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