

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 man-

agement. 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

management of long-term conditions, increased focus on health and preventing illness and access to urgent care. If this is so, why does the report neglect so many of the proposals of its Staying Healthy Working Group such as the redesign of services for childhood immunisation and the prevention and treatment of sexually transmitted infections, the co-location of new centres with social and leisure services and, above all, to increase the investment in prevention. It is particularly disappointing that the tackling of health inequalities, seems to have disappeared, in spite of possible available measures.

It is of interest that my editorial has not been challenged about its comments on the lack of methodological rigour in the development of models, the lack of concern with social services coordination, or mental health services, lack of concern with training or the prediction that unnecessary use will be made of technological equipment and specialist expertise and thus the costs of care will increase.

There is no doubt that secondary, hospital care in London needs to be reorganised and rationalised. The need for better general practice facilities in some parts of London is accepted by all. But the justification of radical changes in the organisation of primary, general practitioner care, made largely by hospital practitioners, has not been made. It is dispiriting that with our experience of repeated changes in health services over the past 20 years that solutions are still being made on the basis of opinions rather than actual practical, evaluated trials – and that instead of rectifying known deficiencies, unproven organisational solutions are advanced.

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Never say die?

We are encouraged to see Alex Paton, a retired physician, using his long experience in medicine to consider such an important issue as euthanasia (*Clin Med* February

2008 pp 106–7). There are aspects to Paton's article that all doctors would agree with, such as the need for even better and more widely available palliative and supportive care. We recognise too how carefully powerful tools in the care of patients such as attempted resuscitation must be used and are heartened by the British Medical Association's recent review of this.¹ However there are errors of fact and interpretation in Paton's article. To deal with them all would be wearisome but there are some which it would be wrong to leave unchallenged.

The suggestion that reluctance to kill patients is evidence of 'physicians being loath to show compassion' is at best puzzling: compassion is manifestly not exclusive to either side of this debate. The palliative care services in Oregon (we assume Paton does not mean Orlando) are fundamentally different to the UK and so much of the Oregon experience is not directly transferable.² The practice of so-called 'involuntary euthanasia' in Holland suggests fears of a slippery slope may not be quite as misplaced as Paton suggests.³

Any doctor assuming the doctrine of double effect to be hypocrisy is labouring under a misapprehension. Of the four clear criteria that must be met to invoke double effect, a cardinal one is that the intention is to relieve a symptom and not to cause the death of the patient. Recent work has shown double effect to be largely irrelevant in palliative care.^{4,5}

Advance death planning is important and this is enshrined in the new lasting powers of attorney (LPA) which have replaced the enduring powers of attorney mentioned by Paton.⁶ The great value of these lies in the discussions they provoke between patients, those close to them and their medical staff. The views expressed in LPA can change, as can individual views on euthanasia, and it is this continuing communication while the patient is still able which is so valuable.

The whole tenor of Paton's article implies an irresistible tide of natural justice in favour of euthanasia being obstructed by a small and unrepresentative minority of doctors. The vast majority of doctors working in palliative care – not 'the slimmest of margins' – are against euthanasia.⁷ There is clear evidence of the danger of taking requests for

euthanasia at face value.⁸ There is also increasing recognition, even legally, of the importance of giving patients autonomy to refuse life-prolonging treatments.⁶ We too believe passionately in a 'gentle and easy death' but know that assisted dying is increasingly peripheral to achieving this.

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Practice-based commissioning

Charlton's article (*Clin Med* February 2008 pp 61–4) throws up major challenges for UK secondary care physicians. New imperatives may change specialist care in a fundamental way; 'shifting care into the community' may destabilise existing secondary care services.

Specialist care reconfiguration cannot be moulded into a nationwide template. Some plans, for example the Independent Clinical Assessment and Treatment Service (ICATS) network proposed for Lancashire and Cumbria designed to make care more convenient to patients actually made things worse. We must weigh up local advantages