psychiatrists are (1) excellent listeners; (2) rarely judgmental; and (3) grateful to a patron who speaks out firmly against the stigma that still bedevils their profession and, more importantly, those whom they treat—or should be treating? No issue in the college's 150th anniversary year is more important than this.

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1 Widgery D. The prince and the psychiatrists. *BMJ* 1991;**303**:723. (21 September.)

SIR,—David Widgery draws somewhat belated attention to the visit to the 150th anniversary annual meeting of the Royal College of Psychiatrists of our patron, Prince Charles, on 5 July.[1] Widgery is essentially hostile in his report, but it is difficult to discover exactly what he finds objectionable. He describes the Prince of Wales's speech as platitudinous, a standard parliamentary strategy for expressing agreement with a statement made by an opponent. He criticises the college's response as "near trance" and my introductory remarks as "an extravagant show of deference," and he deprecates the absence of "republican spirit." I wonder how else Widgery would expect us to have welcomed our royal patron on an important occasion for the college. We were indeed grateful to Prince Charles for joining us, and we were certainly interested to hear what he, speaking on behalf of the non-medical public, had to say.

Widgery has missed the significance of the prince's visit and speech. There is still stigma associated with mental illness, with those who suffer from it, and indeed even with those who come into contact with sufferers. This makes it difficult for the sufferers to talk about their illness, even after they have recovered, without fear of losing their job; it is a potent factor in the low level of funding for psychiatric research, and the stigma is as conspicuous within the medical profession, as exemplified by Widgery's article, as outside. Our patron, by taking up the cause of the mentally ill, has made a personal contribution to reducing this stigma, and the college is totally without embarrassment in welcoming this. His interest has already been beneficial to our patients, and we hope for a long continuing relationship to further our objectives of raising clinical standards in psychiatry, promoting psychiatric research, and encouraging professional and public education in the discipline.

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1 Widgery D. The prince and the psychiatrists. *BMJ* 1991;**303**: 723. (21 September.)

Junior doctors' hours

SIR,—Dr Anthony Naughton's letter, written after a visit by the north west regional task force to Blackpool, illustrates both the magnitude of the problem facing task forces nationally and the inadequacy of the resources allocated to do the job.[1] The North West Junior Doctors' Committee is anxious to correct the impression that the problem is due to a lack of commitment by the local regional health authority; rather the difficulty lies with the government, which has failed to allocate adequate resources for reducing junior doctors' hours of work.

The north west regional task force is pursuing "the new deal" with energy and imagination: it has already met seven times since April, has appointed a full time junior, will shortly allocate the few posts at its disposal, and is pushing to implement the interim goal of 83 hours a week by the end of this year.

Blackpool has always had special problems arising from its situation and perhaps incorrectly expected that the task force would offer some of the meagre resources at its disposal to solve them. We understood that the visits in August were proposed as a means by which to begin to study the problem in detail before finding ways of solving the "seemingly intractable problems" that are the task force's remit. With allocated funds limited to 14 consultants and four staff grade posts this task will not be easy. How to square the circle: reduce hours without an increase in manpower or a reduction in service and at no extra cost? No wonder they were asking if anyone could tell them how to do this.

This regional task force is doing its best to work within the constraints under which it is obliged to operate. The understandable anger at the inability to achieve change should be directed not at the task force itself but at those who sent it out to battle so woefully underarmed.

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1 Naughton A. Junior doctors' hours. *BMJ* 1991;**303**:586. (7 September.)

SIR,—Dr Stephen Hunter is right to draw attention to the need for an increased flexibility in consultant working practices if the new deal is to produce real reductions in juniors' hours.[1] The new shift patterns work only where there are enough staff to do the work. There are many small and medium sized hospitals with insufficient numbers of juniors to bring down hours in line with the agreement, even with shift systems. Only if the new consultants take on this workload do the figures add up. The paradox is that the agreement Dr Hunter negotiated on behalf of juniors specifically excludes consultants from taking on work currently performed by juniors. Paragraph 4.6 of the heads of agreement says, "It would be inappropriate and wasteful use of the skills of consultants to require them to undertake tasks which are easily within the competence of other doctors." The reasons for including this restriction in the agreement are not immediately clear. It is difficult to see which clinical tasks involving patient contact are beneath consultants. As fully trained doctors they are best placed to perform clinical duties more safely and efficiently than anyone else, to the benefit of patients and service alike.

The new deal has been resourced with an extra two hundred consultant posts. If these consultants are to make a real difference in the small hospitals where they are needed most they will have to take on part of the emergency workload. If Dr Hunter is to see the changes he hopes for then he will have to ensure these unnecessary and incomprehensible restrictions on consultant working practices are removed from the agreement.

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1 Hunter S. Commitment vital for new deal. *BMJ* 1991;**303**:840-1. (5 October.)

SIR,—At the Labour party conference recently the shadow chancellor, John Smith, pledged that under a Labour government there would be a minimum working wage of £3.40 per hour. I will be intrigued to see if this will apply to junior doctors, who currently receive about £2.20 per hour when on call.

I realise that the rest of my salary is much better than that of the people to whom Mr Smith refers, but it still irks me that for a large proportion of my working time, when I am making grave decisions on which lives may depend, I am paid only two thirds of the minimum working wage.

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Outpatient physicians

SIR,—In many district hospitals around the country medical departments must be agonising over arrangements to bring about the proposed reductions in junior hospital doctors' hours without reducing the quality and continuity of their services. The continuity of inpatient care to which we have all been committed seems likely to be sacrificed to shift and partial shift systems.

One of the ways in which this problem might be eased is by reducing the amount of time spent by senior house officers and registrars in outpatient clinics. This might particularly help the problem of the long periods of continuous duty, which have rightly been criticised.

One of the most widely suggested solutions is to appoint staff grade doctors. I believe that this grade is a disastrous invention. Doctors can be appointed to a post from the age of about 27 and be there for the rest of their lives. This grade seems to me to encapsulate the worst form of recurrent clinical assistantship, which helped out with "service requirements" in many of our departments in the past. This category of doctors seems set to multiply and fossilise.

There may be many physicians like me who would dearly like to reduce their number of hours of work, not because they want to give up clinical medicine but because they want more time for other things. For many years we have been working 50 or more hours a week and have been on call on one in two or three nights and weekends. Now we would like to do rather less without, let's face it, sacrificing our pensions.

The scheme for general practitioners whereby they retire on their 60th birthday and are re-employed a day later on a part time basis has, I believe, been an enormous success. From being weary 59 year olds, haggard, disgruntled, and bowed, they become bright, enthusiastic, and cheerful 60 year olds. A similar scheme for those of us who work in hospital would be of enormous benefit.

We could become part time outpatient physicians. We could take over some of the massive amount of work that junior hospital doctors do in outpatient clinics. We could relieve our consultant colleagues of some of their work, thus enabling them to give more time to inpatient duties, which will surely be required once the juniors are not so continuously there. The reduction in the time spent by juniors in outpatient clinics, which is such an important part of their training, would be counterbalanced by the possibility of greater supervision there by senior experienced physicians. These senior outpatient physicians would have inbuilt obsolescence and could be appointed on short term contracts of one to five years as appropriate. Because of their reduced overall commitment they could be paid at a basic consultant sessional rate.

If the Department of Health could be persuaded to allow these posts to be extra to the current consultant establishment this could have great benefit to the consultant expansion that the NHS and its senior registrars so badly need.

Perhaps this is one solution to a difficulty that would be acceptable to all parties.

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