

Protective Medical Legislation Deficient knowledge of Maternity (Health and Safety) Rights for work-adjustment exists amongst flexible trainee doctors: Is there a risk to maternal and foetal health?

B.R. Pal^{*}, N.R. Hussein^b, A. Howlett^b, Y.E. Harun^b, R. Rajaratnam^b

^a Department of Paediatrics, Worcester Acute Hospitals Trust, Alexandra Hospital, Woodrow Drive, Redditch B98 7UB, UK

^b Department of Epidemiology and Public Health, University of Birmingham, City Hospital, Birmingham, UK

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Abstract

Objective: To assess awareness, identify knowledge source and evaluate uptake amongst doctors of “health and safety rights” (HSR) contained within the current European protective medical legislation for pregnant workers.

Study design: A descriptive cross-sectional pilot study, by a postal questionnaire during the period 1998–1999, targeted 97 UK doctors (West Midlands region) after their first pregnancy.

Results: Of 67 respondents (response rate 73%), 41 (61%) were Registrars (SpR) and 25 (37%) SHOs: 80% work-schedules did not change during pregnancy. Only 11% (95% CI, 4–21%) of the doctors surveyed actually knew their maternity rights. 66.2% had no knowledge of maternity legislation; 80% of respondents had not taken up health and safety rights. Fifty-two percent (95% CI, 40–65%) reported maternal and neonatal complications.

Conclusions: In a self-selected group of flexible trainees following their first pregnancy, only one in five female doctors have adequate knowledge about the legislative “health and safety rights” of work-schedule adjustment. A combination of reasons may contribute to the low uptake of these rights. The question of whether or not poor knowledge and uptake of legislative rights may be detrimental towards pregnancy and neonatal complications requires a large prospective study. An improvement in the knowledge of current maternity legislation could occur by targeting all medical students, all doctors, postgraduate trainees and National Health Service (NHS) employees.

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1. Introduction

The workforce in all the countries of Europe is rapidly changing: women in their reproductive years now make up 45% of workers, 83% become pregnant during employment and continue working in pregnancy. Increasing numbers of women are entering the medical profession [1] and the majority of female medical students plan to have children

[2]. Pregnant female doctors are often lost from the NHS workforce or compromise their medical careers [3].

Protective medical legislation for pregnant workers is built on over 80 years of attention to maternity protection by the International Labour Organisation (ILO Maternity Protection Convention first adopted in 1919 (Convention No. 3), revised in 1952 (Convention Nos. 103 and 95) and European Directives (European Social Charter). PML has been established in most European countries and applies to women working in the UK National Health Service (NHS) [4]. The Maternity Protection Act, 1994 repealed and re-enacted, with amendments, the Maternity Protection of Employees Act, 1981, while also implementing the

* Corresponding author. Tel.: +44 1527 503030x44057;
fax: +44 121 313 0057; mobile: 07979454365.

E-mail address: Rani.Pal@worsacute.wmids.nhs.uk (B.R. Pal).

employment rights aspects of the EU Pregnant Workers Directive (92/85/EEC). The Act, which has subsequently received several amendments between 1999 and 2003 and most recently in 2004, then introduced a new entitlement to health and safety leave for such employees, particularly if there is a risk to them in the workplace.

Doctors usually comprise a body of young, fit, healthy and educated individuals. Such a group of women with ready access to high quality medical care may be expected to have few pregnancy complications and good perinatal outcomes. However, there are aspects of on-call duty and service that might influence this outcome including prolonged working hours and sleep deprivation ([Appendix A](#)). For the most part, there are no direct studies of these issues as they affect pregnant female doctors.

Work by Klebanoff et al. [5] obtaining retrospective data from medical graduates in the 1980s compared female medical graduates with the spouses of peer male graduates and found no differences in pregnancy outcome. However, other authors provide contradictory data confirming increased incidence of maternal complications [6], preterm birth [7], foetal growth reduction [8] and occupational exposure risk of high cumulative work fatigue score, including physical exertion and mental stress [9].

Our pilot study surveyed female doctors after their first pregnancy to identify knowledge and uptake of “health and safety rights” (HSR) expected within PML and descriptive information about pregnancy experience. We recommend measures that could be taken to optimise the working capacity both for pregnant doctors and their employers.

2. Materials and methods

A retrospective cross-sectional study was performed. The subjects were contacted by obtaining the names and employment addresses of all flexible trainees from the Associate Postgraduate Dean at Birmingham Medical School, who held training responsibility. Regional ethical approval was not sought. Verbal self-consent was assumed if questionnaires were returned completed.

Flexible trainee doctors elect to continue their post-graduate training on a part-time basis because of domestic commitments. The length of training is increased in proportion—for example, a flexible trainee doing 50% of full-time work would double the length of training. The minimum number of daytime hours worked is 20 h per week (50% of full-time), the maximum being 28 h (70% of full-time). In addition to these hours, the flexible trainee is required to do on-calls on a pro-rata basis according to their percentage of full-time work. This means in reality that most flexible trainees are working in excess of 40 h per week.

The aims of this pilot study were to: (1) establish the level of awareness of HSR amongst female doctors during

their first pregnancy when working full-time, (2) identify the source of this knowledge, (3) gauge the level of uptake of these rights, (4) identify the reasons why HSR was not taken up and (5) describe any pregnancy-related health morbidity.

A questionnaire was compiled, together with an explanatory letter. This was piloted on 10 female doctors at a hospital in Birmingham following which amendments were made to generate a more user-friendly, self-explanatory questionnaire with concise focused questions for ease of completion, data analysis and standardization. A section for expressing views, describing any issues about recent pregnancy experience was provided, this being a very emotive subject.

All questionnaires were first sent on the 1 February 1999 with a pre-paid envelope. Two reminder letters and questionnaires were subsequently sent (21 February and 7 March 1999). As the responses were mainly descriptive in nature, a contact phone number was provided to respondents for any other matters. Data from the questionnaire was analysed manually using an Excel'98 spreadsheet package. Statistical analysis using StatsView and StatsDirect programmes.

3. Results

Of 97 questionnaires sent out, 72 were returned (initial response rate of 74% of all trainees). Of these, 67 (93%) had experienced a recent pregnancy, and 5 (7%) stated that the questionnaire was not applicable. The results are based on the questionnaires completed by 67 flexible trainees who had experienced a primigravid pregnancy during the year January 1998–1999. The median age was 32 years (range 27–43 years). The majority of respondents were UK trained (61/67). Of these 59 (97%) were Caucasian (56 English and 3 European) and 2 (3%) were Asian. Six (9%) were from other countries and trained abroad.

3.1. Employment details

Forty-one respondents (61%) were Specialist Registrars (SpR), 25 (37%) Senior House Officers (SHO) and one House Officer (HO). During their first pregnancy, the trainees reported working an average of 55.1 h per week with an average rest period of 5 h (range 0–8 h) during a shift or on-call. This suggests that they were working on a full-time basis during their pregnancy: 45 (67%) on-call rota basis; 11 (16%) on full-shifts; 5 (8%) on partial-shifts; 6 had a different work pattern.

3.2. The level of awareness of HSR ([Table 1](#))

Sixty-five respondents completed this section ([Table 1](#)). All these statements regarding work adjustments are in fact true. Generally, those respondents who claimed to know

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