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

work but allow some shades of grey. Finally, it is necessary to keep the rules simple and easy to understand, as doctors change posts so frequently.

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1 Junior doctors' hours [letters]. *BMJ* 1995;311:632. (2 September.)

Flexible partial shifts should be made to work

EDITOR,—The new deal on junior doctors' hours arose out of an agreement signed in 1990, the government having been forced to address the issue of hours of work by a sustained campaign of publicity by junior doctors over the preceding 3 years. Under the terms of the new deal no doctors should work more than 56 hours, whatever their working pattern. Set in the context of a maximum average of 72 hours on call, this obviously implies periods of rest.¹ Despite the rantings of Christopher Wong this is not a new policy.^{1,2}

The new deal is far from perfect and fell far short of our aspirations. It was, however, the best agreement that could have been attained within the financial constraints set by the government and was signed in the belief that a little progress was better than none at all. The 100 hour week that Wong refers to as "gone" could easily return if we were to allow the new deal to be renegotiated. Much criticism of the agreement arises out of misconceptions about training; misunderstanding of the agreement; improper implementation; and ignorance of the fact that rates for additional duty hours were an improvement on units of medical time, leading to a substantial pay increase, which has been partially eroded by the reduction in hours.

Wong's enthusiasm to gain experience is commendable and, I am sure, is fuelled by the desire to provide patients with the best possible care. Wong would do well, however, to remember that he needs adequate rest to perform optimally. Fatigue often causes error. In the same way that the public is entitled to safe passage on commercial air flights, which is guaranteed in part by strict controls on pilots' working hours, it is entitled to safe medical care.

I found some amusement in Wong's banal adage that "practice makes perfect" and in being told that "training in any profession requires exposure and practice."³ Junior doctors are usually unsupervised when providing services out of hours. I contend that only supervised practice makes perfect and merits description as training. Imperfect practice repeated without constructive criticism does not lead to perfection. It will, however, provide exposure. It exposes patients to the imperfect practice of medicine or surgery by partially trained and often inadequately rested staff. It exposes junior staff, and the consultants supposed to be guiding their practice, to the possibility of litigation. Patients are not guinea pigs to be practised on. As the confidential reports on mortality and morbidity indicate, patients are entitled to the highest standards of care provided by fully trained doctors.

To Wong I would say, "If you do not like the partial shift you are working, take steps to amend it to your satisfaction. If you do not like the policies of the Junior Doctors Committee,

then get elected, attend its meetings, and change them."

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1 Wong C. Junior doctors' hours. *BMJ* 1995;311:632. (2 September.)
2 Wong C. Junior doctors' hours. *BMJ* 1995;311:1093. (21 October.)

Wong has support of retired physician

EDITOR,—I congratulate Christopher Wong for his letter opposing further statutory reductions in hours.¹ I should like to remind the current whingers that in the early 1950s the BMA's official view was that, when possible, the hours worked by house officers should be less than 168 hours a week, or words to that effect. The salary was £250 a year, with £100 being deducted for full board and lodging.

Times have certainly changed for the better for junior doctors, and I applaud this. But juniors should remember that if they want to be good at something then they have to work at it, and this should include the experience of working unsocial hours.

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

Wong should join Junior Doctors Committee

EDITOR,—I strongly second S J Krikler's suggestion¹ that Christopher Wong² should join the Junior Doctors Committee. If he and like minded colleagues think that the committee is not representing them, why don't they try to be constructive rather than damning and destructive? Why aren't they active members of their regional junior doctors committee? Why don't they come to the next national meeting of the Junior Doctors Committee, on 16 December, through the new visitors' scheme? Why don't they stand for election to the committee?

If Wong and Chris Davies³ and others believe that the Junior Doctors Committee has no mandate, who has? The committee is composed of highly committed people who spend a lot of time endeavouring to do their best for junior doctors throughout Britain. As a relative newcomer to the committee I am amazed at the emptiness of the debating chamber. It is a measure of the inherent apathy in junior doctors, which we can't afford to have, especially with issues such as the Calman report and contracts going down to trust level just around the corner. The emptiness of the chamber is balanced, however, by the commitment of those who religiously attend national meetings of the committee at the expense of their personal time. If juniors like Wong believe that committee members like Keith Reid have no mandate they should first acquaint themselves with what he and all current active members are trying to do. Reid is one of the people most committed to improving junior doctors' education and working and living conditions.

Partial shifts and reductions in the hours of work are ways of improving our lot, but we must also look at inappropriate duties and inadequate education if we are to remain truly professional (and stop ourselves becoming the poor relations of the European Union) and not just NHS dogsbodies.

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1 Junior doctors' hours [letters]. *BMJ* 1995;311:1093-4. (21 October.)
2 Wong C. Junior doctors' hours. *BMJ* 1995;311:632. (2 September.)

Harmonising specialist training in Europe

EDITOR,—As a German junior doctor who has studied and trained in Germany, England, the United States, and Canada, I strongly support Stephen Brearley's general view about the harmonisation of specialist training in Europe.¹ Specialist training and medical systems adapt to the requirements of each particular society with its needs, beliefs, and financial potential. Medicine has its place in each society and cannot be separated from it; differences between medical systems are thus inevitable. While it may be possible to improve specialist training by importing ideas from other medical systems, complete unification is undesirable. The evolution of several medical systems brings forward more valuable ideas than does a large, unified medical system. Each national system then serves as an example to others.

Modern medicine cannot exist without an international exchange of ideas, data, and staff. Undoubtedly the best way of obtaining insight into other medical systems is to work in them, which makes exchanges of trainees and specialists between countries of the European Union desirable. Unfortunately, however, experience abroad may not be credited towards specialist training.

What the European medical community needs is not more rules and regulations but the flexibility to allow movement between the systems. The result of specialist education depends at least as much on the individual as on the system in which he or she trains. The curriculum vitae, references, a personal interview, and perhaps a period of probation may show much more about the abilities of an applicant than any certificate.

It is time that the European bodies realised the strength of diversity. The European and national specialists' organisations should acknowledge that medicine can be practised in various ways with equally good results. Future goals of European medical bodies should shift from harmonisation to the creation of a framework that permits the recognition of carefully chosen training abroad. This would allow trainees, specialists, and their patients to benefit from the positive aspects of the diversity among national medical systems in Europe.

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1 Brearley S. Harmonisation of specialist training in Europe: is it a mirage? *BMJ* 1995;311:297-9. (29 July.)

Summative assessment for general practitioner registrars

System is currently used in west of Scotland

EDITOR,—Linda Beecham's report that general practitioner registrars may withdraw from summative assessments—because of their uncertainty about the validity of the assessment package, the lack of a unified national assessment, poor communication within English regions, and inadequate testing of the assessment package¹