Inevitably the majority of training takes place when consultants are present during the day. Consultants must have teaching and training time identified in their job plans and must reflect the needs of trainees. It is perhaps an anomaly that a weekly ward round is still considered by some to be sufficient for patient care and training. The EWTD cannot be met simply by altering junior doctors' rotas if training is not to be compromised; the role of the consultant as trainer needs to be defined in relation to the patterns of work for trainees not simply in relation to the academic curriculum.

The role of the consultant physician needs to be addressed by the leaders of the profession; is it not time that the most sick patients were seen by trained medical staff with sufficient skills and experience to improve outcomes? Consultants are more evident in acute care than in the past and we would suggest that standards are raised when a greater proportion of acute care is delivered by trained doctors. We cannot go on leaving all direct care after 5 pm and before 8 am to less than fully trained doctors.

New ways of working?

Hospital at Night is a proven tool, not only for EWTD compliance but also for improving service and training. There are other changes in ways of working that are having, and will continue to have a positive impact on patient care. The reorganisation of services, development of clinical care networks or hub-and-spoke models will be necessary for some specialties and has already been successful in, for example, vascular work. The role of other healthcare professionals such as anaesthetic practitioners needs to be scrutinised so that the impact is not to reduce training experiences for doctors but enhance them and improve the service. There are several working parties investigating specific specialties where cross cover is impossible such as obstetrics and gynaecology, paediatrics and anaesthesia, where examples of best practice in relation to EWTD are being identified.

What should you do?

Pounder suggested that physicians should take a great interest in solutions and rotas proposed for juniors from 2009. We would propose that physicians show leadership and use the emerging evidence base to meet the challenge of the EWTD rather than waiting for others to propose solutions. All of us are responsible for, at the least, maintaining patient safety and protecting training. We need to meet the EWTD challenge with the changes necessary across the workforce not just in the training grades.

The greatest barrier to achieving the EWTD compliance is professional rigidity. Some of our traditional ways of working need to be challenged as they are simply not fit for modern patient care. We adopt clinical innovations that have a clear evidence base and need to do the same to protect the public from tired doctors, improve out-of-hours care and training.

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References

1 Hospital at Night. *Hospital at Night baseline report 2006*. London: Hospital at Night, 2006.
2 Hospital at Night. *Benefits realisation and business case*. London: Hospital at Night, 2007. www.healthcareworkforce.nhs.uk/working_time_directive/hospital_at_night/benefits_realisation_%26_business_case.html
3 Murray A, Pounder R, Mather H, Black C. Junior doctors' shifts and sleep deprivation. *BMJ* 2005;330:1404
4 NHS National Workforce Projects www.healthcareworkforce.nhs.uk/wtd
5 Paice E, Reid W. Can training and service survive the European Working Time Directive? *Med Educ* 2004:38:336–9.

Junior doctors' working hours (2)

The call upon doctors to take more interest in the European Working Time Directive (EWTD) and possible solutions is long overdue and very welcome (*Clin Med* April 2008 pp 126–7). The lessons from 2004 show that if nothing else early planning is crucial to the successful implementation and sustainability of new working practices. Early planning allows time to develop more innovative solutions, identify additional local resource and ensure thorough local consultation. Trusts waiting until summer 2009 to start thinking about EWTD are more likely to opt for the easier, quick-fix solutions of rota redesign with little or no increase in resource, leading to the adverse impact upon service delivery and training that Pounder warns us about. It is unclear, however, as to which approach was taken by the trust cited within the cautionary tale and would be unfair to take this one example as representative of 48-hour rotas. Within NHS North West approximately 50% of the current medical rotas are already fully EWTD compliant experiencing much more positive outcomes and we are planning 100% compliance across all specialties and grades by August 2008. I would also recommend the joint British Medical Association, National Patient Safety Agency and NHS guidance on *Safe handover: safe patients* to address concerns relating to continuity of care.[1]

While many organisations accept that an increase in resource is likely to be required to deliver sustainable 48-hour solutions, this can be delivered in many different ways. Cell sizes, for example, can be increased through cross-cover, Hospital at Night and service reconfiguration before we start considering additional recruitment. Even if additional recruitment is deemed essential there is then the following question as to which grade requires expansion? While the utopian answer to this may be consultants and middle grade junior medical staff, the reality is that NHS resources are unable to support this without significant impact upon resource availability. If one has to chose, surely the most sensible option is expansion at the most senior level? Not only would this move further towards the NHS's vision of a consultant-delivered service but it would also provide employment opportunities for current specialist/specialty registrars who it is feared would otherwise not have consultant posts to progress to. Places such as the Royal Free Hospital, London, have already implemented similar models in paediatrics and the Royal College of Surgeons are accepting this as a sensible way forward in the future.[2,3]

