European Working Time Directive implementation and cardiothoracic training: larger centers may optimise training

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I read with interest the article by Lim and coworkers, detailing the effect of implementation of the European Working Time Directive (EWTD) on operative training at Papworth Hospital [1]. The findings of this study are impressive, but may not reflect the wider experience of UK trainees.

The Royal College of Surgeons of Edinburgh has performed nationwide surveys of the attitudes of UK and Irish cardiothoracic trainees towards their training in 2003 and again in 2005–2006, before and after implementation of the EWTD 58-h limit [2]. There are important contrasts between their results and the Papworth study.

During the initial study period at Papworth, 39% of all cardiac cases were performed by trainees, rising to 40% after EWTD implementation. In the year after EWTD implementation, the seven trainees performed a mean of 99.3 cases each. Papworth is a large hospital, performing 3312 cardiac procedures in 2 years.

In contrast, the UK survey respondents performed a mean of only 42.6 cardiac cases/year after EWTD implementation, and worked in units performing a mean of 1043.9 cases/year. Only 37% of respondents expressed satisfaction with their training in 2003, falling to 30% in 2005–2006. 100% of respondents who expressed a view felt that EWTD implementation had impacted negatively upon training.

There was an important correlation between trainee satisfaction and their cardiac operative experience (72.7 cases/year vs 26.7 (satisfied vs not satisfied), \(p = 0.005\)). Larger units, as assessed by the annual number of cardiac cases (1586.2 vs 828.4, \(p < 0.001\)), number of intensive care beds (20.6 vs 8.9, \(p < 0.001\)) and ward beds (68.7 vs 35, \(p < 0.001\)), was also associated with increased trainee satisfaction.

Trainees’ satisfaction with EWTD implementation and the quality of their training in the UK is worryingly low. Large hospitals with many trainees may find it easier to implement shift working while continuing high-volume operative training. Trainees appear to prefer such environments. It may be that larger units such as Papworth will be better able to provide training following EWTD implementation — certainly, Lim and coworkers’ findings suggest they are adapting well.

Registrar numbers are set to decline, and it is likely that not all units currently training will continue to do so. Evidence of high-quality operative training, and trainee satisfaction with individual units, will be crucial to decide where the smaller cohort of future trainees are best employed.

References

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Reply to the Letter to the Editor

Reply to West

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We thank Mr West for his comments [1] on our paper [2], and agree that the experience at Papworth is not reflective of the wider experience of UK trainees. It was certainly not our intention to deliver such a message.

From the United Kingdom survey, it is clear that the majority of trainees are dissatisfied with their training and all felt that their training was negatively impacted by the shortening hours.

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