present training period for would-be surgeons is essential.

The public should be fully informed concerning this dangerous proposal. They ought to be very worried indeed.

JAMES DIXON

Torquay, S Devon TQ2 5NZ

Excessive working hours of junior doctors

SIR,—Having recently completed my year as a preregistration house officer, I have been following the recent discussion concerning the work load and long hours enforced on junior doctors with great interest.

My attention was drawn by the proposal of Dr Anthony Kaiser in his recent letter (2 January, p 55), in which he suggests that working a shift system would be an improvement on the present inadequate state of affairs. The system which he proposed, in which doctors work a two weeks of "days" and one week of "nights" type of rota, is in my opinion just as unsatisfactory as the present situation. The disorientation and general upset of body rhythms caused by working at night and sleeping during the day for seven days is considerable and, as I have recently found out, one finds oneself in a state of extreme tiredness for a number of days following the return to normal timing, and thus prone to the same weaknesses as the present house officer.

May I suggest the system which I experienced as a house officer as a more acceptable method of organising the junior hospital doctors' rota? This system is currently in operation at St James's University Hospital, Leeds, and at present is only for the medical admissions. There are 12 medical house officers employed by the hospital and they are arranged in groups of four. Every evening two of the four doctors in each group are on call, one admitting new acutely ill patients while the second looks after the patients already admitted. After 11 00 pm only two of the six on-call house officers remain on duty, one again covering the wards, the other admitting patients. Thus each junior doctor works alternate nights until 11 00 pm and all night on a one-in-six basis. The hours worked using this system are approximately the same as with a conventional one-in-three rota.

Both I and my colleagues found this system much less exhausting than the standard rota found in other hospitals, and I would like to suggest it to your readers as at least a short-term solution to the dangers, for patients and doctors, brought on by too many sleepless nights.

G PHILIP WILDE

Accident and Emergency Department,
University College Hospital,
London WC1

SIR,—I am delighted that you are publicising the excessive hours worked by junior hospital doctors (2 January, p 55). It is quite wrong that while on board ship the watch is changed every four hours to avoid accidents there is no such change among doctors, who collectively must be in charge of just as many patients as the seamen are of passengers and crew.

I have noticed how inefficient most doctors become when tired. They may not be able to make simple decisions and their pace of work is greatly reduced. With a few hours' sleep the NHS would get much better value for money out of them and patients would have less waiting and less morbidity from mistakes. These considerations also apply to catastrophies, where one usually reads that surgeon and anaesthetist have worked non-stop for 24 hours or more. They would get through more work and do it more quickly and better if they took off time to sleep—though at the time one does not realise this, with patients in droves waiting for treatment. I have seen both systems in operation.

It is an anachronism that near the end of the twentieth century this glaring fault in organisation still continues.

J S PHILLPOTTS

Guildford, Surrey

SIR,—Having read with interest the letter by Dr E Willis (7 November, p 1267), I would like to add a few comments. I have been working as a senior registrar in the department of anaesthesia, University Hospital of Aarhus, "on loan" from the South Western Regional Health Authority for six months. It has made me aware, without complacency, of some advantages of the NHS in Britain, although there are some lessons to be learned from the Danes.

I agree with the view that, at present, the Danish system has advantages for the junior doctors in terms of reduced hours of work and time off; if one has worked during the night, the compulsory five and a half hours' sleep usually means that the following day is free. The normal working hours of 8 am to 2 20 pm are highly conducive to a happy family (or social) life, and allow more time for research interests. However, five main disadvantages result from the reduced hours of work. (1) Continuity of patient care is poor—I cannot agree with Dr Willis that it is not necessary for an operating surgeon to see his patient awake preoperatively, or an anaesthetist for that matter. (2) Clinical experience is gathered more slowly, since the doctors are more often not in hospital to see the more unusual or interesting patients. (3) Organised teaching is greatly reduced. (4) The hospital "hibernates" after 2 30 pm, since only the on-call staff are present. (5) It is very expensive to run. I believe that it is a sad day when a medical system becomes part time.

