- University of Warwick, 1987. (Unhealthy housing: prevention and remedies.)
- 7 Burr ML, Mullins J, Merrett TG, Stott NCH. Indoor moulds and asthma. *J R Soc Health* 1988;108:99-101.
 - 8 Burr ML, Neale E, Dean BV, Verrier-Jones ER. Effect of a change to mite free bedding on children with mite-sensitive asthma: a controlled trial. *Thorax* 1980;35:513-4.
 - 9 O'Riordan MC. *Human exposure to radon in homes. Recommendations for the practical application of the Board's statement.* Chilton: National Radiological Protection Board, 1990.

- 10 Lowry S. *Housing and health.* London: British Medical Journal, 1991:59-66.
- 11 Conway J, ed. *Prescription for poor health. The crisis for homeless families.* London: London Food Commission, Maternity Alliance, SHAC, Shelter, 1988.
- 12 Ramsden SS, Baur S, El Kabir DJ. Tuberculosis among the central London single homeless. *J R Coll Physicians Lond* 1988;22:16-7.
- 13 Health Visitors' Association and General Medical Services Committee. *Homeless families and their health.* London: British Medical Association, 1989.
- 14 Foster S, Burrows L. *Urgent need for homes.* London: Shelter, 1991.

Junior Doctors. The New Deal

Commitment vital for new deal

Stephen Hunter

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

The publication of the new deal on junior doctors' hours is one step in a negotiating process which, for junior doctors at least, began over three years ago.¹ But the problem of the excessive hours of work of junior hospital doctors has been with us for much longer. This series of articles explores some of the elements of the package and explains the mechanisms which have been designed to implement it.

There is overwhelming evidence that the hours of work of junior doctors must be reduced. Juniors have long maintained that long hours not only influence their own health and morale but also that they are damaging to patients. Research into psychological

flexibility in working practices and contractual arrangements and to acknowledge that there is a considerable difference between the working experiences of senior registrars who have a low intensity of specialised on call work and the more junior doctors whose experience is exactly the opposite.

Legitimate fears

Consultants have legitimate fears that the burden might simply be transferred to them and these fears are reflected in the package. Certainly the evidence that consultants already work well in excess of their current contracts is well documented.⁸ What has to be acknowledged equally, however, is that *Achieving a Balance*⁹ and the current package refer to the need for greater flexibility in consultant working practices. It has been assumed that as consultant numbers increase relative to other grades so the proportion of direct patient care, including emergency work, undertaken by consultants would increase. Comparison of indices of consultant workload, however, indicates that despite a marked expansion in consultant numbers the emergency workload per consultant over the same period has fallen rather than risen.¹⁰ There is a need to ensure that the new consultants appointed under this agreement do, in practice, reflect the philosophy inherent in the agreement; this is why the agreement states that they should deal with existing rather than new workload.

Similarly, consultants could facilitate fairly major reductions in juniors' hours by encouraging a move away from the individual consultant firm method of working towards a more team oriented approach, but there is evidence that this is not happening, particularly in teaching hospitals. It is paradoxical that in teaching districts there are more junior doctors and hours of work are longer than in non-teaching districts.⁷ The obvious conclusion is that consultants in non-teaching districts use junior medical manpower in a more effective way.

The heads of agreement in December 1990 contained long overdue admission from the medical royal colleges that they could see no reason why a reduction to 72 hours a week should compromise the quality of medical training.¹¹ This is particularly welcome because the reports of district working parties set up under the earlier initiative on juniors' hours frequently suggested that local college representatives had resisted reductions because it was thought that lower hours would offer insufficient experience for training. This argument has considerable but false attractions. There is no evidence that the quality of training experience relates to the amount of out of hours work done. There is considerable evidence to the contrary in the Dowie report. The suggestion that training in some specialties might have to be longer to accommodate

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distress^{2,3} and morale⁴ illustrates this and there have been a plethora of reports and verdicts at coroners' inquests supporting the contention that stress associated with sleep deprivation is an important factor in unnecessary morbidity and mortality.⁵ This evidence, coupled with an imaginative and effective campaign by junior doctors, overwhelming public sympathy, and 19 out of 20 junior doctors saying they would be prepared to take industrial action in support of reductions in their hours of work,⁶ led directly to the current agreements. These were produced by a ministerial working party comprising junior doctors, consultants, representatives of the royal colleges, and NHS management, and chaired by the Minister for Health, Mrs Virginia Bottomley.

But for the complicated and diverse structural and cultural forces at work solutions would have been implemented long ago. The Bottomley working party, chaired by a minister acknowledged by the junior doctors' representatives as being committed and sincere, is only the latest in a long line of initiatives. The current average contracted hours of house officers are 89 a week but the Dowie report suggested that they actually work nine hours more than this. Over 70% of house officers are contracted to work more than 77 hours a week and 30% more than 100 hours.⁷ The responsibility for this lies partly with the Department of Health, partly with NHS management, partly with consultants, and partly with junior doctors.

Junior medical staff have sometimes been less than imaginative in acknowledging the diversity of the obstacles to reducing their hours. It is only recently that the Junior Doctors Committee (JDC) has indicated that it would be prepared to explore greater

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reductions in hours of work is unnecessary and unjustified. A recent survey by the Standing Committee on Postgraduate Medical Education illustrates this by showing how the demands on junior doctors to provide a service interfere with their ability to take study leave.¹² Excessive hours of work hamper rather than help junior doctors in attaining adequate training opportunities, and clearly the opportunity should be taken to ensure optimal training within the context of lower hours of work, emphasising contact with senior staff with formal organised didactic teaching, and with more time available to read and assimilate information.

