	On call rota (OCR)	Partial shift (PS)	Full shift (FS)	F ratio	P value	Difference*
<i>Preregistration house officers</i>						
	<i>n=178-9</i>	<i>n=4-6</i>	<i>n=7</i>			
Job satisfaction	72.06	56.75	75.57	3.08	<0.05	—
Mental ill health	61.38	67.83	59.14	0.69	NS	—
Physical ill health	33.73	43.67	29.009	3.16	<0.05	PS > FS
<i>Senior house officers</i>						
	<i>n=226-7</i>	<i>n=18</i>	<i>n=42-3</i>			
Job satisfaction	78.13	88.17	84.17	4.53	<0.05	PS > OCR
Mental ill health	58.73	53.11	56.16	1.94	NS	—
Physical ill health	32.81	30.56	30.14	1.88	NS	—

*Tukey's procedure.

rota, as there is relatively little contact between the doctor, his or her colleagues, and consultants. The doctors may be exposed to emergencies with less supervision by more experienced doctors and less back up from more experienced nurses. An inexperienced preregistration house officer would be particularly vulnerable in this scenario, and patients' care and the doctor's wellbeing may therefore suffer. Conversely, senior house officers may welcome the chance to care for patients relatively independently, which would improve their job satisfaction.

These findings are based on small numbers and are therefore vulnerable to chance statistical results. None the less, they support the need for further research to determine the most effective working pattern to improve job satisfaction and the wellbeing of junior doctors. Implementing changes to the way that junior doctors work without knowing whether any improvements are being achieved may result in a decrease in the quality of patients' care rather than the increase striven for.

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- 1 NHS Management Executive. *The new deal: hours of work of doctors in training*. London: NHSME, 1991.
- 2 Cooper CL, Sloan SJ, Williams S. *Occupational stress indicator. Data supplement*. Windsor: NFER-Nelson, 1993.
- 3 Rees DW, Cooper CL. Occupation stress in health service employees. *Health Services Management Research* 1990;3: 163-72.

New deal not satisfactory for cardiothoracic surgery

EDITOR,—We are pleased to read that the junior doctors' conference endorsed a motion arguing that implementation of the new deal may jeopardise the training of some higher specialist trainees.¹ All the enrolled higher surgical trainees in cardiothoracic surgery currently working in the United Kingdom strongly support this view and believe that it cannot be dismissed by facile jibes of the type made by S Hajioff at the conference.

Cardiothoracic surgery is by reputation, and often in practice, an arduous specialty. It tends to require a commitment that is not easily measured in hours worked. Although good exposure to elective surgery can be achieved within the limits imposed by the new deal, this is not so for emergency work. The two tier (registrar and senior registrar) on call system resulted in the senior registrar having greater availability for relatively uncommon emergencies while the registrar provided routine cover. While the new deal may be satisfactory for some specialties, we believe that it,

along with shorter training resulting from the Calman report, will compromise training in our specialty.

Although numerically few, we represent more than a "few senior registrars in cardiothoracic surgery" and believe that the current utilitarian approach of the new deal is a fundamental error. Not all hospital based specialties are similar. If the proponents of the new deal aim to make all junior doctors equal, we would wish to be less equal than others.

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- 1 Beecham L. From the junior doctors conference. *BMJ* 1995;310: 1539-40. (10 June.)

Faulty blood bags

EDITOR,—I wish to reply to the comments of senior managers of the Scottish and English blood services about the recent recall of faulty blood packs.^{1,2} Firstly, although I agree with John Cash that septicaemia due to bacterial contamination in recipients of blood in faulty bags is "exceedingly rare," it is also exceedingly rare—in fact, unheard of—for 7000 units of blood to be withdrawn, with the accompanying disruption, waste, and financial loss.

Secondly, Cash congratulates the English National Blood Authority for having broken the monopoly of the original supplier. Unfortunately, the authority did not do this. What it did was to allocate certain pack types to each of two suppliers, Baxter and Tuta. Each company then had a monopoly of its allocated pack type. All the authority has done is to replace a blanket monopoly with a compartmentalised monopoly.

Thirdly, although the quality of Tuta packs is comparable with that of Baxter packs, the real point is that the appropriate quality checks and validation studies were not performed by the National Blood Authority when it first introduced Tuta packs. As usual with the authority, change was not thought through and was introduced in a rush.

The whole incident was unnecessary. The blood authority, operating out of its ivory tower in Watford, has consistently acted high handedly and secretively, with little input from staff on the ground.

Angela Robinson, of the National Blood Authority, claims that it is streamlining the

service.² Before the existence of the authority there were 14 regional directors and a national directorate of just three people. This will be replaced by a burgeoning bureaucracy of highly paid managers with their secretaries, offices, and "remuneration packages" (plus cars, worldwide travel, and attendance at conferences), as well as three separate zonal bureaucracies each consisting of a chief executive, personnel manager, public relations manager, and operations manager. Many of these zonal posts seem to duplicate those at the headquarters in Watford. The administrative costs have gone through the roof, as any proper audit of the service would show. All this is, of course, paid for by "top slicing," which translates into plain English as "cuts in the front line service."

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- 1 Cash J. Faulty blood bags. *BMJ* 1995;311: 389. (5 August.)
- 2 Robinson A. Faulty blood bags. *BMJ* 1995;311:389. (5 August.)

Concerns about "lookback" exercise for hepatitis C

EDITOR,—The chief medical officer has kept general practitioners informed about the "lookback" exercise being undertaken to detect recipients of blood products donated by donors found to be positive for hepatitis C virus. Several concerns, however, have not been answered in the documentation distributed. To delegate to general practitioners the task of counselling patients found to have been given blood from donors positive for hepatitis C virus is inappropriate. Individual general practitioners will have only one or two such patients on their list and will not necessarily have the time, the manner, or, most importantly, the knowledge to counsel and guide such patients—even more so because the treatments currently available for hepatitis C are relatively ineffective. It is imperative that general practitioners are given immediate access and funding to refer such patients to regional specialist counsellors, who are able to develop specific skills and knowledge in this rapidly changing subject: few general practitioners have had more than a couple of hours' education on viral hepatitis during their medical training, much of which took place before non-A non-B hepatitis was even considered.

A more worrying concern is that this lookback exercise is creating a population with false negative results. Reassurance is being offered to members of the community who have had blood transfusions, in that "no news is good news." In my experience in hospital medicine, no news is more likely to mean "notes misfiled" or "notes lost." The lookback exercise depends on hierarchical tracing from donor to recipient. Any loss of records will mean that for a proportion of recipients of blood transfusions no check will be made. We will be left with a group of patients who have been exposed to hepatitis C virus as a result of failure to screen by the transfusion service; they will continue to expose others to risk, having been given false reassurance by the chief medical officer and transfusion service that they are negative for hepatitis C by exclusion.

It is imperative that this lookback exercise switches to a proactive and true look back from recipient to donor, not from donor to recipient. Any breaches in the hierarchy should allow recipients to have a test that uses the polymerase chain reaction for hepatitis C virus to ensure that they are not at risk and that their sexual partners and children are not exposed to this disease.

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