Survey illustrates misconception of the Calman proposals

EDITOR,—In their survey of consultant physicians' attitudes to the Calman proposals Hugh M Mather and Robert S Elkeles show an important misconception about the nature of those proposals and the manner of their implementation.¹ Nevertheless, we shall do well to heed the responses they obtained.

In summarising the Calman proposals the authors assume that what was envisaged was a service essentially provided by consultants resident on call. Indeed, they repeatedly refer to a "consultant provided service." In fact, the Calman report referred only to a "consultant based service," and, while I accept that neither of the two terms has been defined, I know, having been a member of the original working party, that emergency services were never intended to be routinely provided by resident consultants. The report was published less than two years after the ministers had signed up to the principles of the new deal, which included the three explicit provisos that: "First, it would be an inappropriate and wasteful use of the skills of consultants to require them to undertake tasks which are easily within the competence of other doctors. Second, consultants should not be compulsorily resident when on-call, although they must reside within a reasonable travelling time from the hospital. Thirdly, the problem of excessive hours should not be transferred from trainees to consultants."²

Since then, ministers have often reiterated their commitment to the new deal, and it was in the light of this commitment, and on condition that a considerable, funded expansion in the number of consultants would occur, that the Central Consultants and Specialists Committees gave qualified support to the Calman proposals. The overwhelming view of the physicians in North West and South West Thames—that they would not wish to return to regular residential emergency duties—is therefore not surprising; indeed, it would be unreasonable and wasteful to require them to do so, and the Central Consultants and Specialists Committee would vigorously oppose such a proposal.

Nevertheless, perceptions about the implications of the Calman report are clearly running ahead of its actual implementation and are being influenced by factors such as the activities of purchasers in the internal market and the debate about the future configuration of hospital services. It is precisely for this reason that, over the past year, the Central Consultants and Specialists Committee has promoted a major debate within the profession about the future of the consultant grade.³ Contrary to the authors' assertion, we are extremely anxious to hear the views of consultant colleagues.

If the postgraduate deans believe that "involvement of the consultants in the provision of emergency care will need to be extended and formalised into their job plans," as a recent paper from the Committee of Postgraduate Medical Deans and the United Kingdom Conference of Postgraduate Deans suggests,⁴ I am sure that they would expect this to be discussed with the BMA. It would not be acceptable simply to foist such duties on to the already overloaded schedule of consultants, and we therefore first need to formulate new ideas of how

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consultants will work in the future in order to have a yardstick for that discussion and protection for consultants against the unreasonable expectations of hard pressed employers.

The Central Consultants and Specialists Committee is working hard to formulate such ideas, and, while the responses received by Mather and Elkeles are informative, a survey that sought not only reactive but also constructive views about possible ways forward for the consultant grade would have been more helpful.

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1 Mather HM, Elkeles RS, on behalf of the North West Thames Diabetes and Endocrinology Specialist Group. Attitudes of consultant physicians to the Calman proposals: a questionnaire survey. *BMJ* 1993;311:1060-2 (21 October.)

2 NHS Management Executive. *Junior doctors: the new deal*. London: NHSME, 1991.

3 Central Consultants and Specialists Committee. *Consultants for the future: report of a CCSC seminar held on 6 April 1995*. London: CCSC, 1995.

4 Committee of Postgraduate Medical Deans and the UK Conference of Postgraduate Deans. *SHO training: tackling the issues, raising the standards*. London: CPMD, 1995.

Nurses may make surgical house officers obsolete

EDITOR,—Sue Dowling and colleagues' article on nurse practitioners mentions the perceived benefits and costs for the related doctors, nurses, and managers but does not deal with relationships across specialties.¹ The role of surgical house officers has always been, among other things, to liaise with anaesthetic staff in the preoperative management of patients having both elective and emergency surgery. The recent introduction of surgical nurse practitioners in my hospital (the posts are similar to posts A and B described in the article) has led to an increase in discussions with anaesthetic staff after preassessment and, therefore, to more appropriately tailored investigations, while fewer important drugs are omitted. This improvement will undoubtedly have its own cost benefit in terms of more efficient use of operating time in the event of a cancellation and, one would hope, a decrease in operative complications.

If the surgical house officer can be replaced—or, indeed, bettered—then surgery would become a postregistration specialty, which would allow the

little used option of a preregistration post in general practice to become compulsory. The result would be an improvement in relations between hospital and general practice. Alternatively, the increase in numbers available as house physicians, or even a shortened probation, would reduce total hours spent in specialties.

The impetus behind nurse practitioners may have been to reduce junior doctors' hours and improve conditions of work, but the knock on effects, if appropriately managed, will improve patient care and communication in our profession.

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1 Dowling S, Barrett S, West R. With nurse practitioners, who needs house officers? *BMJ* 1995;311:309-13. (29 July.)

Junior doctors' hours

Flexible partial shifts can work

EDITOR,—There is a lot in the press about junior doctors' hours at the moment, none of which is very joyful.¹ We believe that the continuing failure to reduce hours in a way that is satisfactory to both junior and senior doctors and management is caused by several factors. Firstly, the present alternatives to on call work are full and partial shifts. The only full shift that is fully staffed that we know of is for a 44 hour week, and there are external pressures to change that. Partial shifts create several problems: doctors lose their social life, post-take rounds are few, education suffers, and managers find it impossible to recruit staff. Secondly, the system currently assumes that doctors must work Monday to Friday, that if they work at the weekend then that is bad luck, that ward rounds occur once a day, and that no other kind of handover can occur.

The best way to improve doctors' hours and still recruit staff is to try something different. The following are some of the solutions that we have used at Arrowe Park Hospital. We have a ward round later than usual (for example, at 11 am) so that the doctor can start on call later but still get a handover. We start on call at 4 pm as most people have finished their routine work by then. This simple measure does not alter continuity of care and decreases hours by four a week. At weekends we work the pattern shown in the table. This

Pattern of work of three doctors over weekend at Arrowe Park

	Friday	Saturday	Sunday	Monday
Dr A	On call	Off	Off	Normal day
Dr B	Off	Off	On call	Normal day
Dr C	Normal day	On call	Off	Off

not only splits the weekend but also gives all of the doctors two days off, reduces hours, and has the added bonus of allowing the doctor who works on Sunday to be present at the post-take ward round.

In conclusion, the black and white of the new deal can be more of a hindrance than a help in reducing hours. Let us aim for the 56 hours of