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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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