Establishing a classless society would not necessarily produce this outcome, although it would vastly increase the likelihood of doing so.

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Junior Doctors. The New Deal

The negotiating perspective

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For many years the problem of the excessive number of hours worked by doctors in training simmered quietly below the surface of hospital life. Now, however, their plight is more recognised and public opinion is firmly behind them in their attempt to provide a safe service for patients by securing a reduction in the hours which they are expected to work. Junior doctors are no longer willing to sit back and suffer in silence. A survey conducted last year by the Hospital Junior Staff Committee (now the Junior Doctors Committee) emphasised the intensity of feeling: 98% of doctors in the training grades were prepared to take some form of action to limit their hours, with 53% willing to provide an emergency only service.[1]

The government has also been aware of the problem for a long time and in 1990 the Minister for Health set up a working party. In December 1990 heads of agreement was published, committing all the signatories "to reduce average contracted hours to 72 per week, particularly for those in hard pressed posts.... In the short term ... no junior in a hard pressed post should be required to be on duty for more than an average 83 hours a week."[2] The Junior Doctors Committee was asked to "open negotiations immediately in the appropriate negotiating forum to secure the necessary changes in the contracts and conditions of service of junior hospital doctors—and rates of remuneration—to reflect and encourage flexible working patterns."[2] In conjunction with the Department of Health the committee's negotiating subcommittee decided to divide the task into two phases. The outcome of the first phase was the new deal launched in June.[3] The second phase—to agree rates of remuneration for the new working patterns which had been established—is now under way.

In the past the JDC's negotiations on hours of work have had two objectives: to introduce legislation to limit hours or to persuade the Doctors' and Dentists' Review Body (DDRB) to recommend penal rates of pay for out of hours work. Neither objective has been achieved. The Department of Health and the DDRB are reluctant to agree piecemeal changes to the out of hours pay rates, arguing that this would be expensive and inefficient—those who would gain most were not necessarily the most hard pressed—and might encourage juniors to contract for excessive hours for personal financial gain. Furthermore, the prospect of legislation to limit hours is remote—at least in the short term. The government has consistently dismissed legislation as a crude weapon.

The DDRB's 1990 report suggested that the most satisfactory solution to the problem would be to negotiate a new contract for junior doctors.[4] The present contract is incapable of recognising variations in workload with no incentive to health authorities to decrease hours. And the remuneration for out of hours work is totally inadequate.

Basic principles

Three basic principles should be borne in mind in any attempt to renegotiate the contract. Firstly, there is a more pressing need to reduce hours for pre-registration house officers and senior house officers. The Dowie report showed that the percentage of average duty hours actually worked varied in a predictable fashion between 56% for senior registrars and 71% for house officers.[5] On average senior house officers worked for 66% of their duty hours and registrars for 59%. Secondly, advances in medical practice have taken place since the contract was last negotiated. The same type of contract is, in most instances, no longer appropriate either for doctors in general professional training or for doctors in higher specialist training. Finally, in renegotiating the contract it is essential that the majority of doctors in training do not suffer financially from any new arrangements. With these principles in mind we embarked on negotiations with the Department of Health to secure alternatives to the present system.

Out of hours cover is normally provided by doctors working a rota system with its inherent disadvantages

of long average contracted hours and long periods of continuous duty. Although rotas more onerous than one in three, and this includes one in three rotas in which the three doctors contract in advance to provide cover for their colleagues' annual and study leave (prospective cover), are theoretically illegal, there are a substantial number of rotas still in existence which include a more onerous commitment than this. The Department of Health puts the figure at 22% this year but we believe that this is a considerable underestimate. For example, even in posts where the contracted hours do equate with a one in three rota the intensity of the work when on call and the large number of non-contracted hours worked can cause the post to be onerous to the detriment of both patient and doctor.

... under the new arrangements all doctors at the same level in the same grade should be paid approximately the same salary...

Hours of work in accident and emergency departments have consistently been lowest when compared with other specialties, with an average of 65 hours a week, the average for all specialties being 86 hours.[6] In virtually all accident and emergency departments a partial shift system already operates. If hours are to be reduced in other specialties to the same levels as in accident and emergency departments a shift system of some description is an obvious model. With changes in working practices (both for medical and non-medical staff) including changes in crosscover arrangements and delegation of non-medical duties, some form of shift system could be safely introduced for many junior doctors. In simple terms payment for out of hours work on these systems would be made for the number of shifts worked and limitation of maximum hours and protected time off would be built into the system.

