- 2 Martin E. The psychological consequences of drug abuse on the patient. *Maternal and Child Health* 1989;14:344-6.
- 3 Martin E. Organising the practice to cope with drug addicts. *Update* 1991;42:130-6.

Junior doctors' hours

Shift work is poisoning juniors

EDITOR,—Christopher Wong is right when he says that the current trend towards a reduction in junior doctors' working hours has gone too far.¹ Doctors have always worked long hours and were paid nothing for being on call until the 1970s, when they began to be paid some 30% of their standard pay for night duty, weekends, etc. All that was needed to improve the system was to pay more than 100% for on call duties and perhaps double on bank holidays and for uncivilised hours. I can guarantee that no doctor would complain of overwork under this system. After all, what happens now is that they do locums and so earn a similar amount in a roundabout way.

Keith Reid's reply to Wong's letter is woolly.² Absence of evidence is not evidence of absence, and therefore I cannot accept his point that British specialists may be no better than European specialists. If training has indeed been so bad in Britain should we let doctors who were ill trained decide what is good for junior doctors' training? To quote accident and emergency departments as successful examples of a shift system shows a lack of appreciation of the distinction between a specialty that has no beds and minimal follow up and all the major specialties, in which continuity is essential for learning. Perhaps the Junior Doctors Committee will do a trial to see how much better experiential learning is than so called structured learning, which is being thrust on an unprepared infrastructure.

Junior doctors do not dislike shift work for no reason. They like the sleep and being paid to sleep but recognise that they become nonentities in a conveyor belt health system. More importantly, their experience becomes limited because of time constraints, and learning opportunities are lost. They may never see the result of their work. Political correctness has not allowed many like me to speak out against these attempts to protect patients' and junior doctors' health, but the new system poisons the caterpillars (the juniors) so that all the butterflies that emerge will be substandard.

V VASANTHA KUMAR
Consultant physician

Milton Keynes General Hospital,
Milton Keynes MK6 5LD

- 1 Wong C. Junior doctors' hours. *BMJ* 1995;311:632. (2 September.)
- 2 Reid K. Junior doctors' hours. *BMJ* 1995;311:632. (2 September.)

Don't blame the Junior Doctors Committee

EDITOR,—As one of only a few higher surgical trainees on the Junior Doctors Committee, I have some sympathy with the views expressed recently about the quality of specialist training since the introduction of the new deal.¹⁻³ The quality of training may have decreased in a small proportion of units, but the authors are wrong to put the blame at the feet of the Junior Doctors Committee.

The conference of royal colleges, one of the signatories of the new deal, has stated that training requirements can be met within the package, and what Christopher Wong¹ and other junior doctors forget is that the new deal is just that—a package. If juniors in surgical specialties are being pushed towards partial shifts (often by overaggressive managers of trusts) then it is a sign that other parties are not keeping to their side of the bargain. Too many procedures are still being performed out

of hours, nursing staff are not taking on full "extended role" duties, and extra consultants are not being created to provide the extended support required. If implemented properly the new deal will allow Wong to operate on most orthopaedic cases the next day yet to stay on his 1 in 4 on call rota.

What has not been pointed out is that the new deal was designed to protect patients from overworked junior staff. Tired junior doctors are dangerous—a fact that was noted by the Confidential Enquiry into Perioperative Deaths⁴ yet has been ignored by the authors corresponding on this issue.¹⁻³ From my own surgical experience, performing repeated procedures while exhausted in the early hours does not provide as good training as performing those procedures with a clear head in the daytime and with the support of senior colleagues.

Chris Davies is wrong to presume that the Junior Doctors Committee can insist on higher rates of pay for overtime. These rates are set by the independent Doctors' and Dentists' Review Body, and the Junior Doctors Committee always provides a strong case for premium rates for overtime in its annual evidence to the review body.

The junior doctors' conference held a heated debate on training and the new deal last year. I hope that the authors will attend this year's conference on Saturday 8 June and add their grassroots opinion to what will hopefully be another informed debate on this subject.

