commitment to outpatient clinic, annual and study leave. At the end, the trainees performed 39% of the cases before and 40% after the EWTD was introduced. The question that arises now is: How were the trainees able to do the same or more surgical work with an average of 5 days less in theatre? If we understand this, what were they doing in theatre? If we understand this, what were they doing before the EWTD with 5 more days in surgery? Did that represent that the system did not properly work at this Institution? Or, who does the work these people did in the past? As a matter of fact, the European Court of Justice was asked by an Spanish doctors union (SIMAP CASE, ECJ Case C303/98, 3 October 2000) to pronounce, inter alia, whether time spent on call, either at the medical centre/hospital or away from it, counted as ‘working time’ and therefore should be counted towards the 48-h week. The Court responded that ‘The characteristic features of working time are present of
time spent on call by doctors ... where their presence at the health centre/hospital is required ... the fact that such doctors are obligated to be present and available at the workplace with a view to providing their professional services means that they are carrying out their duties in that instance’. This means that time spent on call by doctors, staff and trainees must be regarded in its entirety as working time. To make this European Court of Justice Judgment simple: A 2 days on call a week means a ‘non-surgical week’.

Another problem is that the surgical responsibilities are not well defined on a year-by-year basis despite that in the discussion section there is a brief mention to the changes in the training system in the UK is undergoing. However, there is no mention to what such changes are. The reader would like to know what the trainee has to perform every year and how many procedures he/she has to perform at the end of the training. The reader would also like to know the distribution of non-operating responsibilities on a year-by-year basis. This is not addressed in this paper. This is a critical issue, too. On the one hand and as in many other countries in Europe, we understand that there is no official caseload that is expected for specialist recognition in the UK and this represents another major drawback. In Spain, the official training programme in Cardiovascular Surgery contemplates a minimal official caseload that the trainee must complete at the end of the training period [5]. This makes a difference as then, the trainee will not rely strictly on the certification of any given director on the fitness for practice. This latter term ‘fitness for practice’ sounds too ambiguous. A proper and well-established training programme also takes for granted that all trainees will be carefully supervised throughout the entire course of their training and this is what a system like the Spanish guarantees.

A major limitation of the study, as the authors rightly state, is that they focus mainly on the operative surgical training. It is very doubtful that the full-shift pattern may eventually make possible a complete surgical education. Surgical education is a very complex concept that includes many other issues than the ‘hands-on’ practice. If we only rely on pure manual practice of constructing vascular anastomoses or approaching the mitral valve, then we are not educating surgeons, we are educating technicians. They are those who will ‘take the vein’ at Papworth theatres as confirmed by the authors. In many places there is no such a possibility in a public or university Hospital in other countries in Europe for a number of reasons including the negative influence of the Workers’ Unions. Surgical education includes a critical intellectual component, clinical conferences, judgment, common sense and progressive incorporation in terms of responsibility to the patient care, which cannot be monitored or analyzed using logistic regression.

An approach to the caseload presented here using simple mathematics shows that in a 2-year period, 3312 major cardiac operations were performed by a team that includes 12 consultants (9 plus 3 locum consultants). This represents an average of 138 operations a year per consultant. This is not a great deal and does not favorably compare with many other institutions with a lesser number of responsible consultants. If we include all 19 registrars (according to the list provided at the end of the text), these 3312 operations performed in the 2-year period represent an average participation by registrar per year of 87 operations if we assume that the vein in coronary cases is harvested by technicians. Even though Table 4 shows a distribution of the surgical activity according to the seniority of the trainee, it is not clear how many cases each individual actually performs with the assistance of a scrubbed consultant, which is the right way to teach and learn. And the reader does not know what a ‘Year 5 or more’ is. This approach may not be truly accurate as the internal departmental organization could be different but it is a simple example to stress on caseload.

Reading the paper of Lim and Tsui is a very interesting exercise as it brings the reader to the real problem. This is not the degree of training achieved by the trainees at Papworth. The real problem is that we are evolving towards and organization of our Hospitals where the people is asked to work some hours (shift pattern) but there is no interest on what will happen to the patient. More importantly, absolutely nothing has been said with regards to the responsibility, which is also a very complex concept, of the surgeon in dealing with the patients. If a trainee at Papworth has completed his/her shift and the patient operated by him/her is still having problems, the ETWD obliges the trainee to go home. In practice, it is not feasible and it is irresponsible. The commitment of the professional, the commitment of the surgeon has been one of our major standards in the past and the changes in the healthcare systems and hospital administration are challenging these standards that may eventually be exceptions in future times. The vast majority of the readers of the European Journal of Cardio-thoracic Surgery have already spent days and nights during their careers looking after patients and most of the times for nothing else that the patient’s benefit. Hospital administrators, physicians that jumped into administration business (usually the worst among the worst when it comes to deal with the former medical colleagues) and politicians do not care about individual responsibilities at the time of analyzing regular work. Individual responsibilities are only counted when the professionals get into trouble and then are left alone before the society and justice by the Institution and their governing bodies. In addition, current trends show that the system gets perversive as administrative tools are being used by administrators to monitor the quality of medical care [6]. The shift practice induced by the EWTD is a good example of this challenge to our previous ethical standards.

The impact of reduced working time on the salaries should not be neglected. Nothing is said in this paper in this regard. If the trainees are supposed to work less time as it is clearly stated in the introduction, then what will be the impact on their salaries? No answer to this. In addition, will this be a matter of concern for the administrators and even for the departments? Will this be extended to the faculty members also at some time down the road? This is a significant problem but it has not been addressed in this paper. Obviously this was not the main objective of the paper by Lim and Tsui, but it is also a very important point that may eventually hit all of us, at least to those working in the public sector.

In any case, the readers of the European Journal of Cardio-thoracic Surgery must pay much respect to our colleagues
from Papworth, who have been able to produce an elegant contribution on a very complex problem we are facing today. And this is just the iceberg’s tip. Worse times are ahead of us. But, believe us, this is just the iceberg’s tip and not only in Cardiothoracic and Vascular Surgery. Worse times are ahead of us regarding everything we, Europeans, do. When carefully analyzed and not only with the perspective of our surgical practice, the EWTD is another phenomenal European step backwards. France has recently witnessed the problems of reducing the weekly working time to 35 h. The country has recognized this as less worked hours does not match with increasing productivity and quality. The report of the Central European Bank [7] on the evolution of the average yearly worked hours per worker in the period 1970–2004 between the US and the Euro Zone shows that there has been a significant decrease in the working hours in the Euro Zone (from 1938 to 1526 per year) when compared to the US (from 1936 to 1825 per year) and this leaves Europe far away from competition. What else do we need to confirm that working less makes a difference? Spain has already gone through this [8].

At last, but not least, it is again strongly recommended the reading on the real threat to Europe at any level, namely China [9]. Among many other realities, it seems that the new factories in China are extremely hard to beat, in part because workers work so hard and so long. Furthermore, it also seems that the goal in Europe is to ask professionals to work for as low as in China workers do. For European standards this is obviously, not acceptable. This is the problem; the next superpower challenges the world. Where is Europe going? Perhaps nowhere.

In closing, we wish to look to the next half century by mentioning some of the opportunities that will help us to overcome the problems we are facing now. Please leave Cardiothoracic and Vascular Surgery to its professional body to develop better ways to treat our patients and to adapt to changing needs of the Society.

References


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