Junior Doctors—The New Deal introduces two types of shift system to complement the current rota system: full shifts and partial shifts. In a full shift system each member of a group of doctors works a shift on a regular basis, either permanently on one shift or rotating around the shift pattern. This is the standard industrial shift worked in many factories. In medicine it would be appropriate only in circumstances where the work intensity is heavy and potentially evenly distributed over 24 hours, but it is nevertheless the most effective means of reducing both overall average contracted hours and the length of the periods of continuous duty. It is difficult to envisage many instances where a full shift system would be suitable to medicine as practised in the NHS today where the majority of work is done during the day, but there will be some areas where full shifts can be introduced.

In a partial shift system each member of a group of doctors works a shift on a part time basis returning to essentially normal duties for the rest of the time. These shifts maximise medical manpower during the day and are more suitable for most medical work where there is a substantial routine workload during the day. Such systems can allow marked reductions in average contracted hours but their most important effect is to reduce the longest period of continuous duty. The partial shift pattern of work is best suited to most house officer and senior house officer posts but again flexibility will be required. Some registrars will require this form of contract—for example, paediatric registrars who are resident first on call—and in some smaller district general hospitals it may be inappropriate for house officers to have this type of contract. The key to introducing any new system is local flexibility where all parties concerned at local level have a range of options from which they can choose those best suited to the needs of individual posts.

Potential obstacles

There are several potential obstacles to the introduction of such systems. The educational implications concern the royal colleges who think that there might be less face to face contact between the junior doctor and his consultant mentor and less opportunity to attend postgraduate teaching sessions. The royal colleges have, however, agreed in the heads of agreement that "the educational objectives of doctors in training can be met within a maximum 72 hour week."[2] Implicit in this statement is approval of the new working practices which have been negotiated and this will undoubtedly lead to a reappraisal of the suitability of the consultant firm to modern medical practice.

Concerns have also been expressed about the maintenance of the safety net, a key concept in the manpower agreement *Achieving a Balance*.[7] It is, of course, critical that an adequate level of cover is provided during out of hours periods to ensure patient safety at the same time as hours are being reduced, but patient safety is not simply a matter of providing several tiers of doctor of increasing experience between the house officer and the consultant. This inevitably results in those doctors closest to the bottom of the career ladder being overworked and overtired while those closest to the top maintain a reasonable salary by contracting for excessive hours on call from home during which they are infrequently called out. Such a position is wasteful of medical time and skills and a system must be devised whereby all doctors in training are working (as opposed to being available for duty) for substantially the same length of time. In an attempt to eliminate unnecessary duplication of cover the royal colleges were asked to issue guidance on the level of experience needed by intermediate grade doctors to enable them to provide sole cover between a house officer and a consultant. These guidelines form part of the new deal and, following further refinement, will have to be considered when planning shift systems.

One means of achieving the aim of having all doctors at all levels of the career ladder working for the same amount of time would be the introduction of a more professional type of contract for those in higher professional training—namely, all senior registrars and many career registrars. Such a system might entail paying the doctors a basic salary for the standard working week (as now) with an additional lump sum for extra duties so that all doctors at the same level in the same grade earn the same salary. The limit on hours worked for each post could then be made inversely proportional to the intensity of work and could also be regulated on educational grounds in line with royal college recommendations. This would recognise the subconsultant nature of the work which higher trainees do and satisfy their need for more flexible working patterns on educational grounds. In addition it would reassure the small, but vociferous, minority of such doctors who maintain that they need to be available for work for more than the allowed maximum for educational reasons. This proposal has the additional attraction of hastening the ultimate objective in *Achieving a Balance* of a unified higher training grade. As there are no obvious manpower implications introduction of such a contract would seem to be relatively simple. Unfortunately, it is unlikely that this professional contract would suit all career registrars, as many find themselves resident on call on onerous rotas in busy specialties. For such doctors the partial shift system

would be appropriate and local flexibility would have to ensure its availability.

