Junior doctors' hours — the chance for change?

THE struggle to improve the lot of junior doctors has been long and hard, and it is not yet over. Nor is it a struggle which general practitioners should ignore — almost every trainee reaches the practice year after three or more years in hospital and it is general practice's loss if trainees arrive tired and demoralized, their enthusiasm dampened and their desire to learn subdued.

The agreement on hours of work for doctors in training was announced in June this year,[1] after months of negotiation between the government and the medical profession. The agreement provides targets and timetables for the reduction of junior doctors' hours of work; recommendations for minimum living conditions and working conditions; and guidelines for regional task forces to oversee the changes. While the timetable of change is still too slow for many,[2] the organizational upheaval involved means that this may be the best compromise that can be hoped for. Far more worrying, perhaps, are the implications of those aspects which have not yet been agreed.

It has long been acknowledged that the education of general practitioner trainees in hospital is woefully inadequate — in 1990, 75% of respondents in the national general practitioner trainee survey stated that they thought their hospital education was unsatisfactory (unpublished results). This has been partly due to lack of time for teaching on the part of consultants. It is often, however, more related to pressure of work on the part of junior doctors who, when they do have free time, are too tired to study constructively. This deficiency is especially important to general practitioner trainees, who are more likely than others to find on-the-job learning irrelevant and to benefit from teaching aimed at aspects of the post that they are likely to encounter in the community. A major part of the new agreement is dependent on a change in the present working patterns within hospitals, with more cross-cover between specialties. However, there is a danger that this will reduce the continuity of contact with consultants and intermediate grade staff, to the detriment of continuity of teaching. Furthermore, registrars may find themselves with an increased workload as the balance of work shifts, thus reducing their availability for teaching. In-post teaching may be still further jeopardized by the increased workload of trainees while on duty, leaving them with less time to learn from individual patients and still too exhausted by the greater intensity of work for private study.

Implicit in the agreement is the assumption that reducing doctors' hours will improve their quality of life and their morale and, consequently, the standard of patient care. This simplistic conclusion is by no means assured. One of the greatest obstacles to the reduction of junior doctors' hours has been the attitude of many senior doctors who persist in the view that the junior doctors of today are merely going through the same process that they themselves undertook. Professor Sir Christopher Booth recently spent a night on call to find out more about the present situation.[3] He confirmed the view widely held among young doctors that advances in technology, increased bureaucracy, and falling standards of staff facilities have made the job of junior doctors on call today far more onerous than that of their predecessors.

The exact specifications for cross-cover have not been set and are, therefore, open to potential abuse by health authorities under pressure to comply with the working hours regulations. There may be a danger that patient care will suffer from inadequate cover if junior doctors are required to cover for yet more potential emergencies while they are on duty.

General practitioner trainees are already in the unusual position among junior hospital doctors of embarking every six months on a completely different medical specialty. Often, in such posts as obstetrics and paediatrics, they have had no teaching in the subject since medical school. Those on self-constructed training schemes may need to work in different hospitals in order to obtain jobs in popular specialties, with the added stress of starting a new job requiring new skills, in a strange environment. Induction courses are rare, and the lack of overlap between posts means that they may never meet their predecessor who knows the routine. It is not uncommon for hospital doctors to start a new job and be on call on the first day or for a weekend, sometimes being the only doctor for that specialty resident in the hospital. The hospital accommodation which may be their home for up to 110 hours a week[4] is often rundown, and the common room in which they could relax with colleagues may be limited or non-existent. In addition, the doctor may find that there is no nutritious food available outside limited hours. This must inevitably be stressful and it is hoped that the stated aims of improving living conditions in the hospital and of reducing working hours may go some way towards alleviating this. Yet these very aims may produce other problems.

By working for long hours within a specialty, which included routine ward work, and being able to ask colleagues for advice, the stress of feeling bewildered was relatively quickly dispelled. Under the proposed agreement if general practitioner trainees are on call, covering areas in which they have no expertise, with no opportunity to consolidate their knowledge with everyday work, this demoralizing feeling may be perpetuated. It should be noted, however, that for general practitioner trainees, unlike some potential specialists, the provision of cross-cover may, with sensitive handling and adequate senior cover, be advantageous. It may allow them useful experience in, for example, ear, nose and throat specialties and ophthalmology, which tend to be poorly taught at undergraduate level, despite forming a major part of a general practitioner's work.

Reducing the hours of doctors in training offers them a real chance to improve their quality of life and to embark with enthusiasm on a career in general practice. It would be sad if such advantages were not used to the full and if one set of problems were substituted for another in the name of progress.

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References

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