Imaginative idea

One of the most imaginative ideas to reduce juniors' hours which came out of the ministerial working party was the enhanced use of shift and partial shift systems, particularly at the most junior levels of cover. The need for and viability of these systems was shown by a report by the London School of Economics commissioned by the Department of Health,¹³ and by Finn and Speidel¹⁴ and Nasmyth.¹⁵ The ministerial group

If the monitoring highlights problems the ministerial group will be pressed hard to offer solutions.

evaluated several experimental shift systems. The royal colleges, however, have tended to dwell on the problems which this approach might entail rather than seize the opportunities that shifts offer, particularly with reference to continuity of care. The inclusion, at the insistence of the JDC, of compulsory handover periods in any shift system actually offers the chance to improve continuity of care outside normal working hours; under the current rota system there is rarely any handover and continuity after 5.00 pm and at weekends is more myth than reality. In accident and emergency departments, where admittedly the need for continuity is low, shift and partial shift systems are now the norm, and both the quality of training and the quality of care have improved rather than been compromised.

By their peripatetic nature junior medical staff present a considerable problem for NHS management, and it is understandable that the needs of junior doctors have always been given low priority. An example of this has been the systematic deterioration of the standard of accommodation available to junior doctors over the past two decades in order to achieve relatively small revenue savings. The guidance in the new deal attempts to redress this by promulgating new minimum standards for residential accommodation which managers are asked to meet and by proposing good practice in such areas as catering, job descriptions, libraries, and recreational facilities.

In other areas, too, the new deal requires major additional resources and only the Department of Health can find these. The first need is for a marked increase in medical manpower at all levels, but particularly for extra consultants. The Secretary of State for Health has committed himself to resourcing this aspect of the new deal and the JDC will have to remind him and his successors of that commitment in years to come. But unless the additional manpower is directed solely to out of hours work there is a danger that it will simply be sucked into a system that has in the past shown itself well able to absorb increased manpower

purely in increased work rather than to distribute the existing workload more evenly. Furthermore, unless there is a marked change in the working patterns of career grade medical staff the amount and nature of the work currently done by junior doctors will change very little.

Importance of support staff

Additional resources are also needed to provide adequate numbers of support staff—nursing, clerical, technical, and ancillary. There is no prospect in the new devolved managerial structure of the NHS of those resources being provided centrally and the likelihood is that regions, districts, and individual hospitals will have to prioritise junior doctors' hours of work ahead of other needs if these resources are to be found. Here, too, the commitment of ministers will be crucial.

Regional task forces constituted under the heads of agreement will have the vital task of ensuring the implementation of the new deal and monitoring its effects. The results of that monitoring will be fed back to the ministerial working group which intends to continue to meet at frequent intervals. If the monitoring highlights problems the ministerial group will be pressed hard to offer solutions. Experience of the task forces' work so far has been constructive, but the most difficult area, the configuration of hospital sites, has yet to be tackled. After 31 December 1996 it will no longer be possible to employ junior medical staff in excess of 72 hours, and authorities and trusts will have to take action well in advance of that date to ensure that they can continue to provide a service. Where some rationalisation of sites is clearly the only answer the new systems of contracting for services and capital charging will undoubtedly identify the way forward.

The strategy of the juniors' campaign has always centred on the need for a locally implemented but centrally driven initiative. Early on we identified three possible central driving forces: legislation, pay, or regulation. The new deal is designed to achieve reductions in hours using the third of these driving forces. No one should assume, however, that the new deal is the end of the road. Many difficulties persist and new ones will present themselves, but they will all be overcome if the experiences gained in one place are shared with others.

- 1 NHS Management Executive. *Junior doctors. The new deal*. London: NHS Management Executive, 1991.
- 2 Firth-Cozens J. Emotional distress in junior house officers. *BMJ* 1987;295:533-6.
- 3 Firth-Cozens J. Stress in medical undergraduates and house officers. *Br J Hosp Med* 1989;41:161-4.
- 4 Allen I. *Doctors and their careers*. London: Policy Studies Institute, 1988.
- 5 Poulton EC, Hunt GM, Edwards RS. The performance of junior hospital doctors following reduced sleep and long hours of work. *Ergonomics* 1978;21:279-95.
- 6 Delamothe T. Juniors favour action over hours. *BMJ* 1990;301:1235.
- 7 Dowie R. *Patterns of hospital medical staffing. Interim report: junior doctors' hours*. London: British Postgraduate Medical Federation, 1989.
- 8 Review Body on Doctors' and Dentists' Remuneration. *Twentieth report*. London: HMSO, 1990. (Cmd 937.)
- 9 Department of Health and Social Security, Joint Consultants Committee, chairmen of regional health authorities. *Hospital medical staffing: achieving a balance—plan for action*. London: DHSS, 1987.
- 10 Review Body on Doctors' and Dentists' Remuneration. *Eighth report*. London: HMSO, 1978. (Cmd 7176.)
- 11 Department of Health, Welsh Office, Department of Health and Social Services (Northern Ireland), Scottish Home and Health Department. *Heads of agreement. Ministerial group on junior doctors' hours*. London: DoH, 1990.
- 12 Standing Committee on Postgraduate Medical Education. *Survey of the uptake and costs of study leave*. London: SCOPME, 1991.
- 13 Bartholomew DJ, Balmer DW. *A study of junior hospital medical manpower in the NHS*. London: London School of Economics, 1990.
- 14 Finn A, Speidel BD. Shift system for senior house officer on call duties on a neonatal intensive care unit. *BMJ* 1988;296:343-4.
- 15 Nasmyth DG, Pickersgill A, Hogarth M. Reducing hours of work of preregistration house officers: report on a shift system. *BMJ* 1991;302:93-4.