A SIMON CARNEY
Chairperson

Junior Doctors Conference,
BMA,
London WC1H 9JP

- 1 Wong C. Junior doctors' hours. *BMJ* 1995;311:632. (2 September.)
- 2 West S, Stephenson TP. Junior doctors' hours. *BMJ* 1995;311:1093-4. (21 October.)
- 3 Davies C. Junior doctors' hours. *BMJ* 1995;311:1094. (21 October.)
- 4 Campling EA, Devlin HB, Hoile RW, Lunn JN. *The national confidential enquiry into perioperative deaths 1991/2*. London: HMSO, 1993.

Committee agrees that pay for additional duty hours is derisory

EDITOR,—Chris Davis has been misinformed about the Junior Doctors Committee's policy on pay.¹ The committee shares his and his many colleagues' view that additional duty hours should be paid at least 100% of the standard hourly rate, if not at premium rates. The committee has held this position since the inception of additional duty hours in 1992. Sadly, neither the independent review body, which suggests the rate at which additional duty hours are remunerated, nor the government, which ultimately decides this, agrees with us—hence the current derisory situation.

SIMON SMITH
Chairman

West Midlands Junior Doctors Committee,
BMA West Midlands Office,
Birmingham B15 3AJ

- 1 Davis C. Junior doctors' hours. *BMJ* 1995;311:1094. (21 October.)

Committee is split on whether to reduce senior trainees' hours

EDITOR,—Much of the recent correspondence on junior doctors' hours starts from the premise that the Junior Doctors Committee is unanimous in its determination to reduce hours.¹ This is far from the truth. At the most recent meeting of the Junior Doctors Committee, in September, a motion that I put forward—to make it the committee's official policy not to attempt to reduce the hours of senior trainees below 72 or 83 hours—was so narrowly defeated that two recounts were required.

I would echo the words of S J Krikler that doctors who believe that their views on junior doctors' hours are not adequately represented should stand for election to the committee.¹ Change can come about only from within.

ANDREW J LYONS
Member, Junior Doctors Committee

Queen Alexandra Hospital,
Cosham,
Hampshire PO6 3LY

- 1 Junior doctors' hours [letters]. *BMJ* 1995;311:1093-4. (21 October.)

Reporting poorly performing doctors may seem an expensive waste of time

EDITOR,—If doctors are to be forced to report colleagues whom they consider to be incompetent then the exact mechanisms and procedures need to be streamlined and spelt out.^{1,2} Several years ago I and two consultant colleagues became so alarmed at the standard of practice of another consultant in our unit that we approached our unit general manager and the regional health authority. Both were receptive, having had longstanding worries about the situation.

Instead of organising an inquiry the regional health authority informed us that we had to produce evidence in the form of case notes showing poor practice. This proved difficult. Opinions regarding another doctor's competence are formed in numerous ways. Presentations and comments made at clinical meetings, the practices unearthed during clinical audits, and patients who are seen jointly either because of direct referral or because of contact in an emergency all play a part. The cases that cause disquiet, however, are not recorded systematically, and finding them again can be a problem. Nevertheless, appropriate evidence was collected and supplemented by cases brought forward independently by some of the junior medical staff who had also been alarmed. The cases were reviewed by an independent assessor, who agreed with the concerns, and we were all interviewed by an eminent government medical adviser, who was also most supportive. We then awaited the disciplinary hearing.

Years passed, with our colleague suspended on full pay and the hospital served by a succession of short term locums. The hospital then became an NHS trust, and the regional health authority merged with its neighbour. On the advice of the new regional health authority the suspended consultant's contract was transferred to the trust, but assurance was given that the authority would pursue the disciplinary action. After some attention in the media the regional health authority retracted from this position, and it apparently plans no action.

The action that we took after much soul searching now seems to have been an expensive waste of time. My colleague has been suspended on full pay but without having been given an opportunity to clear his name. The hospital has been unable to employ a substantive replacement until the case is settled. I and my coaccusers feel badly let down by both the original regional health authority and its larger successor and wish that we had continued to turn a blind eye. Richard Smith refers to "changing the culture."¹ Our experience suggests that more than the culture needs to be changed, and those who are now faced with colleagues whose performance is giving cause for anxiety should seek detailed information about exactly what will ensue before they formally voice their concerns.

- 1 Smith R. British government's proposals on poorly performing doctors. *BMJ* 1995;311:402. (12 August.)
- 2 Smith R. Government wants doctors to report unfit colleagues. *BMJ* 1995;311:406-7. (12 August.)