features of the populations served by individual hospitals. Uniformity of practice in regard to this particular operation is far from being achieved.

Indications for Sterilization

In the questionnaire on indications returns were asked for under the following five headings: (a) physical diseases or defects making further pregnancy dangerous to health; (b) psychiatric indication; (c) domestic and family problems, including high parity, marital stress, etc.; (d) in association with repeat caesarean section; and (e) in association with therapeutic termination of pregnancy.

In 48.7% the indication was given as domestic and family problems (c). In 27.7% of the cases sterilization was carried out in association with either repeat caesarean section or termination of pregnancy. In 16% there was a physical disease or defect, and in only 7% was the primary indication a psychiatric one. As many of the sterilizations carried out in association with caesarean section and even therapeutic termination may have been carried out for broadly social reasons, it is clear that this is the main indication for this operation. The figures suggest that there is less hesitation than might have been thought among gynaecologists in carrying out sterilization for broadly social as opposed to strictly medical reasons.

Difficulties.—The questionnaire included a question about waiting-lists. Gynaecologists were asked if there was a difficulty in admitting patients for operation, with consequent lengthening of waiting-lists, either because of shortage of beds or for any other reasons. Seventy-seven per cent. replied that there were no limiting factors in their capacity to carry out an operation of sterilization where it was indicated. Replies from 23%, however, indicated that there was such a difficulty because of the attitudes of the gynaecologists, objections on the part of

patients, or because of shortage of beds. In several instances the replies gave an indication that it was expected that there would be a considerable increase in the number of sterilizations carried out in future years which might create a difficulty for the departments from the point of view of accommodation.

Conclusions and Discussion

The purpose of this questionnaire was to obtain facts about the current situation in regard to sterilization. The purpose of this short communication is to make known these facts rather than to discuss all the many and varied implications and problems concerned with sterilization. From the point of view of limiting family size, for either medical or personal reasons, sterilization can make a valuable contribution. It obviously cannot solve all the problems associated with unwanted pregnancies. The fact that there are such wide differences of practice between different parts of the country suggests that perhaps not sufficient thought has been given to the use of this valuable preventive measure and it is clearly necessary to carry out further investigations in greater detail, perhaps more extensively over the whole country.

We would like to record our thanks to all those fellows and members of the College who filled in questionnaires and so participated in this inquiry. We would also like to thank the senior hospital administrative medical officers who advised us about the hospitals to whom we should direct our questionnaire and to the chiefs and their staff who filled in the questionnaires and made the collection of these data possible.

Many more details have been obtained from the data collected from the questionnaires returned than are reported in this brief communication. These are available at the Royal College of Obstetricians and Gynaecologists if any readers are interested to see them, and some will be published later.

AROUND EUROPE

Compensatory Leave for Doctors in Sweden

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Compensatory leave for junior hospital doctors working beyond usual working hours was adopted in Sweden two years ago, and later it was extended to include the consultants and senior registrars. The leave is intended to give doctors adequate rest, and rules to work the scheme have been agreed on between the regional administrative medical boards and the medical association. It is intended that clinics at the same hospital and near-by hospitals should combine to provide emergency services and so prevent overlap and use manpower economically.

The leave is given: (a) as direct compensation for hours worked attending emergencies, (b) to make up any loss in the number of minimum free days each month, and (c) as special leave for seniors who provide prolonged supervision and back cover. The guaranteed minimum of four free days, usually Sundays or public holidays, each four-week period was extended to junior doctors after it had been granted to employees in public services.

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Compensation Scheme

Compensation is worked differently for junior and senior doctors and will be described separately. Previously strong emphasis has been on compensation for the younger doctors, and more experience has been obtained in making it work for them.

Junior Doctors

Leave to Compensate for Broken Free Days.—Four free days are allowed each calendar month worked and should be taken on Sundays or public holidays whenever possible. A free day is considered broken if the doctor is on call at the hospital, or if he is obliged to come into the hospital from home when on call. Telephone interruptions do not break a free day.

Direct Compensation for Emergencies.—A minimum of four hours' and a maximum of 12 hours' compensation is given for call on each duty period (see below) and the doctor keeps a record of hours worked.

Duty Periods.—Compensation is granted only for duties carried out during duty periods that run between 7 p.m. and 8 a.m. the next day (weekdays). On the day before Sunday and before public holidays the period is from 3 p.m. to 8 a.m. No compensation is allowed for Sundays or public holidays, but on Christmas, Whitsun, and Easter day a compensation period runs from 8 a.m. to 7 p.m.

On Call at Home.—Travelling time and working time are summated, with a minimum of one hour each visit.

Senior Doctors (Consultants and Senior Registrars)

The consultant, of whom there is usually only one for each specialty, is responsible for the proper running of his clinic at all times, but he may delegate this responsibility to an experienced doctor in his department, and is expected to do so if he is away for a whole day. All locums are appointed by Socialstyrelsen, the central medical advisory and disciplinary body in Stockholm, and it is the rule that locums are appointed to cover holidays and sickness.

