I congratulate my hon. Friend Charlotte Leslie on securing this important debate. Why it matters so much is summed up well by Sir John Temple, in his report, “Time for Training”:

"Training is patient safety for the next 30 years", and that is absolutely right.

My own experience is as one of the junior doctors who worked those catastrophically long hours, having qualified at Guy’s in 1986. Before coming to the House, I was involved in teaching and training junior doctors and medical students, including F2 “foundation year 2” doctors, so I have the advantage of seeing the system from its very worst through to the current practice. What we had in 1986 was entirely unacceptable. I was routinely working 100 hours a week, and sometimes up to 120 hours a week. I often worked very long shifts, from Friday morning at 8 am through to 6 pm on a Monday, sometimes without any sleep. It was catastrophic, demoralising, dehumanising and, frankly, dangerous. Training was acquired simply through saturation exposure to techniques. Often the training was ad hoc and the supervision was not ideal. There was an ethical practice that we would find unacceptable today. Often the attitude was: see one, do one, and teach one. Sometimes the see-one stage was omitted.

I remember: “I hope that this never happens now because it would be, and it was then, entirely unacceptable” having to insert a chest drain into a patient for the first time. I had a telephone propped on my shoulder and a terrified patient on the bed, but there was no alternative to carrying out the procedure. I am happy to report that the patient survived that experience, but it was not enjoyable for either of us. Both of us were half scared to death as the process went ahead. It was the equivalent of being bayoneted by someone who looks about 12 years old. As I have said, extra time was no guarantee of better training in those days. Happily, the NHS today operates to far higher ethical standards.

However, the firm structure that existed then guaranteed a continuity of care. There was not an issue about contacting the junior doctor because the junior doctor never left the hospital. Professionalism was affected in some ways, especially in the attitudes that were engendered. Sometimes there were very paternalistic attitudes from senior doctors, and certainly attitudes towards consent were not as high as they are today. That was engendered by very long hours and not enough attention given to the quality of training for junior doctors. In addressing this matter, we have to be cautious about referring to the old days as the good old days.

We now have a situation in which there simply are not enough staff to cover shifts. Clinics are routinely cancelled as a result of the inflexibility of compulsory rest periods. For example, if a consultant is called in to carry out an emergency endoscopy, they might then be forced to cancel their clinic for the next day, whereas if we had a little more flexibility about the timing of the rest period "perhaps it could happen within 48 hours" we would not see our patients being unnecessarily inconvenienced.

The availability of experienced staff is poor, as has been highlighted in many reports. Nor
are we addressing issues of staff fatigue, to which other Members have referred. I want to read out an e-mail that I received this week from a junior doctor who did not wish to be named, who says, "I regularly do seven 13-hour nights on the trot. The argument is that we are given time off to average out our hours over a six-week period. However, we all end up doing the extra hours anyway, partly by covering for colleagues who are off or who do not exist, or simply by staying on after our shift's end because there is so much more to do. So we foundation years are doing the long hours but we are just not being paid for them."

Professionalism faces two problems: either junior doctors work the extra hours and are not paid for them, and are told not to record them sometimes by management; or we develop a clocking-off mentality, which I started to encounter towards the end of the time that I was training junior doctors. For the first time in my career, I heard junior doctors openly talk about clocking off and something not being their problem because they had handed it over to the next doctor on the next shift. That was unheard of when I was a junior doctor: we left when the job was done. We have to be cautious about some consequences in that regard.

Staff absenteeism, which is almost unheard of, is increasing. According to a survey by the Royal College of Physicians, the absenteeism rate has increased from 0.8% to 3.5% since the implementation of the directive in 2009. Therefore, the changes towards exhausting shift patterns have not only not resulted in doctors who are less tired, but have led to increased absenteeism. Whether that is due to sickness or to a change in professional attitudes to taking time off is a fine point, but the implementation of the directive has led to serious consequences.

In my area, we have heard about some rotas starting at unacceptable times. I do not think that any hon. Member here would accept that starting a shift at 2 am is acceptable, but it is going on.

As hon. Members have said, we are hearing in our surgeries and postbags that patients and their relatives are noticing changes in continuity of care. The other serious issue is handovers, particularly where senior doctors or consultants are not present. The fact is that shifts do not tally up between junior and senior doctors. Again, referring to the e-mail that I received, on continuity of team, where senior doctors are in different shift patterns there is no sense of a team structure or possibility of handovers being carried out professionally.

Margot James (Stourbridge, Conservative)

My hon. Friend is making an eye-opening speech. Does she agree that there are implications for health inequalities? For a patient who is well educated and knowledgeable about medical matters and/or has a supportive, informed family around them, the issue of handover is perhaps not as serious as for a patient who is not similarly advantaged.

Sarah Wollaston (Totnes, Conservative)

Yes, I agree. But even articulate families of patients tell me that sometimes they find it impossible to track down the doctor who has been looking after their relative. It is not just relatives, but general practitioners, who are having this difficulty. I am afraid that, as a result of this loss of continuity, the times have gone when GPs could phone and be guaranteed to have some feedback regarding patient care. Handovers have been identified, time and again, as a
significant source of mistakes in the NHS, leading to incorrect diagnoses and treatments, often repeated, unnecessary or even inappropriate investigations and poor communication between patients, relatives and medical colleagues.

The directive results in poor team work, a loss of training opportunities and is, as we have heard, "expensive, not only in terms of staff time, but in the penalties that are applied to trusts if they breach it. Finally, it does not stop doctors working at other hospitals, so it does not necessarily even address the problem that it was designed to address.

That is enough about the problems. What about the solutions? Nobody here advocates a return to dangerously long hours for junior doctors, because tired doctors are dangerous doctors. We want the safest care for our patients. I should like the Minister to respond to the idea that the definition of "on-call" is overly restrictive. Doctors should be able to sleep on site and be available for occasional emergencies without that counting towards the 48-hour week. The requirement for compulsory rest periods should be far more flexible on timing, and we need special consideration of the problems facing district general hospitals. The directive is one thing for staff in a metropolitan centre, but it is causing a particular crisis in many of our district general hospitals. We should maintain individual opt-outs.

The point about the European working time directive, as has been made so eloquently by Kate Hoey, is that European time is not the same as human normal time. Being realistic, the possibility of a rapid change in the directive is small, so we must look at the alternatives. What progress are we making towards a consultant-delivered service? There is no doubt that the directive does not affect all specialities, and its effect can undoubtedly be mitigated by moving towards a consultant-led service and taking up many of the points raised by Sir John Temple in his report.

There is no doubt that consultant-led care is the safest care for our patients. Much more can be done to make use of existing training opportunities. Not all specialties are affected, but when they are the effect can be mitigated by greater use of, for example, simulation, better design of rota to enable the shifts and working patterns of seniors and juniors to dovetail so that there are better opportunities to train, using hospitals at night, and separating the emergency model from the routine model so that we have far more emphasis on juniors being able to get the training they need.

Real problems are facing juniors now with getting assessments signed off by senior colleagues, and in the level of their daytime routine supervision. The problem is also that they are not having enough experience signed off, so many doctors have to extend their training, which is a huge source of extra cost for the NHS. Some of that could be addressed with better rota and service design.

We all recognise that the NHS functions as a result of the dedication of its staff, and I pay great tribute to all my former colleagues, and recognise what an excellent job they do on our behalf.

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Sarah Wollaston (Totnes, Conservative)

Does my right hon. Friend think that one of the problems with the EU's priorities is that it is demanding a 6.8% rise in its budget, rather than dealing with more pressing problems?

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