There will, of course, be several doctors in some grades for whom the present rota arrangements will continue to be the most suitable. For those doctors appropriate hours limits have also been negotiated.

There will, of course, be several doctors in some grades for whom the present rota arrangements will continue to be the most suitable.

For all types of contract it is essential that certain parameters are clearly defined within the contract and these are laid down in the agreement signed in June. These definitions will be critical in deciding at local level the type of contract best suited to a particular post.

Same pay for same job

Having achieved these agreed limits, the possibility of reduced pay for those who agree to change their pattern of working will undoubtedly be the single greatest obstacle to the introduction of the new shift systems. Obviously shorter but more intensive periods of work require a higher hourly rate of pay and the JDC has agreed with the department that under the new arrangements all doctors at the same level in the same grade should be paid approximately the same salary irrespective of the type of contract they hold. This is a logical extension of the notion that all doctors in training will be working substantially the same number of hours.

It is likely that the basic working week—the first 40 hours of duty—will continue to be paid separately from out of hours work. For out of hours work the rate of remuneration must reflect the intensity of work during the period of contracted duty. Work intensity out of hours will be greatest for those on full shift systems where it is envisaged that doctors will be working substantially all of their contracted hours and these doctors deserve to be paid for their out of hours work at a premium rate—that is, on an hourly basis more than they are being paid for their basic working week—in order to encourage doctors to move on to these shift systems. Remuneration for doctors on partial shift contracts will then have to be pitched between this rate and the rate for a conventional rota system where work intensity should be lowest, but we envisage higher pay for out of hours work even for doctors remaining on rotas because they too will be working more intensively under the new arrangements.

Pay mechanisms like these will provide a spur to the profession and managers to find solutions to the hours problem, but they will undoubtedly require a financial commitment from the Department of Health and the Treasury who cannot be allowed to see these changes as a mechanism for saving money. Junior doctors will want to see a modest incentive incorporated into their pay system to encourage them to adopt the radical changes to their working practices proposed in the new deal and they are unlikely to regard as acceptable any solution which does not take account of this. If the government continues to show the willingness it has so far and if the review body is prepared to be as innovative as it has been in the past we could, at last, see the end of the Victorian working patterns which have blighted junior doctors in the NHS for so long.

This is the fourth in a series of articles which explore the new deal on junior doctors' hours of work and explain how it will be implemented.

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ANY QUESTIONS

An otherwise healthy but anxious woman in her late 60s has suffered from occasional faecal incontinence for many years. Fifteen years ago the result of a barium meal examination was normal and a specialist confirmed that she had a normal anal sphincter and colon. Her stools are within normal limits. What treatment and advice should be given?

Faecal incontinence is common among women of this age group: more than one in 100 are affected.[1] It is socially disabling and extremely embarrassing, but many patients do not seek medical help for even 20 or 30 years. Incontinence may be due to high colonic pressures overwhelming a normal sphincter, as seen sometimes with the urgency of patients with the irritable bowel syndrome or colitis. This urge incontinence is in contrast to the passive, unconscious incontinence experienced by women with a sphincter defect. This latter group either may have progressive weakening of the sphincter muscles due to stretching of the pelvic nerves many years earlier during childbirth or may have sustained a tear to the sphincter during childbirth that remained unrecognised. These are both common and may coexist; as the muscle weakness progresses the previously torn sphincter can no longer compensate.

This patient is unlikely to have the irritable bowel syndrome or colitis if the stools are normal, but these conditions should be excluded. Her sphincter mechanism should be evaluated as normal findings on digital examination can be misleading. Measurement of the anal sphincter pressures provides information about the integrity of the smooth muscle internal and striated muscle external anal sphincter muscles.[2] Anal ultrasonography allows these muscles to be imaged directly and reveals tears to the sphincter.[3] Measurement of nerve function in the pelvis will show whether the nerves are damaged and whether nerve damage will limit the success of a surgical repair.

When the sphincter is normal urgency due to high colonic pressures can be decreased and sphincter tone increased by a small dose of loperamide or codeine. These drugs are often dramatically effective. In patients with a tear to the sphincter surgical correction is often possible. Surgical treatment of a weak intact sphincter is possible, but the results are sometimes disappointing.

No patient with faecal incontinence should be denied evaluation by a specialist with an interest in this condition.

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