Compensatory leave for senior doctors is given as direct compensation for emergencies, and as additional special leave.

Direct Compensation for Emergencies.—Regular participation for more than one week as "first on call" entitles the doctor to claim direct compensation for emergencies in the same way as junior doctors, but, in addition, compensation can be claimed on Sundays and holidays. At present there is no compensation for second call on weekdays, even if the senior is working.

Additional Special Leave.—This is intended to recompense the doctor for loss of free days to which he does not have a guaranteed minimum, unlike junior doctors, and to compensate him for giving background cover and supervision. In estimating this special leave it is first necessary to calculate its maximum. This is done over the whole year and is influenced by one of three scales to which the doctor may be allocated. Whenever cover is provided on a Sunday or holiday a number of hours is added to the pool and these accumulate. This cover must extend for a minimum of 24 hours, which begins at the earliest on the morning of the day before and ends at the latest on the morning of the day after Sunday or the holiday.

Scales.—(1) This applies to doctors who are first on call and who must be immediately available to answer the telephone and able to reach the hospital rapidly, or doctors staying in the hospital. Eight hours is added to the pool for each 24 hours of cover. (2) The doctor is first on call or providing back cover but need not immediately be available. The frequency of requests to visit the hospital must exceed by more than 50% the figure for days on call. Six hours are allocated. (3) Other first on call or back cover, four hours are added.

These scales are negotiated between the hospital administration and the doctors concerned, and can be altered if the pace of work changes. The volume of work is considered over a period of at least six months before this is done.

Calculation of Leave Compensation

(A) At the end of the period in question the doctor will have accumulated a pool of hours. From this is deducted all the direct compensation earned for emergencies on Sundays and holidays.

(B) Next is calculated the number of free days during the period that were not broken. Note here that housebound call with telephone interruptions and a routine visit to the hospital do not constitute a broken free day. However, an extra visit to the hospital to attend a very ill patient or an emergency does constitute a broken free day. The doctor is entitled to four unbroken free days each four-week period he has worked

provided these are covered by the pool and so he gets these as compensatory leave.

(C) In addition, for scales 1 and 2 the doctor gets up to 12 days' leave for the year, which is limited only by the number of days left in the pool. For scale 3 up to six days' leave is given.

Example

A doctor on scale 2 covers 20 Sundays and holidays in a year and so obtains $20 \times 6 = 120$ hours of credit in the pool. From this is deducted 24 hours of direct compensation already claimed for emergencies on Sundays and holidays. The remaining 96 hours amount to about 12 days, because usually eight hours count as one day (see below). He has worked 44 weeks in the year and been able to take 45 free days (35 free Sundays and holidays plus 10 unbroken days on call on Sundays and holidays) so he is not entitled to draw compensation from the pool for broken free days. However, he gets 12 days' compensation according to the lump sum in section (C). He is able to take this full lump sum because it is covered by 12 days in the pool. If there were only nine days remaining in the pool this lump sum would be reduced to nine days. In this example the doctor gets three days' direct compensation plus 12 days' special leave.

Compensation Leave for All Doctors

Usually eight hours' compensation is equivalent to one day of leave, except when leave falls on a Saturday, which requires only six hours. The first two Sundays and public holidays falling in a continuous period of leave do not use up accumulated compensation; further Sundays in a leave extending over more than two weeks consume eight hours.

Period of Grace

Direct compensation for emergencies must be used up within two months for juniors and 12 months for seniors. Other compensation can be carried over until 31 May. The taking of leave in anticipation of entitlement is encouraged. In circumstances when leave cannot be taken financial reimbursement is made.

Discussion

This compensatory leave system appears to be working well, particularly for junior doctors; and during their participation time was had to iron out difficulties. The newer regulations for consultants and senior registrars are more complicated and open to different interpretations at present. It is, of course, easier for large clinics to fit in leave when, for example, it may be possible to employ a locum all the time so as to enable doctors to take holidays in rotation. Two recent papers from Britain (Nightingale and Taylor, 1966; Northern Physician, 1968) have suggested that at least this method of evaluating time spent by a doctor on call might be of interest; especially might this be so if the forecasted change in the pattern of work towards more emergencies to be undertaken by consultants is correct (*Brit. med. J.*, 1968). In conclusion it is perhaps permissible to mention that it has been possible in Sweden to compensate doctors for attendance on emergencies, and it will be interesting to see the direction of future progress.

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REFERENCES

- Nightingale, D. A., and Taylor, T. H. (1966). *Brit. med. J.*, 1, 1218.
Northern Physician (1968). *Brit. med. J.*, 4, 571.
Brit. med. J., 1968, 3, 133.