juniors) resulting in a consultant based service, preserving the career prospects of future doctors.

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1 Godlee F. Juniors' hours: is the end in sight? *BMJ* 1992;305:937-40. (17 October.)

2 Vassallo DJ, Chana J, Ingham Clark CL, Smith RE, Wood RFM. Introduction of a partial shift system for house officers in a teaching hospital. *BMJ* 1992;305:1005-8. (24 October.)

EDITOR,—D J Vassallo and colleagues have devised a shift system for the eight preregistration house surgeons who work for three general surgical firms such that each doctor works on average less than 64 hours a week.¹ Each surgical firm comprises two consultants, one senior registrar, and a senior house officer. Two firms have three preregistration house officers and one firm has two. These doctors are responsible for 80 general surgical patients, and the house officers also look after 20 radiotherapy inpatients.

Vassallo and colleagues thus show that with an abundance of junior medical staff it is possible to devise a rota such that the preregistration house officers work less than a 64 hour week—well within the maximum working week of 72 hours to be allowed after the end of 1994. In their conclusion the authors suggest that the principles of this partial shift system are generally applicable and that the model can readily be adopted by general district hospitals.

The authors seem to be unaware of the staffing levels that exist in many departments in district general hospitals. In my orthopaedic department there are two senior house officers and a preregistration house officer, who at present work a one in three rota. Each of these doctors is responsible for 1000 consultant episodes each year. They have the advantage of exposure to abundant clinical material. But no computer designed shift system would allow these doctors to work for a maximum of 72 hours a week and still provide continuity of cover for the department. The obvious solution is to appoint an additional preregistration or senior house officer to work in the department and thus establish a one in four rota. This, however, is not possible because of restrictions on staffing.

The difficulties that I describe will be faced by many departments throughout the United Kingdom, and attention should be directed to them. Complacency should not be allowed to develop: Vassallo and colleagues describe a shift system for a department that could be considered to have a glut of junior medical staff.

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1 Vassallo DJ, Chana J, Ingham Clark CL, Smith RE, Wood RFM. Introduction of a partial shift system for house officers in a teaching hospital. *BMJ* 1992;305:1005-8. (24 October.)

EDITOR,—Heartening as it is to see a centre of excellence embracing the new deal on junior doctors' hours,¹ we believe that some fundamental difficulties need to be addressed before such a scheme can be implemented in a district general hospital such as ours. Unfortunately, we also believe that these may apply to many new district general hospital trusts.

"Related specialties" in this hospital are general surgery—providing four consultants, two registrars, two senior house officers, and four house officers—and urology (on a split site)—providing two consultants and a single senior house officer. They have access to 60 beds. Orthopaedics and

fracture surgery have 48 beds, with three consultants, one staff grade surgeon, one career registrar, and four senior house officers. Though not doing higher surgical training, each of these senior house officers is in a post recognised for training for the FRCS.

In our case, combining orthopaedics and general surgery would result in 11 junior staff (seven senior house officers and four house officers) being available for shifts to cover nine consultants' firms. Safe cover of emergency admissions and 108 inpatients could be achieved only with a minimum of two doctors on call during night shifts as at least one would often be assisting the registrar or consultant on call in emergency surgery. The introduction of such a system in our district general hospital would be to the detriment of the quality of emergency care we currently provide and the training given to senior house officers. There would be no continuity of care by junior staff for emergency admissions after 10 pm. Decreased hours worked by junior doctors are not likely to be perceived as beneficial as the number and frequency of night shifts worked would cause much dissatisfaction. The out of hours commitment of consultants and career registrars would certainly be increased; as their commitment is already considerable this might well prove unacceptable.

We too have outlying patients for whom we must share responsibility, but direct comparison of our 108 inpatient surgical and orthopaedic beds with 50 general surgical beds at St Bartholomew's Hospital indicates that only after doubling our number of junior doctors would we have equivalent staffing. Thus we cannot accept that this system has any benefits to offer a district general hospital as we do not have the capacity for 50% redundancy in our junior staff. The standard of health care that is currently perceived as desirable can be achieved only at the expense of long hours worked by relatively few doctors for relatively little pay. Unless the number of doctors is increased, hours cannot be reduced without a lowering of that standard.

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1 Vassallo DJ, Chana J, Ingham Clark CL, Smith RE, Wood RFM. Introduction of a partial shift system for house officers in a teaching hospital. *BMJ* 1992;305:1005-8. (24 October.)

EDITOR,—The Junior Doctors Committee purports to represent our interests. D J Vassallo and colleagues' article on partial shifts¹ illustrates much of the double speak about the real views of many junior doctors.

"The new deal" is designed to bring about major reductions in junior doctors' hours of work and improve overall working conditions while maintaining clinical and educational standards. Without an increase in the number of junior doctors simple arithmetic dictates that to reduce our hours the volume of work and number of patients covered while on duty must be greater. In a busy faculty such as general medicine it is hard to see how this could be tolerated. Most of our colleagues view with scepticism the idea that this will be alleviated by the appointment of one or two more staff grade doctors.

The argument that a shift system can enhance social and family life when you work a week of nights is beyond us. Vassallo and colleagues gloss over the fact that only six of the 16 house surgeons concerned preferred partial shifts to their old on call rota.

The new deal also fails to mention the best method of learning, which will inevitably be destroyed—namely, having a close working relationship with your consultant, whose experience can never be substituted for by additional out of hours work in the library.

It is true that nobody likes change—but especially when it is for the worse.

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1 Vassallo DJ, Chana J, Ingham Clark CL, Smith RE, Wood RFM. Introduction of a partial shift system for house officers in a teaching hospital. *BMJ* 1992;305:1005-8. (24 October.)

EDITOR,—Having vivid memories of working a one in two on call rota in a professorial surgical unit (average weekly number of hours on call 116-128), I was pleased to read of D J Vassallo and colleagues' introduction of a partial shift system for house officers in a similar unit,¹ with a reduction in working hours to the more acceptable 64 per week.

It is unfortunate that the government has not chosen to address the problems of providing 24 hour cover 365 days a year in general practice, particularly in semirural areas. Although the intensity of work during time on call is less than it was in my professorial house job, disruption of sleep can impair performance during the next working day. To address this problem one of my colleagues (W M Campbell) has produced a model rota for a practice of three doctors (figure). The

Rota for general practice with three doctors (A-C)

rota reflects the partners' wish to have a rolling rota and complete weekend cover. It employs the concept of an on call doctor each day. The on call doctor holds an early surgery but has an unstructured day from 11 am, which allows him or her to carry out new and return home visits and deal with all problems arising over a 24 hour period. Before a weekend on call the doctor has the preceding Thursday off. On the subsequent Monday he or she has a half day. Thus 76 hours on call is buffered by a definite off period. In the remaining week of the rota each doctor has a half day on Wednesday.

We believe that the rota minimises the cumulative effects of multiple nights of disturbed sleep, and all partners have felt able to cope with the demands of providing 24 hour care. Now that the problems of junior hospital doctors' hours are being addressed, however, it is to be hoped that general practice hours and rotas could be given similar consideration.

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1 Vassallo DJ, Chana J, Ingham Clark CL, Smith RE, Wood RFM. Introduction of a partial shift system for house officers in a teaching hospital. *BMJ* 1992;305:1005-8. (24 October.)