A very good practice is that of starting each day's work with a departmental conference. Apart from getting "warmed up," the teams discuss both the clinical and the administrative problems, and decide on plans of action. Most of the departments in the hospital hold these morning conferences, starting at 7 45; it is a good way of organising medical audit. My own department also holds an intensive care unit conference at 2 pm every day, which most of the anaesthetic consultants and all interested residents attend.

New conditions of work, to start on 1 January 1982, have been agreed on unilaterally by the Government, whereby all resident doctors (including the senior residents) will only work for 40 hours a week, including "on-call" hours. The original plan was to do this in eight-hour shifts, but after representations to the Minister of Health and the Prime Minister 16-hour shifts are being allowed. The conditions are going to be implemented despite the fact that 98% of the doctors voted against them; they bring the doctors and nurses in line with the rest of the workers in Denmark, and include a compulsory 11 hours' sleep after each shift. This state of affairs has been brought about because the Danish junior doctors' union, far from being a strong, independent union as Dr Willis stated, is a minority part of a larger union, the Academic Central Organisation, comprising lawyers, engineers, university lecturers, and economists, which has accepted the new proposals. The junior doctors' union has decided to leave the parent union, but too late to alter the "agreements."

As a result of these new conditions, all the 800 junior doctors who are at present unemployed, as a result of overproduction through not limiting university places several years ago, will have a job. Furthermore, more training places will be created in the popular specialties such as obstetrics, surgery, and medicine. However, the disadvantages of the short hours already mentioned will be accentuated; in practice, teaching is usually the first casualty when working hours are reduced. Moreover, since trainees in the specialties will acquire even less clinical experience each year, the time required to attain specialist status will have to be increased.

At present the mean age of qualification is 27 in Denmark, and then several years are spent working in departments not related to the chosen specialty. Most junior doctors start their specialist training between 30 and 35, and the majority cannot expect to attain consultant status until they are well over 40; however, they are experienced, well-rounded doctors by that time. There is talk of creating a permanent, junior specialist position in the hospital system, since the consultants spend much of their time in administration rather than patient care and teaching, particularly in central hospitals. This would reduce the long, stressful wait that the senior registrars can expect for consultant positions, and would reduce the wastage of fully trained specialists entering general practice, having lost patience or hope. The creation of more specialist positions would create a consultant-based service, obviating these problems and leading to greatly improved patient care and teaching.

The Danish system of specialist training, like that of many European countries, relies mainly on papers and research carried out by the trainee and a two-year "course rotation," with lectures totalling 120 hours a year, and no postgraduate examination. Candidates for the few, highly competitive rotations are judged almost exclusively on how many publications they have produced. This certainly induces a lively interest in fields of research within the specialties, and one finds many registrars with 5-15 publications behind them. However, this is often achieved at the expense not only of the broad-based knowledge necessary for a postgraduate examination but also of clinical interest, experience, and—most importantly—ability. The trainee develops deep understanding of a few subjects that interest him, but many have rather large gaps in between. Maybe this does not matter in an age of super-specialisation, but one is tempted to summarise the training in the phrase "Never mind the quality, just feel the width."

There is very little private medicine in Denmark, about 3-5% of the total, although the first private clinic has recently been opened in Aarhus. The salaries are somewhat higher than in England, but attract a vindictive 65% tax unless large sums of money are borrowed. The administration is non-medical and very powerful; recently the discussions have generated far more heat than light and have led to much distrust on both sides. In all, one sees the signs of many years of Socialist philosophy, for better or for worse.

I hope these facts and opinions will be viewed constructively, since there is always room for improvement in any medical system.

A N BURLINGHAM

Department of Anaesthesia,
University Hospital of Aarhus,
DK8000 Aarhus C,
Denmark

Correction

ABC of alcohol

We regret that in the letter by Dr B M Wright (2 January, p 51) there were two errors. In line 4, first paragraph, and line 7, second paragraph, the word "alcometer" should read "Lion Alcolmeter." In reference 2 the word "London" should read "Melbourne."

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