neighbouring practices in the area so that they can come to see if they might like us better or just to check that they have already made the correct choice?

I am prepared to accept any patients in the area who wish to come on to my list. Occasionally if I later find their behaviour and demands unreasonable I suggest that another practitioner would be more appropriate; sometimes patients find me wanting in understanding or ability and, under the present arrangements, still manage to change to another doctor with a minimum of fuss and bother.

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1 Loudon I. Finding a doctor: too much of a lottery. *Br Med J* 1989;**298**:670-1. (11 March.)

Shift working for consultants

SIR,—Dr J M Manners predicts shift working for senior doctors.[1] In Grimsby the three consultant paediatricians have been operating a shift system for the past 27 months. We share care of paediatric and neonatal inpatients, with two consultants working by day and one by night through the week. We work long weekends in sequence, and consultant leave modifies the system.

We serve a population approaching 0·25 million; our only junior staff are three senior house officers, who rarely have any previous paediatric experience and are mainly general practitioner trainees on a six month contract, and we are not allowed locums. Our clinical problems present round the clock, frequently with little or no warning.

Except in the simplest of cases the demands of modern neonatal and paediatric care are too onerous to be left to inexperienced senior house officers, particularly if limited resources are to be managed effectively. This leaves considerable out of hours work that is best dealt with by the consultant.

Our system would be impracticable with fewer than three consultants as we average about 80 hours' work a week to allow for overlap and leave. It has increased consultant availability to our patients and is more acceptable to us than traditional work patterns.

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1 Manners JM. Lack of sleep in junior doctors. *Br Med J* 1989; **298**:527. (25 February.)

Junior doctors' pay

SIR,—I endorse Dr K G E Brown's views on junior doctors' pay.[1] The need to reduce working hours will soon be forced on our profession if we cannot come up with a satisfactory solution ourselves. The problem entails continuity of care, gaining adequate training experience, avoiding fatigue, avoiding consultants being resident on call, and, finally, still paying junior doctors a decent salary.

Balancing all these factors is not easy, but if standard units of medical time were paid for the first 72 hours worked, whether these were day or night hours, then a balance might be achieved. This would allow doctors to work overnight and to bridge the gaps in the normal working week and to have adequate time off after each on call period. They would not have to take unofficial half days with the risk of losing precious standard units of medical time if they have worked on call more than once in a week. The total number of hours would fall, and junior doctors would no longer be used as cheap out of hours labour. This would hardly be expensive as they would be paid only at standard rates. The number of tired juniors in the daytime would fall, and the daytime work could be covered by senior staff.

In New Zealand they have tried "penalty rates" for hours worked over 40 a week. This has led to a pure shift system in which patients and doctors are unhappy. In the short term some junior doctors are making a lot of money, but the junior grade is having to be expanded with doctors for whom there is no future. Medicine is not a 40 hour a week subject.

In Scandinavia hours worked are kept down by having blocks of time off—for example, every eight weeks staff have a week off. This is a pleasant system but one that is a long way off in Britain in view of the increased numbers of doctors and therefore the increased costs.

Calculating the working week on a 72 hour basis may well solve the current predicament faced by junior doctors.

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1 Brown KGE. Junior doctors' pay: a block to reducing hours. *Br Med J* 1989;**298**:527. (25 February.)

SIR,—Dr K G E Brown is incorrect in thinking that allowing junior doctors one and a half days off each week during the daytime would result in a reduction of 3 standard units of medical time (UMTs).[1] It would be unfortunate if this method of reducing hours failed through a misunderstanding.

Junior doctors contract for a minimum of 10 UMTs per week, each unit being four hours of duty. This minimum period of duty for a full time practitioner is the standard working week. There is nothing in the regulations indicating that this minimum period of duty must be worked during the daytime, Monday to Friday, though this is the way most junior doctors work at present. Payments for hours additional to the basic 40 hours per week may be made for class A units (for standby or working in hospital) or class B units (for reduced availability).

Thus the first 40 hours of duty are paid at a standard rate whenever they are worked and any other commitment is paid for at either a class A or, infrequently, class B rate. The effect of allowing junior doctors to take one and a half days off during the daytime from Monday to Friday would reduce the number of class A UMTs by three per week, not the number of standard UMTs. This is why a junior doctor who has an "official" afternoon off each week receives one class A UMT less than would otherwise be the case.

Incidentally, in Dr Brown's example of doctors working an extra 13 UMTs paid at the class A rate a reduction of 3 UMTs would leave an average working week of 40 hours paid at the standard rate (10 UMTs) and 40 hours paid at the class A rate (10 UMTs)—still eight hours a week more than the desired 72.

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1 Brown KGE. Junior doctors' pay: a block to reducing hours. *Br Med J* 1989;**298**:527. (25 February.)

Two tier sight testing

SIR,—The Health and Medicines Act 1988 introduced charges for eyesight tests for most patients with effect from 1 April 1989. The act also defined that it is the duty of an ophthalmic medical practitioner and ophthalmic optician "to perform such examinations of the eye for the purpose of detecting injury, disease or abnormality in the eye or elsewhere."

At the beginning of March proposals were made by the Department of Health for draft regulations "to provide consumer safeguards in relation to sight tests." Patients exempted from paying for a sight test are sure of receiving a full and proper eye examination as defined in the act and, indeed, the regulations go so far as to detail the requirements of an examination. Patients who are not exempt from paying charges, however, will not be so protected. They may choose to have a sight test that does not include the examination.

Doctors are extremely concerned with these proposals, believing it to be clinically, ethically, and medicolegally impossible for ophthalmic medical practitioners to undertake a sight test to determine the need for an optical appliance without examining the eye. How can they fulfil their obligations to the patient and maintain a proper standard of medical care? How can patients be expected to make decisions to opt for a refraction only examination or a full eye examination, and what will be the consequences for both doctors and the patients if they opt for a refraction only examination and are later found to have a disease that might have been prevented?

The government needs to answer these questions and introduce regulations that will truly safeguard the consumer and avoid both unjustifiable risks to the patient's health and unacceptable conflict with the ethical duty of doctors towards their patients.

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Avoiding injuries caused by pigs

SIR,—Dr Paul Garner's editorial,[1] though drawing largely on the experience of hunters, is aimed primarily I think at medical practitioners and students who venture into wild places. Whereas the hunters deliberately take a risk in pursuit of their quarry doctors should try to avoid unnecessary danger. To them I offer a piece of advice that Dr Garner omitted, and that is: make a lot of noise.

In Africa I have collected plants in close proximity to many dangerous animals, among them lions, leopards (unusually in daylight), buffaloes, and hippopotamuses, as well as animals that may threaten the unwary traveller, such as elephants and crocodiles. Approaching a locality where I intended to collect, I used to bang a biscuit tin that I carried for that purpose, and I observed the animals move off in response to my drumming. It is important to avoid startling them so I used to begin with a tentative tattoo as I approached the locality. Equally important is to know something about the animals' habits. For instance, the kind of lairs where leopards lie up by day or the sort of shrubs where a lion may be resting in the shade should be scrutinised before attention is taken up with plant hunting, and botanising between a hippo and a nearby river was a risk I never took, for if startled these animals generally rush for the water and may snap up a human on the way.

As Dr Garner says, "Travellers walking through jungle where there may be wild pigs should be cautious," but cautious should mean noisy, not quiet.

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1 Garner P. Avoiding injuries caused by pigs. *Br Med J* 1989;**298**: 848. (1 April.)