Finally, it should also be noted that although EWTD is always portrayed as the villain in the story around junior doctors'

working hours this is not strictly true. Contractual requirements in the UK relating to New Deal compliance and its link to the national junior doctors' contract on pay since 2000 have been the main driver towards wholesale full-shift working. Possible agreement in Europe regarding 'inactive' time, though unlikely any time soon and certainly not before August 2009, would be of little use to most rotas that left on-call patterns of working many years back due to Band 3 claims for failure to meet overnight rest requirements of New Deal, not EWTD. Unless we see drastic changes to the current junior doctors' contract, again unlikely before August 2009, any changes around the definition of working time in Europe will make little difference to viable EWTD solutions. Not least of all most people would argue that overnight rest is essential for doctors working shifts of 24 hours or more continuous duration and current New Deal rest requirements safeguard this. Funnily enough it appears New Deal and EWTD do in fact protect the health and safety of junior doctors and patients alike.

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References

1 British Medical Association. *Safe handover: safe patients. Guidance on clinical handover for clinicians and managers*. London: BMA, 2004.
2 Newton P. On-call consultants slash waiting times. *BMA News* 19 January 2008:2.
3 Ribeiro B. Achieving a balance – feast and famine. *Ann R Coll Surg Engl* 2008;90:78–9.

Junior doctors' working hours: a view from across the pond (3)

I read with interest Roy Pounder's article (*Clin Med* April 2008 pp 126–7). Viewed from the other side of the Atlantic, the extraordinary mandates imposed by the EWTD are beyond burdensome. I trained on the London thoracic service medical registrar rotation in the early 1990s. Since moving to the USA, I have become a proponent of work hour mandates. In the USA, there is an 80-hour restriction with a 24+6 on-call maximum. However, from the perspective of an academic pulmonary and critical care practice, the proposed 48-hour regulation would pose substantial direct risk for patient harm – as suggested in the editorial.

While the move to the 80-hour work rule has not been associated with measurable adverse effects, fellow trainees entering our training program are objectively less cognitively and technically adept than their predecessors from the previous decade. By inference this would be significantly amplified if further reductions through 56- to 40-hour weeks were to be mandated. I am not aware of any data that rigorously evaluates the impact on subspecialty training – either in Europe or North America – as a consequence of work mandates.

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Ruth Carnall's letter in response to my critique is interesting for what is included and what has been omitted (*Clin Med* April 2008 pp 227–8). I apologise for my error in suggesting that no lay person or patient was a member of any group. I should have said 'no member of the Commission for Patient and Public Involvement in Health, the statutory body responsible for the involvement of the public (until 31 March 2008) was included'. The working groups are listed as having had 123 members (one was on two working groups). A rough classification, derived from their designations, suggests that 44 were secondary care clinicians, 12 primary care clinicians, 34 managers from the public and private sector, 13 nurses or midwives, 8 public health specialists, 6 other healthcare professionals and 6 individuals from charities involved with health services – National Childbirth Trust, King's Fund, Marie Curie Cancer Care, Alzheimer's Society, Help the Aged and a non-executive director of a foundation trust. The latter five were all members of the 'end of life' group.

The conclusion and recommendations of the report are not particularly surprising given the preponderance of members drawn from hospital medicine and management. If the membership had included more population- or community-based clinicians and health service researchers, including statisticians and health economists, the data used for the various analyses might have included appropriate information from general practice and the population rather than being largely restricted to more easily obtainable hospital episode and HRG statistics. Expert researchers would also have been aware of the problem of basing models on opinions of front line clinicians and would have ensured that measures of, for example, variability and sensitivity were included in the analyses.

Undoubtedly front line hospital clinicians will advocate excellent models of investigation, treatment and care for individual conditions, but the preponderance of hospital specialists will have dominated the input to the proposed models, based on opinions, rather than a critical analysis of facts.

It is unfortunate that proposals for changes continue to be made on the basis of opinions rather than on demonstrations and analysis of effectiveness, advantages and disadvantages, tested in a pilot study. Comparisons with the US, Canada and Germany which do not have universal working or adequate primary care services, is not an appropriate comparison. New Zealand has general practice similar to ours and now has a number of polyclinics but I am not aware of any formal evaluation.

It is impossible to comment on the statement that on the basis of 'one centre per 50,000 population…[in] most parts of London this would equate to one centre per kilometre', intuitively this sounds unlikely even if there was complete freedom to build centres throughout London. To quote a recent article:

> *health service planners should begin to acknowledge that policies to improve medical outcome and make best use of internal resources incur social costs outside the health care system. Trade-offs are made, choosing gains in cost, efficiency or effectiveness at the expense of a loss in geographical accessibility, and these decisions are often taken without being acknowledged.*[1]

The initial principles of the report were different to those now listed – improved